

# *Diversity Our Strength*

## ***LGBT Tool Kit***

*For Creating Lesbian, Gay,  
Bisexual and Transgendered  
Culturally Competent Care at Toronto  
Long-Term Care Homes and Services*

"We have to make sure that if you go into a long-term care facility you're not forced back into the closet..."

*The Honorable George Smitherman  
Minister of Health and Long-Term Care  
Xtra-September 27, 2007*

"By taking a leadership role aimed at eliminating discrimination and disadvantage, we recognize that a fundamental strength of our community lies in our unique racial and ethno-cultural diversity."

*Mayor David Miller  
Proclamation of Pride Week- June 15-24, 2007*

"We are committed to making our homes a compassionate option for all Toronto citizens, including LGBT seniors."

*Ms. Sandra Pitters  
General Manager - Toronto Long-Term Care Homes and Services  
New Options in LGBT long-term care- City of Toronto- July 2007*

"As older LGBT people age, they fear receiving inappropriate and insensitive care..."

*Mr. Dick Moore  
Older GLBT Programmes Coordinator  
The 519 Community Centre  
Rebuilding Respect - A progress report for seniors -  
City of Toronto - November 2002*

"We have been made to feel very comfortable at the home. This includes me as his partner. From everyone we have encountered, we have been made to feel welcomed."

*Partner of a new resident admitted into one of the  
Toronto Homes for the Aged, March 2008*

## ***Acknowledgements:***

Toronto Long-Term Care Homes and Services would like to thank and extend our sincere appreciation to the following individuals who not only participated on the lesbian, gay, bisexual, and transgendered (LGBT) Diversity Initiative Steering Committee, but also contributed on the various work groups that set the course for Toronto Long-Term Care Homes and Services in developing the cultural competence that is required in providing care and services for LGBT residents and clients. Without their contribution and thoughtful, and sometimes provocative input, this Tool Kit would not have been possible.

Anna Travers – Sherbourne Health Centre

Dick Moore – The 519 Community Centre

Matt Hughes – Community Member and Member of Fudger House Advisory Committee

Gay Thomson – Concerned Friends

Jack Harmer – Member of the Advisory Committee on Toronto Long-Term Care Homes and Services

Pat Prentice – Ontario Association of Residents' Councils'

Mary Diamond – Ministry of Health and Long-Term Care

Maylin Poon – Toronto Central Community Care Access Centre

Sandra lafrate – Toronto Central Community Care Access Centre

Catherine Anastakis – Toronto Central Local Health Integration Network

Brian Nicholson – Fudger House

Patty Carnegy – Toronto Long-Term Care Homes and Services

Sally Martin – Fudger House

Doreen Calvin – Toronto Long-Term Care Homes and Services

Greg O'Grady – True Davidson Acres

Erin Mulcahey-Abbott – Toronto Long-Term Care Homes and Services

Bob Petrushewsky – Kipling Acres

Sandra Pitters – Toronto Long-Term Care Homes and Services

Michael Saunders – Toronto Long-Term Care Homes and Services

*In addition to the members of the formal LGBT Steering Committee, we are also grateful to the many participants who supported this initiative through various workgroups and consultation sessions. Your dedication and input was invaluable.*

## Table of Contents

Introduction .....	1
A Wake-up Call for Toronto Long-Term Care Homes and Services .....	3
The Beginnings of Our Journey .....	5
Crafting an LGBT-Inclusive Tool Kit .....	6
LGBT Cultural Competency Framework .....	7
Getting a pulse on the social landscape of the home .....	8
Organizational Change and Leadership... learning that LGBT residents, family, volunteers and staff already do exist in our homes .....	9
Creating an LGBT Welcoming Environment .....	11
Gay-Straight Alliance .....	13
Governance and Administrative Processes .....	17
Privacy and Confidentiality .....	20
Human Resources and Staffing Practices .....	23
Staff Education .....	25
Volunteers .....	30
Resident Care and Planning (including companion document: Admission Assessment) .....	33
Leisure Activities and Social Programs: Program Assessment, Program Plan, Planning Template .....	41
Community Engagement .....	49
Self Assessment for a Long-Term Care Home ... beginning the journey towards an LGBT welcoming environment .....	50
Measuring Success Within the Organizational Culture .....	53
Appendix A: LGBT History From the 1900s to Present .....	55
Appendix B: Recommended Steps to Inclusivity .....	69
Appendix C: Principles of a Collaborative Service Model .....	70
Appendix D: Terms of Reference for the LGBT Diversity Initiative Steering Committee .....	71

continued

Appendix E: LGBT Inclusiveness – Personal Assessment Tool .....	74
Appendix F: Glossary and Definitions .....	76
Appendix G: Residents Rights and Responsibilities .....	81
Appendix H: Ethics and Research Committee Policy .....	82
Appendix I: Intimacy and Sexuality Policy .....	91
Appendix J: LGBT Training Plan for Fudger House, True Davidson Acres and Kipling Acres .....	94
Appendix K: Training Resources-Educational LGBT Videos .....	96
Appendix L: Policy Recommendations and Best Practices for Agencies Working Towards Trans Accessibility .....	97
Appendix M: Top Gay Films .....	98
Appendix N: Tool Kit Activities Program Template .....	100
Appendix O: Program Evaluation and Possible Indicators .....	101
Appendix P: Internet Sites .....	103
Appendix Q: Ask the Advocate Newsletter Submission .....	106
Appendix R: Health and Social Services Needs of Gay and Lesbian Elders .....	107
Appendix S: Coming Out to Care .....	118
Appendix T: Rainbow Health Ontario .....	132
Tool Kit Evaluation .....	133

# *Introduction & Wake-up Call*

*Diversity  
Our  
Strength*



## Introduction

A reasonable estimate is that Ontario is home to at least 1.25 million people who self-identify as lesbian, gay, bisexual, and transgendered (LGBT). Depending on the source, it is estimated that seven to 10 per cent of the Canadian population is LGBT, and that number could be higher in large urban centres like Toronto. After decades of struggling to become a legitimate and valued segment of our diverse Canadian society, it is only recently that changes in human and legal rights have begun to create a more equitable landscape for sexual and gender minority communities.

LGBT seniors lived during a time when it was commonly believed that homosexuality was a sin, crime or mental illness. In the past, many LGBT seniors were imprisoned for "crimes" that no longer exist in today's society. Most LGBT seniors were already adults before the gay liberation movement of the 1970s. For them, it was impossible to be openly gay and be safe from violent attacks, harassment, imprisonment, loss of employment and rejection by their families. Although gay and lesbian organizations existed in major urban areas in the 1960's, it was not until the Bath House Raids in Toronto on February 5, 1981 that lesbians and gays formally organized a movement to counter unfavourable media releases and the homophobic attacks from the police. (Please see Appendix A for additional historical facts.)

With the formation of positive gay and lesbian organizations and early newspapers, such as *The Body Politic*, LGBT Canadians began to realize that they had a long and rich history that they could reclaim. This important shift in the formation of the gay liberation movement empowered many to realize that LGBT people could acknowledge and be proud of a rich historic past and could influence and change their future.

**Recognition of Life Influences:**  
Today's LGBT seniors most likely have faced specific life factors that impact on their sense of self and security when entering a long-term care home. These factors include, but are not limited to:

- (i) the "coming out" process;
- (ii) societal oppression (e.g. homophobia);
- (iii) threats to economic security (e.g. housing, employment);
- (iv) internalized oppression;
- (v) loss of family support;
- (vi) personal loss of friends and loved ones (i.e. through AIDs);
- (vii) isolation and alienation; and
- (viii) concerns with aging.

These influences may impact on the ability to be open about sexual orientation or gender identity with the long-term care staff. LGBT persons may feel uncomfortable, anxious, vulnerable or afraid of negative responses should they disclose their sexual orientation and sexual identity.

**"You did what you knew  
how to do, and when  
you knew better, you did  
better."**

***Maya Angelo***

Today, a vast majority of the LGBT seniors over the age of 65 years have lived most of their lives in an environment of overt discrimination and hostility. For many, given the times and societal views, they have experienced different forms of abuse as a result of their sexual orientation and gender identity. For many, it was impossible to be openly gay and to feel safe.

Now, perhaps at a different time in their life where they require the services and programs offered within a long-term care home setting, many LGBT seniors report heightened fear and anxiety should they disclose their sexual orientation to service providers within both health and social service agencies and have little faith and confidence that they would not experience further victimization. Within current literature and research, it indicates that LGBT elders are five times less likely to use services than the population at large as a result of this fear. In addition, there is significant evidence that demonstrates that the needs of LGBT seniors are not well served within the mainstream health care system and certainly is not being addressed within the long-term care sector itself.





## **A Wake-up Call for Toronto Long-Term Care Homes and Services**

Our wake-up call came during an initial interview at Fudger House when a new resident and his partner expressed concern over the absence of a gay-positive environment. We realized then that gay and lesbian clients need evidence in our homes that the LGBT community has been recognized, supported and welcomed in order to feel "at home."

Through research, we learned that many staff members were under the impression that all residents were heterosexual. Since approximately seven to ten per cent of the general population is LGBT, it is acceptable then to assume a similar percentage of our residents, clients, volunteers and staff might well be identified as LGBT. Administration and program planners were often surprised to learn that there may be LGBT residents currently residing within the home or amongst the clients we serve, and sometimes have difficulty in understanding that that this may also include staff and volunteers.

**"A classical scholar, a musician, a meat cutter, a hair stylist, a ballet dancer, an elementary school teacher, a teacher's aid, a minister, a priest, a social worker, an acquisition clerk, a furniture salesman, a janitor, a personal care worker, a nurse, an administrator, a doctor, a line cook, a fund raiser, a secretary. Who are these people? They are LGBT residents in our homes, their friends, families, members of our staff that have bought into creating a gay-positive environment in our homes."**

**Matt Hughes**



## *The Pink Triangle*



The history of the pink triangle begins before WWII, during Adolf Hitler's rise to power. Paragraph 175, a clause in German law prohibiting same-gender sexual relations, was revised by Hitler in 1935 to include kissing, embracing, and gay fantasies, as well as sexual acts. Convicted offenders—an estimated 25,000 people just from 1937 to 1939—were sent to prison and later to concentration camps. As punishment, they were sterilized, often through castration. In 1942, Hitler increased the punishment to death.

Each prisoner in the concentration camps was forced to wear a colored inverted triangle to indicate their reason for incarceration, and hence the designation also created a type of social hierarchy. A green triangle marked its wearer as a regular criminal; a red triangle denoted a political prisoner; two yellow triangles overlapping to form a Star of David designated a Jewish prisoner; the pink triangle was for men suspected of being gay; a yellow Star of David under a superimposed pink triangle marked the lowest of all prisoners: a gay Jew.

Stories from the camps indicate that gay prisoners were often given the worst tasks and labors. Pink triangle prisoners were also frequently attacked by the guards and even by some other inmates. Although gay prisoners reportedly were not shipped en masse to the death camps at Auschwitz, many gay men were among the non-Jews who were killed there. Estimates of the number of gay men killed during the Nazi regime range from 50,000 to twice that figure. When the war was finally over, many gay men continued to be imprisoned in the camps, because Paragraph 175 remained the law in West Germany until 1969.

In the 1970s, gay liberation groups resurrected the pink triangle as a popular symbol for the lesbian and gay rights movement. Not only is the symbol easily recognized, but it draws attention to oppression and persecution—then and now. In the 1980s, ACT-UP (AIDS Coalition To Unleash Power) began using the pink triangle to draw attention to the impact of AIDS on the gay community. They inverted the symbol, making it point up, to signify an active fight back rather than a passive resignation to fate. For many people today, the pink triangle represents pride, solidarity, and a promise never to allow a Holocaust to happen again.

# *Beginning the Journey*

*Diversity  
Our  
Strength*



## **Toronto Long-Term Care Homes and Services: The Beginnings of Our Journey**

Once Toronto Long-Term Care Homes and Services became aware of this disparity in service provision, the division set-out to establish LGBT positive and welcoming communities within our homes that could respond to this gap in service provision, facilitate and promote opportunities for inclusion, while at the same time continuing to enhance residents' quality of life and quality improvement. (Please see Appendix B regarding Steps to Inclusivity.)

In 2004, the division began establishing a gay-positive environment at Fudger House and successfully established a collaborative model of care in association with both the 519 Church Street Community Centre and the Sherbourne Health Centre, both organizations are champions within the LGBT community and have provided expert advice, consultation, collaboration and first-hand experiences that have guided and continues to bring value to the ongoing work within this initiative. A collaborative model of care is seen as essential to the success of this initiative and for it to be sustainable. (Please see Appendix C regarding the Principles of Collaborative Service Model). This initial work was dedicated to developing awareness, training and education and set the foundations for a strong and committed alliance. This initial stage is referred to as phase one within the division's LGBT diversity initiative.

In fall 2006, with the knowledge and awareness gained through the Fudger House journey, Toronto Long-Term Care Homes and Services continued to build on the strengths achieved through phase one and transitioned into phase two. The scope was broadened and the initiative was expanded to include two additional homes (Kipling Acres and True Davidson Acres). As well, a dedicated and vibrant LGBT Steering Committee was established to help guide and provide expert advice to the division on this initiative. (Please see Appendix D for the LGBT Diversity Initiative Steering Committee Terms of Reference.)

Most of the current literature and research focused on LGBT diversity and inclusion have been developed within the environment of a primary or mainstream health or social service agency. There are significant contributions and examples of this leading work through the undertakings of GLBT Health Access Project in Boston Massachusetts and the Halifax Rainbow Health Project, just to name a few.

While this has provided valuable context, assisted in conceptualizing a working framework and flagged lessons learned for the undertakings within this initiative, it is also extremely important to acknowledge that long-term care homes are very different, and can be more complex when attempting organizational change and in creating a welcoming community for LGBT residents, their families and friends, volunteers and staff.

**"When you make a thing, it is so complicated making it that it is bound to be ugly, but those that do it after you they don't have to worry about making it and they can make it pretty, and so everyone can like it when the others make it."**

*Gertrude Stein*

## **Crafting a LGBT-Inclusive Tool Kit for Toronto Long-Term Care Homes and Services**

This tool kit was specifically developed from the experiences and celebrations of the LGBT Diversity Initiative Steering Committee. The goal is to help guide the remaining Toronto Long-Term Care Homes and Services in establishing cultural competencies in providing care and services for LGBT residents, partners and their friends, while also creating a welcoming environment for volunteers, staff and the local community at large who comes in contact with the homes and programs.

The definition of cultural competence that has been utilized as a framework and context in the formation of the tool kit is "cultural competence is defined as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables the system, agency, or those professionals to work effectively in cross-cultural situations" (*Source: Adapted from Cross et al., 1989; Isaacs and Benjamin, 1991*).

While there are some very helpful examples within the literature regarding primary health and social service agencies where they developed both criteria for standards and indicators within the implementation for LGBT inclusion, our approach acknowledges the different complexities of a long-term care home environment and have modeled the Tool Kit within a self assessment/checklist approach in making a long-term care home LGBT welcoming. Using the self-assessment approach, the home is then able to use their findings to chart out home-specific opportunities for their consideration.

The Tool Kit is the culmination of six working groups, each assigned to a specific area of focus and contribution for the Tool Kit and thereby creating a roadmap to developing cultural competency in providing care and services to an LGBT population. These are:

- ✧ Welcoming Environment
- ✧ Administrative Processes
- ✧ Programs and Services
- ✧ Nursing and Personal Care
- ✧ Staff and Volunteers
- ✧ Community Engagement

In crafting the Tool Kit, the Steering Committee felt obliged to share information and facts throughout the body of the Kit. Depending on which section of the Tool Kit is being reviewed, several of the salient facts are often re-stated. This is not by accident. In drafting the Tool Kit, the Steering Committee felt that by not including these facts in the various sections it would have been a significant omission or consideration in developing leading practice within this initiative.

And finally, the Steering Committee also included an extensive appendix section within the Tool Kit. While this is not an exhaustive listing of pertinent and supportive information within the LGBT initiative, the information that has been included is meant as a helpful resource and supplements and augments the material presented within the Tool Kit itself.

# LGBT Cultural Competency Framework

## Programs and Services:

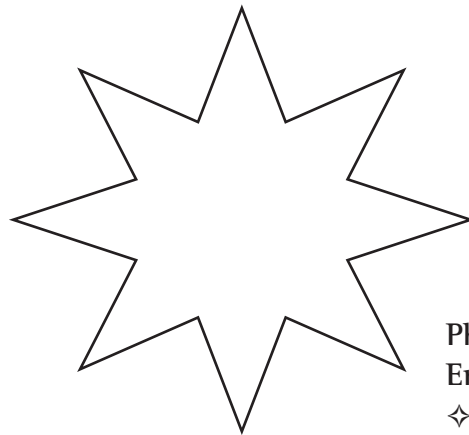
- ✧ Are designed to meet the physical, social, emotional, and spiritual needs of LGBT residents.
- ✧ Are delivered with sensitivity to the history of oppression of LGBT people.

## Governance

- ✧ Toronto Long-Term Care Homes and Services are leading this initiative to respond to the needs of LGBT communities.
- ✧ Policies and strategies are created and communicated to senior staff to the needs, strengths and priorities of clients/communities.

## Human Resources

- ✧ Includes robust anti-discrimination and anti-harassment policies.
- ✧ Creates hiring policies to welcome and promote people from LGBT communities.



## Communications

- ✧ Written and graphic materials are welcoming and inclusive of LGBT residents, families, volunteers and staff.
- ✧ LGBT people are consulted about their needs and issues and are able to register concerns or complaints.

## Community Relations

- ✧ LGBT people and organizations are sought out and welcomed as participants in the daily life of the homes.
- ✧ The Division/specific homes celebrate significant LGBT events with the community.

## Physical Facility and Environmental Design

- ✧ Design and decor provide a welcoming environment for LGBT communities.
- ✧ Care and attention to safety are shown in selecting room-mates or in the sharing of facilities.

## Getting a pulse on the social landscape of the home

When considering an LGBT welcoming and inclusive home, the first step is to become aware and informed about the environment of the home itself. Would the home welcome the opportunity to be identified as LGBT inclusive? What processes currently exist that would support and enable this initiative in the home?

This approach provides the home the opportunity to begin to identify some of the systemic issues and barriers that will need to be addressed prior to initiating an LGBT welcoming environment within the home. Some of the areas that should be considered at this stage of the process are:

- Valuing diversity is reflected in the home's Values Statement.
- Diversity is inclusive of sexual orientation and sexual identity.
- Anti-discrimination and workplace harassment policies are in place and understood by all stakeholders of the home.
- An anti-discrimination statement is visibly posted in an area within the home, stating that equal care will be provided to all, regardless of age, race, ethnicity, physical ability or attributes, religion, sexual identity and gender identity.
- Management staff demonstrates a level of comfort and competence in utilizing the anti-discrimination and workplace policies and tools in mediating situations that have occurred within the home that compromises human rights, etc.
- Assess all policies, guidelines and practices of the home to determine if they contain any barriers to LGBT inclusion.
- The home is willing to increase their knowledge and learn about the issues in providing LGBT inclusive services and programs, i.e. review the literature/research and reach out and learn about LGBT inclusive agencies within the local community.



## **Organizational Change and Leadership ...**

*learning that LGBT residents, family, volunteers  
and staff already do exist in our homes*

Transformational change occurs over a period of time and no single activity leads to permanent change.

- ❑ The first step usually begins with the management team beginning a dialogue regarding the gap in services and programs offered by the home to LGBT residents and their family and friends. This dialogue might be initiated with the management team by self-administering the Personal Assessment Tool (Please see Appendix E) as a launching point for this discussion.
- ❑ The next step is for the management team of the home to liaise with staff from local LGBT community agencies. These partners are invaluable for providing education and information to the managers of the home.
- ❑ This awareness, effort and approach will assist the long-term care home lead to develop the beginnings of a plan that will demonstrate LGBT cultural competency. Cultural competency refers to a set of congruent behaviors, attitudes and policies that enables the system to work effectively with diverse populations and to provide care and services in a sensitive, meaningful and knowledgeable manner.
- ❑ As the home management team begins to extend itself into the LGBT community and builds awareness, they learn that community organizations are often able and very willing to offer educational guidance.
- ❑ The management team should attend educational conferences offered by external organizations such as LGBT community or health centers. Workshops can be arranged by parent organizations or Head Office staff. Printed material is available on the Internet and readings are discussed at management meetings.
- ❑ Once the management team is comfortable with the concepts and the language associated with the LGBT community (see Appendix B- Glossary), they can begin to identify openly gay and lesbian residents and family members, staff, volunteers and community stakeholders. Some are invited to join the various committees already in place to begin a dialogue. These discussions are the beginning of a continuing educational component for residents, staff, families, and volunteers.
- ❑ Input and progress reports are communicated to a variety of stakeholders, including the Home Advisory Committee, Residents' Council, Family Committee, residents, families, staff and volunteers. Input and feedback from these groups will assist the managers to develop programs that are sensitive to the needs of LGBT residents.



### ***The Black Triangle***

Like the pink triangle, the black triangle is also rooted in Nazi Germany.



Although lesbians were not included in the Paragraph 175 prohibition on same-gender sexuality, some seem to have been imprisoned for "anti-social behavior" and designated with a black triangle. As the pink triangle has historically been a male symbol, the black triangle has similarly been reclaimed by lesbians and feminists as a symbol of pride and solidarity.

# *Welcoming Environment*

*Diversity  
Our  
Strength*

## Creating an LGBT Welcoming Environment

All of the literature and research reviewed within this initiative demonstrates the importance and significance of creating a welcoming, positive and safe environment as one of the initial steps in providing competent and appropriate care for LGBT seniors. While this may seem a simple task in the process, creating a welcoming and safe environment for LGBT seniors can be a monumental and somewhat complex undertaking.



“Positive Space” is a program that was developed at the University of Toronto in 1996 and has now been adopted at most universities in Canada. Positive Space refers to an agency that is open and welcoming, as well as equitable and accessible to persons of all sexual and gender diversities, both to clients and employees of the agency. The term also refers to an agency in which all staff has been trained to understand the issues around sexual and gender diversity and are familiar with human rights, diversity and resources. (Ontario Public Health Association: A Positive Space is a Health Space. June 2006).

From the research reviewed by the Steering Committee, we adopted and adapted a simple framework from the “National Health Service in Scotland” toward achieving effective, culturally competent LGBT care and creating a welcoming environment. This simple framework includes:

**See:** In the physical environment, is there evidence of positive signs and symbols displayed throughout the home:

- Written, graphic materials, images, artwork and signage welcomes and are inclusive of LGBT people to the home. This could include displays of the rainbow flag, images of same-sex couples, posters and information relevant to the local LGBT community, display of the homes participation at the Pride Parade, announcements of upcoming community meetings with LGBT inclusive local agencies, as examples;
- LGBT literature and materials, such as newspapers, magazines and brochures are accessible in common areas of the home, i.e., front lobby sitting area, a LGBT section in the homes library, LGBT themed videos and DVDs, inclusion and announcements of LGBT programs and services being offered in the home are included in newsletters;
- Written materials offered to the public clearly reflect non-discrimination policies and practices and reflects a LGBT welcoming environment. This would include information provided to the public during tours of the home;

- Programs with an LGBT focus or interest are advertised or promoted through the resident newsletter, posted in the home and/or announced as a special program; and
- Promotional material prepared by the home, i.e., fact sheet and informational material shared with the Community Care Access Centre, Ministry of Health and Long-Term Care, Local Health Integration Network, etc. reflects the homes initiative to provide a LGBT welcoming environment.

**Hear:** The language heard within the home reflects:

- Written forms and assessments do not assume heterosexuality as the norm, i.e., the use of partner instead of husband/wife;
- There is a broad definition of family to include "family of choice;"
- Staff and volunteers are knowledgeable and comfortable in the use of inclusive language and it is reflected in their language in day-to-day discussions  
(Please see Appendix F for the Glossary and Definitions);

**Feel:** The environment gives a sense of being safe and affirming:

- LGBT residents and their families and friends identity is acknowledged, affirmed and respected;
- There is recognition of residents/family rights and reminders that the home is a safe place. An example of this would include the care and attention taken by the home in selecting roommates or in the sharing of the facilities' common spaces. This holds particularly important and affirming for older LGBT adults receiving care and services;
- There are accessible and supportive processes available in the home that allows residents, family, volunteers and staff to raise issues and concerns, feel that they are heard and that issues will be followed-up on and mechanisms to ensure two-way communication.

While physical safety is an important aspect in ensuring that the environment is LGBT welcoming, it is equally important to consider the aspect of privacy and understand the special importance it can mean to LGBT individuals. (Privacy as a safeguard will be more fully discussed in the Governance and Administrative Processes section of this Tool Kit.)

## **Gay-Straight Alliance**

One important strategy that would be strongly encouraged early on within this initiative is to develop a Gay - Straight Alliance (GSA) within the home. It is also important to understand that given the demographics, this opportunity of developing a Gay-Straight Alliance not only directly benefits residents, but also has the opportunity of benefiting family members, volunteers and staff.

### ***What are the benefits of a Gay - Straight Alliance?***

Developing a GSA within a long-term care facility can provide the necessary guidance, and assistance in supporting, planning and implementing LGBT initiatives, such as:

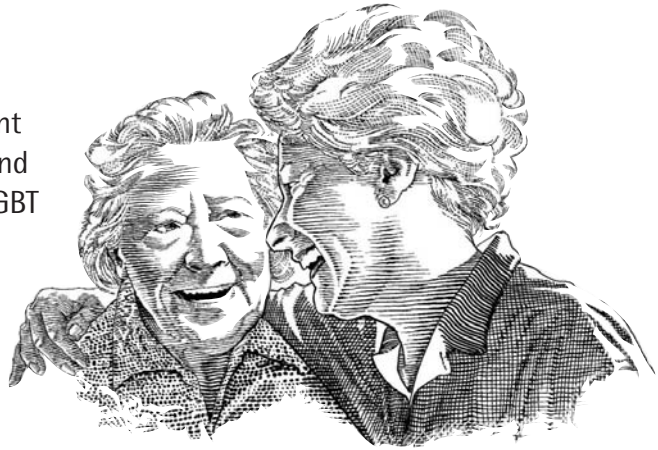
- ✧ The development of inclusiveness through expansion of Residents' Council, Family Councils/Committees, Home Advisory, volunteer and community partnerships that support programs and services for LGBT residents, their partners, families and related community;
- ✧ Increase opportunities for self-identified LGBT members within the community of the home;
- ✧ The development of a safe and comfortable environment in which LGBT related issues, such as sexual orientation, gender identity, homophobia, discrimination and harassment, are openly discussed;
- ✧ The provision of a safe and private space for residents, their partners, families, staff and volunteers who are self-identified and may be fearful of disclosing their identity as gay, lesbian, bisexual or transgendered;
- ✧ The education of the broader long-term care community about sexual orientation, gender identity and other LGBT related issues;

### ***What is a Gay-Straight Alliance (GSA)?***

The primary focus of a GSA is a collective response to the development of a leading practice approach in implementing LGBT diverse, inclusive, integrative and welcoming environments. In the initial stages, it could focus on education and exchange of ideas or social programs and leisure services that meet the needs of LGBT residents.

A GSA is queer friendly, gay and straight individuals and or group that consist of residents, family, partners, volunteers, staff and community members. A GSA works together to discuss LGBT related issues and are proactive in developing programs and services that meet the diverse needs of LGBT residents within the home, as well as ensuring a welcoming LGBT environment within existing programs and services. A GSA within a long term care home encourages all residents, families, volunteers and staff to develop and build a welcoming and mutually respectful community for LGBT residents, their partners, families, volunteers and staff. The Rainbow Pin can be used as a symbol of a GSA in the home.

- ✧ The promotion of community engagement by inviting external speakers to discuss and educate on particular topics related to LGBT history and LGBT societal contributions;
- ✧ The organization of Pre and Post Pride Week Celebrations and other special events related to the LGBT population;
- ✧ The provision of social opportunities for interaction within the home and the community at large; i.e., barbecues, film nights, themed special events, theatre, integrated and specialized programs/activities, etc.;
- ✧ The promotion of LGBT Awareness Events via educational workshops, seminars and role play, etc.;
- ✧ To help recruit LGBT sensitive volunteers for involvement in LGBT programs and services within the Home;
- ✧ To be identified as an employer and an organization of choice amongst potential staff members; and
- ✧ To leverage change and acceptance through innovation of LGBT programs and services.



## ***How to Develop a Gay-Straight Alliance (GSA)***

### **Step 1**

#### *Find a Leader or Champion*

Identify an individual; a champion within your home who is LGBT culturally competent, supportive and has demonstrated themselves to be an ally around LGBT issues. This champion can be a staff member, volunteer, family member and/or a resident.

### **Step 2**

#### *Gaining Support for a GSA*

Meet and liaise with the administrator and management team to discuss your plans for forming a GSA. They will provide guidance, support and will advocate on your behalf with residents, families, staff and volunteers, the Residents and Family Councils and the Home Advisory. They will be able to suggest and recommend other individuals who may be interested in joining the home's GSA.

Meet with the Home's interdisciplinary Teams, Residents Councils and Family Council/Committee and Home Advisory to discuss your plans on forming a GSA. This is another vital avenue for gaining support and recruiting GSA participation.

### Step 3

#### *Advertise*

Maximize all avenues to introduce and communicate your plans for developing a GSA. Advertise in the home's newsletters, post flyers and by word-of-mouth. In your communication strategies schedule a first meeting. Once the GSA is established, provide ongoing communication updates of the home's GSA progress and LGBT initiatives to residents, staff, volunteers and the community at large.

### Step 4

#### *Find a Meeting Place*

Select a location within the home that provides a level of privacy where confidentiality can be maintained.

### Step 5

#### *Your Initial Meeting*

Welcome all individuals; reinforce that this meeting provides an environment of safety, respect and confidentiality to residents, family members, partners, staff and volunteers present. Provide an overview and discuss the purpose for developing a GSA within your home.

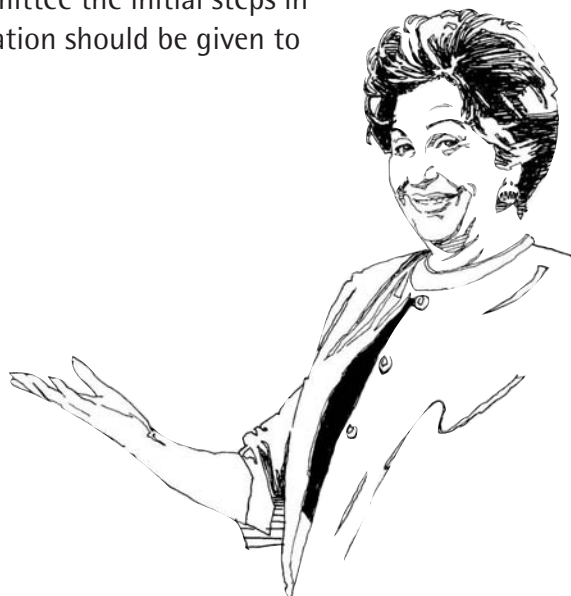
### Step 6

#### *Plan for the Future*

Develop a meeting schedule. Identify potential LGBT programs and services that will support the home's GSA purpose; identify potential champions who can bring these LGBT program and service initiatives to fruition; learn about what is going on in the community that will foster community engagement and support.

Through the experience of the Steering Committee the initial steps in launching the gay-straight alliance, consideration should be given to consult, collaborate and include:

- ✧ Residents' Council;
- ✧ Family Councils/Committees;
- ✧ Volunteer Liaison;
- ✧ Home Advisory Committee;
- ✧ General Staff Meetings; and
- ✧ Linkages with local community service providers.



## ***Bisexual Triangles***



Developed in 1987 by Liz Nania, the bisexual triangles or bi angles consist of pink and blue triangles that overlap to form a purple triangle. As pink and blue have traditionally signified female and male, respectively, the purple represents the attraction of bisexuals to individuals of different genders. The use of the pink triangle also links the symbol to the oppression of people who love others of the same gender, which bisexuals have likewise experienced.

## ***IFGE Symbol***



The IFGE (International Foundation for Gender Education) Logo, or Transgender Symbol, is the widely recognized symbol for or crossdressers, transvestites, transsexuals and transgenderists.



# *Governance & Administration*

*Diversity  
Our  
Strength*



## **Governance and Administrative Processes**

Toronto Long-Term Care Homes and Services' Home Advisory Committee fulfills many of the governance functions that would be traditionally expected of a Board, and it is vitally important to inform and include the Home Advisory Committee members early on in the process of launching the LGBT initiative in the home. As already identified in the Gay-Straight Alliance section of the Tool Kit, members on the Home Advisory have an opportunity to become "ambassadors of the initiative" either through actively participating in the home's Gay-Straight Alliance, or depending on the member, self-identifying as a member of the LGBT community.

This could include:

- Diversity and LGBT inclusion is understood by all Home Advisory Members, management, volunteers, staff, affiliates and community agencies/organizations.
- The anticipation that the Home Advisory would publicly go on record stating their commitment to being an LGBT inclusive organization.
- Diversity and LGBT inclusion in the home's strategic plan.
- Diversity support by local union representatives, i.e., Shop Stewart.

As identified within the welcoming environment section previously discussed in this Tool Kit, and building on the "See-Hear-Feel" framework, another important aspect for consideration within this initiative is administrative processes.

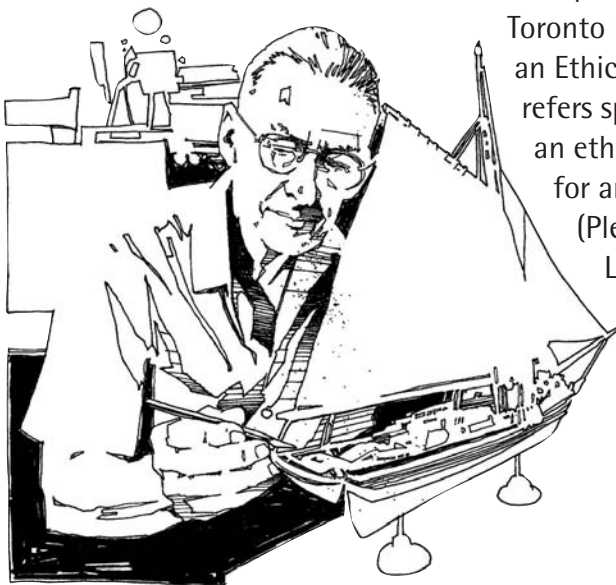
Within this administrative processes section, it is recommended that the long-term care home consider:

- Policies and procedures. All policies and procedures (both current and future) need to be viewed with a lens for inclusivity. Are there any barriers to the LGBT initiative?
- Administrative forms. Toronto Long-Term Care Homes and Services' administrative forms will be addressed further in this section of the Tool Kit;
- Privacy and confidentiality practices. Privacy and confidentiality practices will also be highlighted further in this section of the Tool Kit;
- Residents' and Clients' Rights. Highlighted within the Toronto Long-Term Care Homes and Services "Residents' Rights and Responsibilities" are the residents' rights

**At the "Opening the Closet on Aging" conference held on April 9, 2008, one of the audience participants at the plenary session of the conference indicated that administrative forms that included and acknowledged her and her partner, and that did not have to be revised or adapted when they were being interviewed would be a significant "validation of her life."**

to participate in decision-making, form meaningful relationships, be treated with respect, openly express concerns, receive care and services that supports one's health and well-being, have cultural preferences respected, privacy respected, as to personal space as well as in the provision of care and treatment, have all personal, financial and medical information kept in confidence, live in a safe environment, display personal possessions and expect staff to respect the residents' personal property and expect staff to be knowledgeable of residents' rights and responsibilities and to implement these rights to care. *(Please see Appendix G for a listing of Residents' Rights and Responsibilities);*

- Standards of Employee Conduct are available, regularly reviewed and understood by all staff. Particular attention and ongoing dialogue with staff should include: confidentiality, respect for others (including the Residents' Bill of Rights), and following instructions (which includes reference to Professional Standards);
- Anti-discrimination and harassment policies are in place;
- There are established policies and practices to address issues of anti-discrimination and harassment and they are used effectively by the management staff when addressing these issues/concerns;
- Review and assess all policies, guidelines and practices to determine if they contain any systemic barriers to inclusion;
- Valuing diversity is included in the home's Mission, Vision and Values statements;
- A process is available to ensure that as policies and procedures are developed in the future, they be examined to ensure inclusive wording. Toronto Long-Term Care Homes and Services has an Ethics Committee that the General Manager refers specific draft policies to for review using an ethics lens. This same process could be used for any questions regarding inclusive wording. *(Please see Appendix H to review the Toronto Long-Term Care Homes and Services Ethics and Research Committee policy);*
- Access to an Ethics Committee and/or consultation as issues/concerns arise (and this would help to bring in awareness of ethical dilemmas) and what resources might be available to help address issues/concerns;



- ❑ All promotional materials for the home are reviewed and services and programs are LGBT inclusive. This would include all written material, i.e., brochures, fact sheets, materials used to promote the home and provided to participants on tours of the home, website etc.; and
- ❑ Strong linkages and partnership with the local Community Care Access Centre, Ministry of Health and Long-Term Care, Local Health Integration Networks, etc. in order to inform and communicate the unique LGBT program and services to perspective applicants.

Administrative forms and the associated assessments required within a long-term care home can have a significant impact on the sense of being welcomed, acknowledged and validated by the individual and those significant to them.

Review all forms used and implemented by the home for wording regarding marital status and gender. For Toronto Long-Term Care Homes and Services, many forms already use inclusive language (however, there are provincial forms which are not reflective of this inclusivity).

Examples and suggestions to be aware of, and sensitive to, would include:

- ✧ Delete the use of marital status within forms and revise to state relationship;
- ✧ Delete the identification of male and female from forms and substitute gender identity;
- ✧ Change personal data and family history to family medical history;
- ✧ Forms that require family signature, revise to signature and relationship;
- ✧ Forms that require spouse's name, revise to enter partner's name;
- ✧ On forms that reference family involvement, revise the wording to read social network of family and friends;
- ✧ On forms that provide a space to enter relationship, provide a code to allow entry for spouse, partner, family member, other;
- ✧ On forms that require next-of-kin's last name, enter Substitute Decision-Maker or primary contact;
- ✧ Develop a process and forms for admission and assessment that provides an option for self-identification in all categories of gender identity, sexual orientation, marital/partnership and family status, providing individuals with the opportunity for written explanation, if desired; and
- ✧ Finally, when completing both administrative processes and assessments, the use and comfort with language used by staff can be a significant indicator in making an inclusive and welcoming environment.

## **Privacy and Confidentiality**

In general, assurances in providing care and services in a private and confidential manner is paramount in creating a "safe" place and is essential in meeting the psychological, social, intellectual and cultural needs of all our residents and clients. However, for LGBT seniors, this may be more pronounced and play an even more significant role in their comfort level with the services and programs provided to them by the home.

Making public ones' sexual orientation or "coming out" is often a gradual, ongoing and personal process. Some people may be "fully out", "not out to everyone" or in all aspects of their lives, or may never "come out" to anyone other than themselves. As a result, the home needs to understand and respect that the designation of sexual orientation and gender identity in any public way on any public forms or records should remain confidential and private, and respect the resident's choice as to how the information is used.

This can create some difficulty and ethical dilemmas within our long-term care homes' environment where care and services are provided within an interdisciplinary model. What happens when information is disclosed to one of the members of the team but not to other members of the team? A resident might have shared information regarding their sexual orientation with staff but not with their family of origin. While staff are guided through policies and practices in their need to keep information confidential, a good "rule of thumb" is to ask the resident who else knows and to clarify how the resident would want this information shared.

## ***Profound Invisibility of Older Gays and Lesbians***

**"Past and current experiences of stigma reinforce, in the minds of many lesbian and gay seniors, a vigilance in maintaining secrecy over their sexual orientation. Other seniors may feel it necessary to deny a same-sex relationship for fear of being badly treated in the long-term care network. Many seniors are often cautious about disclosing their sexual orientation. Consequently, they remain profoundly invisible in most segments of society. Older gays and lesbians are hardly ever seen in mainstream senior networks, in health care institutions, and in society."**

***The Health and Social Service Needs of Gay and Lesbian Elders and Their Families in Canada- Shari Brotman, Bill Ryan, Robert Cormier. (Gerontologist).***

*(Please see Appendix R)*

**"It is time we pay serious attention to our gay and lesbian residents.**

**I have known there have been gays and lesbians living here for years."**

*Comment from a staff member during an education session.*

The home must take all reasonable steps to ensure and safeguard the confidentiality of all resident data, including information about sexual orientation and gender identity issues. LGBT applicants and residents should be informed about the Toronto Long-Term Care Homes and Services Privacy Statement and the required data collection

(including references to sexual orientation and/or gender identity) and be assured that no information will be disclosed, except as required by law or as determined/directed by the individual. Individuals should be assured that the designation of sexual orientation and gender identity on forms is at his/her option.

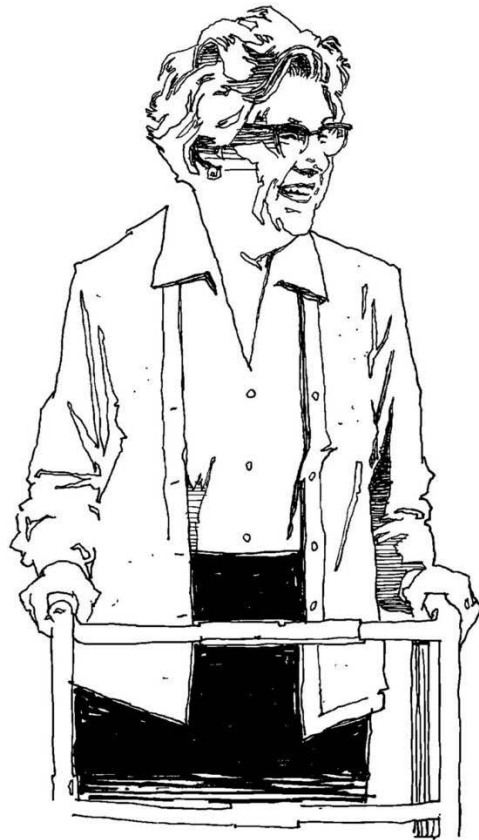
Toronto Long-Term Care Homes and Services is guided by the legal requirements of both the Municipal Freedom of Information and Protection of Privacy Act, 1990 (MFIPPA) and the Personal Health Information Protection Act, 2004 (PHIPA), that require consent of the resident before information regarding sexual orientation is disclosed to anyone.

Under MFIPPA, residents and clients have the right to all personal and medical information to be held in confidence by staff. As a result, staff is expected to refrain from discussing resident or client related information in public and must maintain the confidentiality of records and information. This includes personal, medical and other information concerning residents, clients, their families and fellow employees and staff repeating, or otherwise conveying information to anyone except those specifically designated to receive the information shall be considered in breach of confidentiality.

PHIPA was enacted in November 2004 and governs the collection, use and disclosure of personal health information within the health care system. The objective of the legislation is to keep personal health information confidential and secure. Under this legislation people and organizations that deliver health care are known as "health information custodians" (HIC) and strict rules apply regarding how personal health information is collected, used, maintained, disclosed and disposed of.

Having identified the requirements to protect and preserve resident/client privacy and confidentiality, one of the challenges that the Steering Committee debated at length was the issue of identifying who amongst the current residents might benefit from the implementation of the LGBT initiative within the home. One school of thought amongst the members was that the staff "probably already know which residents are LGBT" and given this assumption, these should be the residents that should be approached and engaged within the initiative. The remaining group of Steering Committee members felt equally strongly that even if staff were aware of LGBT residents in the home, the home had a duty to protect and maintain confidentiality and privacy.

Given our understanding of the underlying dynamics and ethical considerations, an effective way to mediate and bridge this issue was to plan and offer programs and services with a focus on LGBT content, ensure that they were well advertised within the home and simply let the residents choose for themselves if they wanted to attend and participate in that activity. One caveat with this strategy that needs to be pointed out is that unless informed otherwise or directly by the resident, caution and safeguard should be taken not to assume that the residents who do participate are LGBT or by their act of participating in the program that they are self disclosing that they are LGBT. Instead, from a leading practice perspective, it is wiser to assume that this was, at the very least, an opportunity to initiate, develop and support a GSA within the home.





# *Human Resources, Staff Education & Volunteers*

*Diversity  
Our  
Strength*



## Human Resources and Staffing Practices

Toronto Long-Term Care Homes and Services have an established set of values that provide the underpinnings and foundation for the care and service provided to all residents and clients. We are guided by the following values: accountability, compassion, customer focus, ethical decision-making, safety and teamwork.

Under the heading of diversity, it states:

*"We embrace and promote diversity as a strength that enriched the communities in which we live and work. We value, respect and benefit from each other's unique qualities, background, ethnicity, culture, language, religion, sexual orientation, gender identity, age, disability, values, lifestyle, perspectives and interests."*

Human Resources needs to be progressive and inclusive in addressing LGBT needs and those of the LGBT community. The City of Toronto Human Resources Division is aware of the need to recruit and train staff sensitive to a diverse population.

To accomplish this within the LGBT Initiative:

- Corporate policies and divisional policies must assist in supporting the concept of "diversity is our strength".
- Additional resources can be found and are available on the City's website on Diversity and examples of policies can be found at:

[http://inside.toronto.ca/hrweb/human\\_human rights/index.htm](http://inside.toronto.ca/hrweb/human_human%20rights/index.htm)

<http://www.toronto.ca/diversity/index/htm>

**A 2006 job call for a Director of Nursing position did not include any language pertaining to the LGBT community.**

*More recently, under Major Responsibilities the new language reads "Reporting to the Administrator, the successful candidate will be working with a diverse and multi-cultural population served by the home. We welcome all applications and encourage applications from people with experience and/or demonstrated cultural competencies in working with the ethnic and lesbian-gay-bisexual-transgendered (LGBT) communities."*



**What the world is experiencing is not just a gay and lesbian revolution, it is more of a gay and lesbian explosion of human rights.**

***Newsweek Magazine, 2007.***

Policies and procedures that help set the framework for writing job calls, positions descriptions and other verbal and written communication include:

- Employment Equity Policy
- Human Rights and Harassment Policy
- Clear and easy to understand language is used in all communications, including internal and external job calls, policies and procedures.
- With management positions, consideration should be given to advertising in the LGBT media and/or posting opportunities in LGBT agencies.
- In recruiting front line staff, questions used at the time of interview should include at least one question related to diversity and one question related to LGBT sensitivity, to assess suitability.
- All internal and external job calls should reflect that Toronto Long-Term Care Homes and Services welcomes all applications and encourages applications from people with experience and/or demonstrated cultural competency in working with the ethnic and lesbian-gay-bisexual-transgendered (LGBT) communities.

## **Staff Education**

Given the background and experience of LGBT applicants, residents, clients and staff, the underlying principle of all education must focus on the right and dignity of each resident, client and staff member. Human rights, the law of the land that provides the foundation that all residents and clients shall be treated equally and with respect, is the framework that must transcend all educational activities.

Education in itself can be an important catalyst in both initiating and sustaining organizational change and can not be stressed enough as an important tool. For this reason, the Tool Kit is devoting a significant focus in this section and continues to build on other sections of the Tool Kit that references education. Planned and thoughtful educational opportunities not only assists the home to launch the LGBT initiative, but can also support the sustainability of the initiative over time. As already identified elsewhere in this Tool Kit, education and opportunity to initiate and maintain an open dialogue is a crucial component to this and other initiatives that the home may chose to undertake.

Education can be viewed as a very broad, all encompassing term, which can occur through formal and structured mechanisms, i.e., planned in-service educational sessions, as well as informal opportunities that occurs on a day-to-day basis, i.e., discussion and exchanges of ideas by the members of the care team. While both have significant value, for the purposes of this Tool Kit, the focus will be on some of the formal, planned steps that should be considered in launching the LGBT initiative.

It is important to acknowledge that the initial introduction of LGBT education in the home may take several months before managers and staff brings their own personal attitudes and beliefs into line with the concepts of human rights and respect. Success will not occur if a "one-off" approach is taken to education, awareness building and provoking an open

**The divisional LGBT Steering Committee members quickly identified the need for educational opportunities early on in the formation of the Steering Committee. Essentially there were two broad groups within the Committee membership. One group was not necessarily informed regarding the needs of the LGBT community or potential residents requiring long-term care home services, and conversely, those that had expertise and/or knowledge regarding the needs of the LGBT community but did not necessarily know about the long-term home care environment. In recognizing this dichotomy, it was important to initiate a plan that would support reciprocal learning amongst the members of the Committee in order to successfully launch this initiative within Toronto Long-Term Care Homes and Services.**

dialogue but rather must be viewed as planned process if the home is to be successful in initiating this initiative. At the same time, as the educational plan unfolds in the home, it is suggested that each phase or evolution of the process be evaluated, i.e., staff feedback and receptiveness, as these factors, responses and/or potential barriers that will have to be taken into account to adapt and adjust the home's successful educational plan.

- ❑ Education, awareness and innovation take place on many levels. Some staff within Toronto Long-Term Care Homes and Services participates in the annual Pride Parade event. Articles are written for the divisional newsletter (which has carried photos and event information to the division's entire work force), many attend the Opening the Closet on Aging conferences held at the 519 Community Centre, articles within the resident's newsletter are all examples of building awareness and promoting education/information. These events focus on the special issues of older LGBT people and their needs in the areas of long-term care. Throughout the homes, rainbow flags and pink triangle symbols are displayed on office doors, work stations and are pinned to staff lanyards.
- ❑ The concepts of human rights, respect and providing individualized care are not a new concept to Toronto Long-Term Care Homes and Services. However, seniors wanting to be involved in a sexual relationship or seniors having sex have always presented challenges for staff working in a long-term care home environment. These ideas force staff to examine their own personal beliefs and it takes time for staff to appreciate that while working in a long-term care home, it is the right of the resident to be able to continue to enjoy intimate relationships. Given this understanding, the home may want to consider introducing resident intimacy and sexuality as a preamble for setting the stage for the LGBT initiative. *(Please see Appendix I for Toronto Long-Term Care Homes and Services Intimacy and Sexuality policy).*
- ❑ A suggested step in this process is to introduce staff to the notion that all seniors need touch and love. "Intentional touch" describes touching that is appropriate for all persons and is not to be confused with sexual touching. "Intentional touch" indicates to the resident that they are important and validates their personhood. The video Understanding Healthy Relationships and Sexuality introduces staff to these concepts in a non-threatening manner. It focuses on the human need to have trusting, honest, open relationships and what is required to sustain these important relationships.

**Comment: "Not all of the union members are comfortable with gays and lesbians because they hold strong religious beliefs."**

**Response: "The City of Toronto has a non-discrimination policy that does not allow for discrimination using ethnic or religious grounds."**

- ❑ The next step in this ongoing dialogue is to discuss and determine how the home staff can meet the sexual needs of each resident that will eventually include discussions concerning the needs of LGBT residents.
- ❑ In all new positions, staff begins with a general orientation to the home and a specific orientation to the department to which they are assigned. The content delivered in the general orientation will include basic information on resident's rights, standards of employee conduct, emergency procedures and occupational health and safety. The concept of "rights" and "diversity," including acceptance and treatment of LGBT residents, should be introduced and discussed by both the Administrator and the Director of Nursing.

**This Home sits on the doorsteps of the largest gay and lesbian community in Canada. The Home is operated as if all the residents are straight. The home offers no services or programs for its gay and lesbians residents. Looking around at staff, several of them are gay and lesbian as well.**

*Comment from a Satisfaction Survey completed by a Partner. September 2004.*

It is strongly recommended that the orientation for all new staff at all homes include content related to diversity, including LGBT issues. At a minimum, the following content should be included:

- ✧ Definition of diversity and diversity practice;
- ✧ Mission Statement and Values, with emphasis on what it means in day-to-day practice and how all staff are required to "do their part;"
- ✧ The fact that Toronto Long-Term Care Homes and Services welcomes LGBT residents, family, staff and volunteers;
- ✧ The fact that the City provides benefits to same sex partners;
- ✧ The fact that the City has an anti-harassment policy that specifically mentions LGBT-negative comments, jokes, etc., as grounds for harassment;
- ✧ The fact that Toronto Long-Term Care Homes and Services has a complaint process for people complaining of harassment and its details; and
- ✧ The fact that all new employees are expected to sign an acknowledgement regarding respect for diversity, anti-harassment, anti-discrimination and acknowledgment of various policies and requirements.

As previously discussed, ongoing general education for staff follows the knowledge/ education of the management team. Without the knowledge and support of the managers, the education of the front-line staff will not have a lasting effect. *(Please see Appendix J for an example of the LGBT Training Plan for Fudger House, True Davidson Acres, Kipling Acres and Seven Oaks).*

The Management team will discuss and plan the role out of front-line staff education at length. It is best if there is an ongoing presence of senior management at all educational activities, including attendance at in-service training.

The focus of education for front-line staff is designed to remove some of the barriers to providing a gay-positive and inclusive environment. It helps staff provide improved, non-judgmental care and services to LGBT seniors and their families. Given the uniqueness of the long-term care home environment, education must be offered to all staff on all shifts within all long-term care homes. *(Please see Appendix K for a listing of educational LGBT videos).*

There are distinct advantages to having staff from LGBT Community Centers provide extensive education with the intent of ensuring that everyone is comfortable with creating a gay-positive environment. They have the expertise and knowledge regarding LGBT issues that staff can relate to. The Centre for Addictions and Mental Health (CAMH) in Toronto, 519 Church Street Community Center and the Sherbourne Health Centre all provide a range of educational services.

- ✧ Staff education is usually presented in 45-minute modules.
- ✧ The initial in-service session may focus on commonly used LGBT words and language, personal experiences with diversity and understanding myths and stereotypes.

Additional sessions may include:

- ✧ Talk the Talk;
- ✧ Barriers to health care for LGBT clients and residents;
- ✧ Older LGBT issues; and
- ✧ Making Homes a Friendly Place for LGBT Elders.

This type of education offered by experienced presenters is most often well received and staff have a greater understanding of discrimination based on sexual orientation and gender identity. As new vocabulary is introduced and staff develops increased awareness, a trainer with excellent facilitation skills can elicit the feelings and attitudes of staff and their past experiences with the LGBT community.

The goal of all educational activities is to enhance sensitivity and responsiveness to LGBT issues, educate staff, and implement new policies and procedures – with the ultimate goal of making the home a gay-positive, inclusive and welcoming environment for LGBT

**“Losses in the quality of life in all areas of your being become a worry. This is your physical world, your social world and your community”.**

***Community Services Challenges and Opportunities for the 519 Community Centre and the GLBT Community, 2000.***

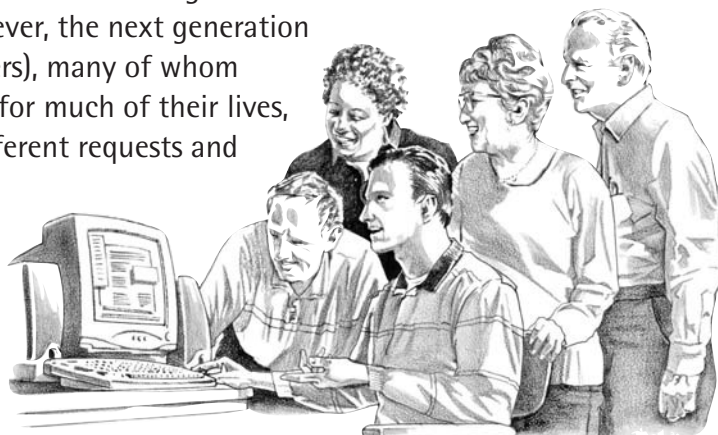
residents. This does not happen overnight. It is a process and will take time, expertise and energy.

An additional valuable staff educational resource for staff, especially programs and services staff and registered nursing staff, is the workshop entitled Asking the Right Questions (offered through Centre for Addiction and Mental Health (CAMH)).

Staff education related to diversity should be included in the annual staff education plan for all 10 homes and community-based services. This diversity education should incorporate a component regarding LGBT issues.

Other educational considerations in planning should include:

- ✧ Research from Centre for Addiction and Mental Health (CAMH) has found that LGBT clients may have somewhat higher rates of addiction to alcohol or drugs. Additional support is required for residents who are experiencing these associated health problems. *Source: Centre for Addiction and Mental Health (CAMH), Toronto, Ontario, 2007.*
- ✧ In Toronto, we are seeing a new trend where transgendered residents are now being admitted to long-term care homes. These residents need to be cared for by staff that understands the psychological and medical needs of the residents, including depression and hormonal therapy.
- ✧ As more LGBT residents are admitted to long-term care homes, it is anticipated that, as additional issues are brought to the attention of managers and staff, the result will be additional policies and/or continued advancements in best practices. Just-in-time instruction and enhanced education needs to be offered on an ongoing basis as a strategy in providing culturally competent and responsive care and programs for LGBT residents.
- ✧ Given the life experiences of our current LGBT residents, it is not difficult to understand that they might be less vocal or demanding of the health or social support system. However, the next generation of LGBT people (as consumers), many of whom have been “out and proud” for much of their lives, are anticipated to make different requests and have different expectations of the health and social support system.



## **Volunteers**

Undoubtedly, volunteers and volunteer services enhance the quality of life of the residents within our homes and helps residents maintain as active, independent and high quality of life as possible by augmenting and complementing the care and services provided by staff.

In understanding the life stories of many LGBT seniors in today's society, the role of volunteers with our LGBT residents may play even more of an important role than traditionally expected by volunteers. While these relationships have the opportunity to help support and enhance the quality of life of the resident, sometimes these relationships reaffirms the resident's identity and reminds them that they are not alone, and at times can be a direct connection, facilitator and link with the local LGBT community. Also, from our experience within the Steering Committee, we have some very successful examples of where gay-straight alliances have been championed through our volunteers.

For these reasons, this section of the Tool Kit visualizes and provides an overview of the role of volunteers within the LGBT diversity Initiative. This is constructed on four pillars that are thought to actively and successfully support the LGBT Initiative. These are:

### **Pillar I. Volunteer Recruitment**

As with any initiative, identifying and recruiting volunteers is essential and finding support from LGBT friendly and welcoming places are good early steps to open up the lines of communication and begin raising awareness and opportunities for community involvement within the home.

At Toronto Long-Term Care Homes and Services, connections with The 519 Church Street Community Centre, Prime Timers, Xtra, Sherbourne Health Centre, Rainbow Health and Metro Toronto Community Church are excellent examples of some potential partnerships for volunteer recruitment.

Many of the early volunteers have been recruited as a result of outreach with these groups and they assisted in setting up the Molly Wood Social Club at Fudger House. This active group helps porter residents to in-home gay and lesbian themed films, escorts residents to off-site programs for gay seniors, attends luncheons at restaurants in Toronto's Gay Village and organizes special outings for residents.

Many residents living in the closet were open with the home's chaplain and it is recommended that confidential support be solicited from Spiritual and Religious Care so that residents seeking volunteer service (friendly visiting and/or escorting) are quietly identified and matched up with well-intentioned volunteers.

**"I thought, my time might come too, and it's been very rewarding because the people who I visit with keep thanking me all the time".**

***Volunteer member of a friendly visiting program.***



The engagement of Recreational Staff, Social Workers and the home's Administrator and Managers is critical to the establishment of an active volunteer environment for LGBT initiatives.

More mainstream events, like the annual Toronto Pride Parade, are another good way to

### **Pillar II. Orientation**

The Coordinators of Volunteer Services highlights the LGBT initiative and the divisional diversity statement during the Volunteer Orientation session so that new recruits understand that all are welcome within the home environment and that we encourage diversity for volunteers, staff, family members and residents at every opportunity. Clear and specific references are made to ensure understanding of gender identity, sexual orientation, the rainbow flag and pink triangle symbols and the significance of the Gay-Straight Alliance within the home.

### **Pillar III. Community Development**

Whenever and wherever possible, LGBT positive wording is included in volunteer opportunity descriptions on bulletin boards and postings on the Volunteer Toronto website.

Social marketing efforts have moved forward with positive attention including;

- ✧ Profiled features in Xtra and/or other local LGBT news media;
- ✧ A gay-themed resident photo in divisional recruitment posters;
- ✧ Through Seniors Pride network participation in the Toronto Challenge; and
- ✧ The Pride Parade participation of Toronto Long-Term Care Homes and Services.

### **Pillar IV. Recognition**

The fourth pillar of any successful volunteer program is acknowledging the service provided by the volunteer.

Active involvement of LGBT volunteers on the Home's Volunteer Executive is a positive step, as is the inclusion of LGBT volunteers in the annual Excellence in Volunteering Awards, at the Home's Appreciation dinner(s) and at every opportunity - newsletter profiles, in-home "Do You Know" postings, all formal and informal recognition to acknowledge the services provided by the volunteers.

## ***Human Rights Campaign***

The Human Rights Campaign, the largest national lesbian and gay political organization, envisions an America where lesbian and gay people are ensured of their basic equal rights—and can be open, honest and safe at home, at work and in the community. HRC has more than 360,000 members, both gay and non-gay - all committed to making this vision a reality.



# *Resident Care & Care Planning*

Resident Care  
& Care Planning

*Diversity  
Our  
Strength*

## Resident Care and Care Planning

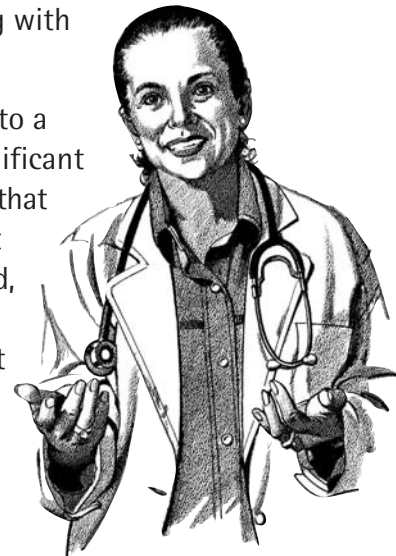
Toronto Long-Term Care Homes and Services is committed to providing a co-ordinated and comprehensive interdisciplinary approach to resident care that encompasses the values, needs, strengths and desires of the resident. Care and service plans for individual residents are developed with the resident and family (or the substitute decision-maker) with the interdisciplinary team through a process that includes assessment, planning, implementation and evaluation. The objective of this process is to ensure that the developed plan of care is highly resident-focused and reflects the resident's values, beliefs and quality of life priorities.

The foundation of the provision of care and services is based on the concepts of "respect, support and enable" for the residents and their families. Consistent with the values of respect, support and enable; care and services are planned and delivered focusing on the residents' right to dignity, respect and freedom.

Integral to this philosophy is the recognition that all residents are entitled to care and services as defined by the Residents' Bill of Rights and Responsibilities (1991). The division believes in recognizing and advocating for the rights and privileges of each resident supportive of their ethnicity, culture, language, religion, sexual orientation, gender, gender identity, age, disability, values, lifestyle perspectives and interests.

For the most part, staff wants to find ways to make the residents and their family members feel comfortable, engaged and involved in their care. It is important that staff take a sensitive approach and not make assumptions when dealing with residents and/or their family members.

For example, if you know that a resident was once married to a person of the opposite sex, don't assume that the most significant person in his or her life was that spouse. If a resident states that they are single, don't assume that they aren't in a significant relationship or has never had a long-term relationship. Instead, ask open-ended questions, such as "who do you consider family?" or "who would you suggest that we speak to about care concerns?" Let the resident know that you are accepting, open-minded and providing them with the opportunity to direct their care and craft their individualized care plan.



**"What is LGBT appropriate care?"**

**LGBT appropriate care is care that positively reinforces LGBT identities, rather than forcing LGBT individuals back into the closet."**

***S. Ryan B. Brotman and R. Cormier, The health and social service needs of gay and lesbian elders and their families in Canada. The Gerontologist, 43(2), 192-202. (2003).***

## ***Companion Document for the Toronto Long-Term Care Homes and Services Resident Admission Assessment***

In the previous sections of this Tool Kit, the LGBT Steering Committee has provided information and advice regarding what the home should consider in implementing the LGBT initiative within the home from a knowledge-base and skill set perspective. In this section of the Tool Kit, there is the opportunity to actually apply this enhanced knowledge and information into practice. Building on the established interdisciplinary resident assessment process that already exists within Toronto Long-Term Care Homes and Services, the following companion document has been developed that will enhance the resident assessment process and increases the sensitivity and knowledge with working seniors from the LGBT communities. Together, with training and the implementation of other policies, the specific objectives of the companion document are to provide:

- Ways to make the assessment process welcoming to LGBT seniors, their partners, families and friends;
- Ways of asking questions that are open, sensitive and that promote a sense of safety for residents and family members;
- Information to consider during the assessment that can lead to a better understanding of the values, needs, strengths and desires of the resident; and
- Knowledge and suggestions geared toward specific professional disciplines involved in the overall assessment process.

### ***What we've learned...***

Our experience in the aging field tells us that in general, providers have a one-dimensional view of older adults.

Most providers aren't comfortable with a client's sexuality, much less a client's sexual orientation. Often, providers do not consider it or address it. Even providers who are LGBT themselves often do not think of their older clientele population as one that may include lesbians, gay men, bi or transgendered people.

***Project Visibility-Boulder County Aging Services Division - Boulder Colorado. 2004.***

### ***Introduction for Staff who are Unfamiliar with LGBT People***

You may have grown up being taught that LGBT people are sinful, immoral, mentally ill or dangerous. These attitudes have been recognized as part of a system of prejudice and discrimination and they are no longer acceptable in Canada or in Toronto's public services.

As a care provider, you are expected to learn about the specific needs of this population and to treat them with dignity and respect.

To help you learn more about the special needs and issues of LGBT people, there are reading materials and training sessions that you can access (some of which are available in the appendices of this Tool Kit). Be sure to read the glossary (which has also been included in the appendices for your reference) if you are not sure of the meanings of terms, such as gay, bisexual, lesbian, transgender, intersex, etc. Try to use the same language the resident uses to describe his/her sexual orientation or gender identity.

Don't assume you can tell whether a resident or family member is LGBT by the way they look or act. Be open to the fact that about 10 per cent of the population is believed to be gay, lesbian or bisexual. In large urban areas such as Toronto, the numbers are higher because many people have migrated to larger cities from other parts of Canada and the world because of our positive human rights record.

Trans identities are less common, but not as rare as many people imagine. There is a wide range of gender expression that involves clothing, grooming, roles and interests, but not body modification, as well as the more permanent changes achieved through hormone therapy or body-modifying surgeries.

Confidentiality is very important to LGBT people – often their safety depends on it. If someone discloses that they are LGBT, it is important to ask who else knows and who else they would like to know. There may be particular people, such as family members, who are not aware of their identity or with whom it is not discussed openly.

You may have to tread carefully in relating to someone who is not "out" but who you know to be LGBT. Try offering safety and support by affirming the existence of all LGBT people and by being knowledgeable about LGBT culture and history.

Remember that even the most closeted LGBT people have usually been "out" in some situations – to partners and friends, in community groups, in recreational spaces – but in the home they may not disclose their identity until they feel safe and affirmed.

Not being open and out is more than keeping quiet about your sex life or your gender identity – it means hiding your most meaningful relationships and experiences, your social history, your friends and partners, your hobbies and interests, etc. Being closeted prevents the development of authentic relationships and reinforces social isolation.

### *Quality of Life Indicators*

Many of the quality of life indicators named in the Resident Admission Assessment, such as interpersonal relationships, culture, leisure, environment, life skills, feelings toward self and spirituality, can be viewed through the lens of sexual orientation and gender identity. For example:

- ✧ A gay resident may wish to visit restaurants or community centres that are meaningful to him/her.
- ✧ A lesbian may have lived very independently, earning her own living or having hobbies more common to men of her generation.
- ✧ A trans woman (born with a male body) who lives as a woman in society has learned skills in changing her appearance, her movements and perhaps her voice. Maintaining good grooming and a feminine appearance may still be very important.
- ✧ A bisexual man may have struggled with a lack of acceptance by both straight and gay communities and may have developed lifelong friendships with men and women like him.

It will be important to factor these into the care plan for the LGBT resident.

### *Admission History and Screening*

When first meeting the resident it is helpful to begin setting a tone of openness and affirmation. Symbols, pictures and other "clues" can be very important in giving a resident a sense that this is a safe place. If the sexual orientation or gender identity of the resident is not known, and this is likely, then it will be important to use open-ended questions and avoid making assumptions, no matter what area of the assessment you are conducting.

The following areas of the assessment require particular knowledge and sensitivity to the values, needs, strengths and desires of LGBT residents, their partners and families.

### *Admission Medical Exam*

#### **General Health Issues**

LGBT people experience higher levels of depression, anxiety and suicidal thoughts than the general population. Research has shown that this relates directly to living as a member of a discredited and marginalized group. These feelings can be intensified by social isolation, harassment or violence, or intense internal conflict.

LGBT people have somewhat higher levels of alcohol and substance use than the general population. This is often related to experiences of oppression, stress, social isolation, etc. and to the fact that social life has often revolved around bars and night clubs.

Due to the fear of coming out to a doctor, or negative experiences with health professionals, some LGBT people have avoided routine screening and tests and may have undetected or more advanced conditions such as certain cancers, diabetes, cardiovascular disease, etc.

The literature shows that older LGBT people rely heavily on their partners or close friends to provide care. Many are estranged from family members or have not had close relationships with them. It is important to ensure that the resident chooses an appropriate person to be their substitute decision-maker.

Gay men and trans women, in particular, have been a high risk group for HIV since the 1980's. Some may have lived with HIV for many years and may be on a well-established regimen of anti-retroviral drugs and other medications; others may have the virus, but not have been tested and are unaware of their status.

Some members of the community may be sexually active well into their senior years and may enjoy casual sex. They may wish to stay sexually active. Asking about sexually transmitted infections and offering STI and HIV testing may be appropriate.

Erectile dysfunction is a common problem for older men and trans women who have retained their penis and can render condom use difficult.

### ***Transgender and Transsexual People***

Most trans people feel particularly vulnerable when undergoing a physical exam and need extra reassurance and support. They may be unwilling to take off their clothes until they are feeling much safer. Protecting the identity, dignity and bodily integrity of the trans person is paramount. (Please see Appendix L regarding Policy Recommendations and Best Practices for Agencies Working Towards Trans Accessibility).

Use the appropriate pronouns (usually the pronouns that correspond to the person's felt gender). When in doubt, ask "What is your preferred pronoun?"

Continue to follow desired dressing and grooming routines that help the person to live in their felt gender. Again, when in doubt, ask!

Recognize that many trans people have a mix of male and female anatomical characteristics. Not all trans people want sex reassignment surgery and the majority is unable to access it in any case. Don't be surprised to see a trans woman (MTF) who has breasts and also male genitalia, or a trans man (FTM) who has had chest surgery or binds his breasts (chest) with a tensor bandage but still has a vagina. It is extremely important to deal with these differences in a supportive and matter of fact way, without showing shock, disgust or too much curiosity. Ask the questions that are needed to deliver care and educate yourself further on your own.



It is important not to assign rooms based on genital anatomy alone, since many trans residents fully identify as members of their chosen gender, even though they have not had genital surgery. This issue may require sensitive and creative problem-solving with staff and other residents. To assume that anyone with a penis must be placed in the male rooms and dressed as a man, or that anyone with a vagina must be placed in female rooms and dressed as a woman is to condemn the trans resident to a highly disorienting and humiliating experience.

For trans people who are taking hormones, it is important to reassure them that their hormone therapy will continue to be prescribed and administered (oral or injection) as usual. These medications are central to the person's identity. Contact the person's family doctor or endocrinologist to get details of his or her hormone regimen and ongoing monitoring strategies.

If a resident has had sex reassignment surgery there may be short or long term post-operative care required. Again, the family physician or surgeon should be consulted in this regard.

### ***Psychosocial Screening***

The psychosocial screening offers a rich opportunity for engaging with the LGBT resident as a whole person, and providing an inviting and affirming experience.

The social history may provide information about important life events (such as coming out), coping in a time when society was not accepting of LGBT people (like living a double life), relationships with partners, friends, etc.

For some LGBT residents, there may be elements of regret or shame about sexual or gender identity based on "disgracing the family," not marrying or having children, and internalized messages of not being "normal," etc. The social work counselor can empathize but also provide affirmation that times are changing and that he/she sees the resident as being a whole and healthy person.

Family continuity may have been affected by rejection on the part of the family of origin, the need to hide identity, etc. Some people show resilience and strength by developing a "chosen family" to spend special occasions with and to provide social support. These people should be treated like next of kin.

Placement in an institutional setting may be especially worrying for the LGBT person due to a fear of ill-treatment by staff or other residents, or concern that a partner will not be welcomed. For some, there could be memories of being institutionalized in hospitals

**"A holistic approach to health embraces both the physical and mental needs of individuals and allows for an integrated approach to service delivery."**

***Supporting Seniors' Mental Health Through Home Care — A Policy Guide. Canadian Mental Health Association. 2002.***

**There is significant evidence, both in the literature and research that demonstrates that seniors' engaged in meaningful social activities and programs report having a higher sense of satisfaction and a better quality of life.**

simply for being LGBT and subjected to psycho-analysis or shock treatment. Remember, until 1973 being gay or lesbian was seen as a mental illness.

During the placement process, it is very important to ask about significant others. A partner may be acknowledged as such or spoken of as "a friend." And chosen family members may also take on significant caregiving responsibilities for one another. The resident may at one time have been involved in a heterosexual marriage and may have children. A partner may also have children who regard the resident as a parent.

The stress of placement may trigger feelings of anxiety, depression and withdrawal that may be common response patterns to stressors related to being LGBT.

Psychosocial needs in the areas of identity, safety and belonging, may all need to be explored in the context of LGBT experience. It is very important that the home is willing to stand up for the resident in the face of homophobic or transphobic remarks or behaviors by staff or other residents.

### ***Recreation Screening***

Since many LGBT people have experienced significant discrimination, many have participated in their own social circles and cultural activities. Even in small communities, LGBT people have gotten together in private homes or participated in hobbies together. In larger centres, many people have been involved in a wide variety of organized LGBT community activities from parties and dances to bridge clubs, sports leagues, arts events and social justice work.

It may be important to stay connected to the external LGBT community through visits to local clubs, events or even news of what is going on.

Regular activities in the home can also be made more culturally relevant simply by attending to and focusing on context – stating that a piece of music is by a gay composer, or a book is by a lesbian writer; showing a film with LGBT characters, reflecting what is happening in current events, i.e., same-sex marriage. *(Please see Appendix M that lists some Top Gay Films.)*

Encourage visits and phone calls from partners, friends or a LGBT volunteer.

As the home becomes more attuned to having LGBT residents, it may be appropriate to have an event with a gay theme that can include everyone, i.e., a concert by a lesbian choir.

### ***Spiritual and Religious Screening***

The majority of religious and spiritual traditions have been unaccepting of LGBT identity or behavior and this has led some people to feel unwelcome in their faith group or to feel bad or unworthy. More recently, some people have been part of affirming faith groups while others have lived their lives with little need for religion or spiritual practice.

This screening provides opportunities for an exploration of these matters and the current desires and needs of the resident in that context.

For LGBT residents who wish to attend services or have visits from a spiritual leader, look for connections with affirming religious institutions, clergy or volunteers.

# *Leisure Activities & Social Programs*

*Diversity  
Our  
Strength*



## **Leisure Activities and Social Programs**

This section of the Tool Kit will offer a template that is a leading practice approach in developing and implementing diverse leisure activities and social programs that are reflective of the needs of LGBT residents within a long-term care home environment. In addition, these leisure activities and social programs offer the opportunity to directly demonstrate that the home is sensitive, inclusive and welcoming to LGBT residents, partners, family and friends.

The leisure activities and social program section of this Tool Kit is designed as an initial resource to ensure that the needs, strengths and desires of all LGBT residents are identified and incorporated into specialty and integrative leisure activities and social programming usually offered within the home. As the home launches the LGBT initiative and becomes more experienced in providing LGBT care and services, it is anticipated that the home will continue to build on its own skill and expertise. To successfully launch meaningful leisure and social programs it is critically important that staff understand the needs of this population and creatively translate these needs into activities and programs that supports the residents quality of life in a dignified and respectful manner.

### ***The LGBT Leisure Activity and Social Program Assessment***

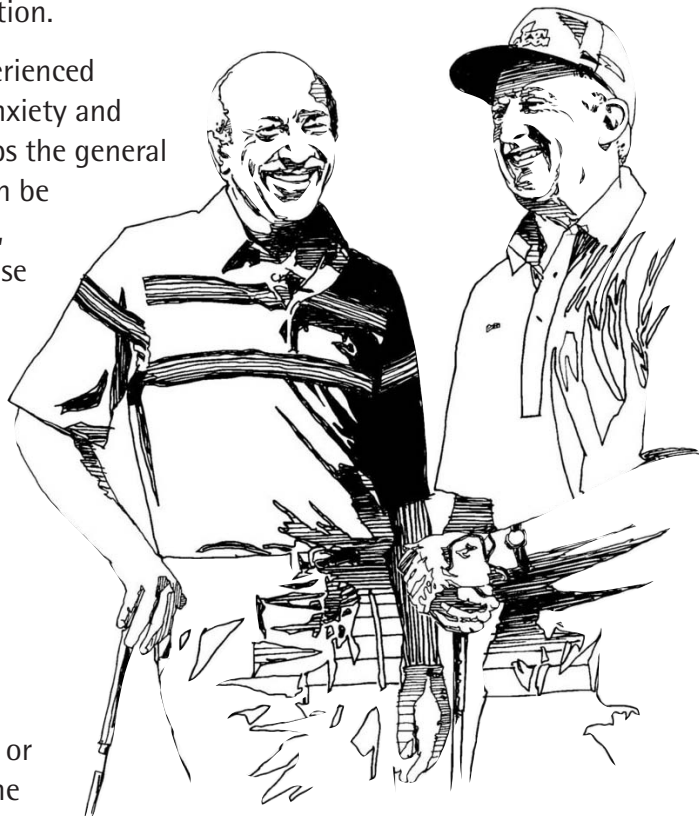
The activity and program assessment is an opportunity for staff to engage with the LGBT resident. When developing and planning LGBT leisure activities and social programs, staff must be knowledgeable and sensitive about the specific needs of this target population. Having a sound knowledge base of the culture and history of LGBT seniors will equip staff with a greater understanding of their values, needs, strengths and desires that need to be considered when developing and planning LGBT leisure activities and social programs.

The assessment for the leisure activity and social programs offers an opportunity for staff to discuss the current desires and needs of the resident. When first meeting the resident, it is helpful for staff to set a tone of openness and affirmation. Symbols, pictures and other clues can be very important in giving a resident a sense that this is a safe place. If the sexual orientation or gender identity of the resident is not known, it will be important to use open-ended questions and to avoid making assumptions no matter what area of the assessment you are conducting. Many LGBT residents may not disclose their identity until they feel safe and affirmed.

**There is significant evidence, both in the literature and research that demonstrates that seniors' engaged in meaningful social activities and programs report having a higher sense of satisfaction and a better quality of life.**

During the activity and program assessment process it is important for staff to consider and be sensitive to the following cultural and social factors:

- The continued need for engagement with the LGBT community through visits to local clubs, restaurants, social gatherings and community events or current LGBT news.
- Involvement in the homes regularly scheduled leisure activities and social programs can also be made more culturally relevant simply by attending to context – stating that a piece of music is by a gay composer, or a book is by a lesbian writer; showing a film with LGBT characters, reflecting what is happening in current events, i.e. same-sex marriage. *(Please see Appendix M that lists some Top Gay Films).*
- Continuity of visits and phone calls from partners, friends or a LGBT volunteer(s).
- A lesbian may have lived very independently earning her own living or having hobbies more common to men of her generation.
- A trans woman's (born with a male body) movements, voice, good grooming and feminine appearance may still be very important.
- Confidentiality is very important to LGBT people; not being open and out about their sex life or gender identity means hiding their most meaningful relationships and experiences, social history, friends, partners, hobbies and interests, etc. Sometimes, being closeted prevents the LGBT resident from developing authentic relationships and can reinforce social isolation.
- The LGBT population has experienced higher levels of depression, anxiety and suicidal thoughts than perhaps the general population; these feelings can be intensified by social isolation, harassment, violence or intense internal conflict.
- LGBT people have somewhat higher levels of alcohol and substance use than the general population. This is often related to experiences of oppression, stress, social isolation, etc.
- The majority of religious and spiritual traditions have been unaccepting of LGBT identity or behavior and this has led some



people to feel unwelcome in their faith group or to feel bad or unworthy. The LGBT residents who express a desire to attend services or have visits from a spiritual leader need to obtain connections with affirming religious institutions, clergy or volunteers.

- ❑ Despite being a group that has experienced significant discrimination, most LGBT people have also participated in their own social circles and cultural activities. Even in small communities, LGBT people have gotten together in private homes or participated in hobbies together. In larger centres, many LGBT people have been involved in a wide variety of organized LGBT community activities from parties and dances to bridge clubs, sports leagues, arts events and social justice work. Many of the LGBT quality of life indicators, such as interpersonal relationships, culture, leisure, environment, life skills, feelings toward self and spirituality can be viewed through the lens of LGBT sexual orientation and gender identity.

The following section was developed as a guide, and provides examples to help staff in crafting meaningful activities and programs for LGBT residents, partners and their friends. Within this context, this includes recreational activities, special events, spiritual and religious care and support groups and program ideas and suggestions. Through these activity and programs, ideas and suggestions, this Tool Kit supports and promotes a safe and comfortable environment for LGBT residents within a long-term home environment. *(Please see Appendix N for the Activities Program Template).*

**The provision of some activities that are geared to particular cultures or a belief systems don't have to be time or resource consuming – it can be as simple as culturally-appropriate movies or taped shows. A resident from a particular culture may be able to link the staff to a community resource to provide or assist with particular activities.**

***Diversity in Action:  
A Toolkit for Residential  
Settings for Seniors,  
2008.***

## ***LGBT ACTIVITIES PROGRAM PLAN***

Staff Name: \_\_\_\_\_ Discipline: \_\_\_\_\_

Date: \_\_\_\_\_ Time/Place: \_\_\_\_\_

Start Date: \_\_\_\_\_ Review Date: \_\_\_\_\_

### ***Activity/Program Type***

- Specialty  Specifically for LGBT residents  
Integrative  LGBT program open to everyone  
Revised

Standard activity/program that has been revised to welcome  
LGBT residents and their needs incorporated

### ***LGBT Activities/Program***

#### ***Name***

- ❖ A meaningful activity/program that is developed based on identified needs of the LGBT resident population.
- ❖ An existing activity/program that will be enhanced that is inclusive and welcoming of LGBT residents.

#### ***Needs Assessment***

- ❖ Based upon a comprehensive assessment of a resident's social, intellectual, psychological, physical and spiritual needs.
- ❖ Definition of an individual's quality of life is subjective; thus the individualized assessment is paramount for each resident in order to enhance the resident's self-esteem and dignity. GOAL
- ❖ The primary outcome/benefits to be achieved for the program and/or residents in the program, i.e., residents will have increased participation in group programs.

#### ***Program Design***

- ❖ Program is designed to meet one or more of the individuals and or target

population social, intellectual, physical, psychological and spiritual needs.

- ❖ Is the program a large group, small group, self-directed activity or one-to-one?
- ❖ Program content, the time frame for this program, the location of this program.

#### ***Indicators For Evaluation***

- ❖ How will you measure the success of the program?
- ❖ What indicators will you develop to measure outcomes, i.e., behavior changes, level of participation, increased attention span, decreased agitation or restlessness.
- ❖ Feedback from the care team regarding the resident before, during and after the program?

#### ***Supplies and Budget Required***

- ❖ What materials will be required to run the program?
- ❖ Be specific. How many volunteers and staff are required?



## ***TOOL KIT PROGRAM PLANNING TEMPLATE***

### ***LGBT Activities/Program***

Discipline \_\_\_\_\_ Staff Name \_\_\_\_\_

Home Area \_\_\_\_\_ LGBT Activity/Program \_\_\_\_\_

Specialty  Integrative  Revised

Start Date \_\_\_\_\_ Days \_\_\_\_\_ Time \_\_\_\_\_

Evaluation Date \_\_\_\_\_

### ***LGBT Resident Target Group***

Cognitive Impairment:

None  Mild  Moderate  Severe

### ***LGBT Target Group***

Special Needs Resident  Bed Bound Resident  Self-Directed  Cultural/Ethnic

Other  \_\_\_\_\_

Please check appropriate Activity/Program SIPPS focus:

Social  Intellectual  Psychological  Physical  Spiritual

## ***Activity/Program Planning and Development***

### ***Needs Assessment***

How was the need for this program identified? \_\_\_\_\_

Activity/Program Goals \_\_\_\_\_

What other discipline(s) will be participating in this program? \_\_\_\_\_

Indicators to be used for Activity/Program Evaluation

*(See examples of possible indicators in Appendix O)*

What Indicator(s) will be used to measure outcomes of program success?

Evaluation Date: \_\_\_\_\_

Discipline Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Managers Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## ***LGBT ACTIVITY AND PROGRAM EVALUATION***

Discipline & Staff Name: \_\_\_\_\_ Date: \_\_\_\_\_

Activity/Program Evaluated: \_\_\_\_\_ Home Area \_\_\_\_\_

- 1) Did this activity/program fit the Model of Care for the resident target group being serviced? Please explain why? \_\_\_\_\_
- 2) Who identified the need for this activity/program and why?  
\_\_\_\_\_
- 3) What other discipline(s) were involved in the planning and implementation of this activity/program? \_\_\_\_\_
- 4) What resident target group is being serviced by this activity/program?  
\_\_\_\_\_
- 5) What is the average Folstein Score of the group participants?  
\_\_\_\_\_
- 6) What Indicator(s) were used to measure activity program success? *Please see examples attached in Appendix O.* \_\_\_\_\_  
Success of the individual participant goals? \_\_\_\_\_  
How did you communicate success in both of these areas to the care team?  
\_\_\_\_\_
- 7) From the time that this activity/program was implemented, have the:  
activity/program participants changed? Yes  No  If so, why?  
\_\_\_\_\_  
Participants' attendance increased? Yes  No  If so, why?  
\_\_\_\_\_  
Participant's attendance decreased? Yes  No  If so, why?  
\_\_\_\_\_
- 8) Do you feel that this activity/program should be:  
Continued?  – Why? \_\_\_\_\_  
Discontinued?  – Why? \_\_\_\_\_  
Revised?  – Why? \_\_\_\_\_
- 9) Other activity/program evaluation comments:  
\_\_\_\_\_
- 10) What other new activity/program ideas have you come up with as a result of this program?  
\_\_\_\_\_

Using this model and its creative and expanding approach to leisure activities and social programs within the division, we now have the following examples of successful LGBT programs:

- ❖ LGBT Empowerment and Adjustment Group
- ❖ True Colours Social Club
- ❖ Gender Bending Sing-A-Long
- ❖ Resident Discussion Group
- ❖ The Rainbow Club – Movie Series
- ❖ LGBT Discussion Group
- ❖ Affirmation of Welcome
- ❖ LGBT Film Program
- ❖ LGBT Author Reading Appreciation
- ❖ Bingo with Empress Michelle Dubarry
- ❖ Bible Study
- ❖ Worship Service for World AIDS Day
- ❖ Mollywood

In addition, there have been some special events including:

- ❖ Pride flag raising and barbecue
- ❖ Pre-Pride dance and celebration
- ❖ Annual special events and celebrations
- ❖ Participation in celebrations of diversity, i.e., historical displays, written materials, personal histories.

# *Community Engagement*

*Diversity  
Our  
Strength*



## **Community Engagement**

In this last section of the Tool Kit, the Steering Committee would like to acknowledge and build on the report released by Concerned Friends of Ontario Citizens in Care Facilities entitled "Creating Welcoming Communities in Long-Term Care Homes" (2008). Specifically, when it comes to community engagement, long-term care homes need to take a broad view and include both the community both inside and outside of the home.

This approach and understanding accentuates the complexity in creating organizational change within a long-term care home, however this initiative proposes that to achieve both success and sustainability in evolving into a welcoming and inclusive environment, community engagement needs to be systemically approached with an understanding that there are two distinct communities that needs to be engaged – the internal community of the home as well as the external community.

The stakeholders within the internal community of the home includes, but are not limited to:

- ❖ Residents;
- ❖ Family and friends;
- ❖ Staff;
- ❖ Volunteers; and
- ❖ Formal bodies that relate to this community, such as the Residents' Council, Family Committee and the Home Advisory Committee.

The external community could include:

- ❖ Local groups of LGBT people and service organizations;
- ❖ Local agencies identified as providing services to, and inclusive of LGBT clients.

Within the realm of community engagement, undertakings need to be approached as a flexible, fluid and ongoing process.

During this journey, opportunities to promote awareness and understanding, and to consolidate inclusiveness within the social fabric of the home are anticipated to be ongoing. The long-term care home would be encouraged to seize these opportunities as part of the ongoing community engagement process.

The first place in beginning with this initiative is through a management self-assessment of the home as a way of identifying possible support and allies to the LGBT initiative, as well as identifying either real or potential threats and barriers to the initiative.

## ***Self-assessment for a Long-Term Care Home ...***

### ***beginning the journey towards an LGBT welcoming environment***

- Given the statistics and current understanding regarding LGBT seniors, anticipate how this initiative may impact the home (both negative and positive outcomes), while directly improving care and services to seven to 10 per cent of your current resident population.
- Anticipate that there may be some negative responses from residents, family/friends, volunteers, staff, affiliates and the community. Consider developing strategies that may proactively mitigate issues or concerns, i.e., individual residents may ask the question "how will this affect me?" Knowing this, there is an opportunity to anticipate this response and proactively address this concern up front within the communication plan.
- Plan on establishing, supporting and facilitating a LGBT Steering Committee within the home that includes both internal and community resources. It is important to include individuals on this Steering Committee who identify with the LGBT community or support a gay-straight alliance and have experience in creating an LGBT inclusive environment.
- Use the expertise of the LGBT community members/partners to plan, deliver and evaluate programs and services directed to the LGBT population.
- Present the concept of developing an LGBT welcoming environment in the home to the Home Management Team with the goal of fostering support and commitment with the LGBT initiative.
- In conjunction with the Home Management Team, begin to identify potential leaders, mentors, supporters and allies within the home amongst the residents, family, friends, staff volunteers and union representatives.
- Ensure that the home has and abides by an anti-discrimination policy.
- The home should ensure that the Home Advisory, management, residents, family/friends, staff, volunteers, affiliates and community groups are aware of their rights to access the complaints procedure to address any incident of discrimination.
- Draft a clear communication strategy and plan identifying key stakeholders (both internal and external) ensuring that key messages are consistently shared amongst the various groups as close to same time as possible. Ideally, the communication strategy should inform the various stakeholders of the intent of developing an LGBT inclusive long-term care home close to the same time (of announcing the initiative) as possible and should invite their participation in guiding the home through this opportunity.
- Present to the Home Advisory on the LGBT initiative with the goal of gaining approval and support of the initiative and to request that the Advisory members go on record

as publicly supporting the initiative and stating their commitment to being an LGBT inclusive organization. This support and commitment could be simply reflected in the minutes of the Home Advisory Committee.

- Encourage members of the Home Advisory to participate in LGBT training to enhance their knowledge of LGBT issues and how this initiative can positively affect and influence the home.
- Explore the possibility of systemic barriers in the recruitment, selection and retention for Home Advisory Committee as well as members of the management team, staff and volunteers.
- Using the Communication Plan, initiate concurrent presentations to internal stakeholders, i.e., Residents' Council, Family Committees, staff, volunteers, individual residents and family members, etc.
- Provide ongoing informational and educational sessions and opportunities for all internal stakeholders to continue to raise ideas and thoughts and to continue the "dialogue".
- Develop a listing of LGBT inclusive groups, agencies and networks and engage them in the homes plans. This listing may include local community, regional and provincial groups and organizations that deal directly with diverse and/or marginalized populations. *(Please see Appendix P for a listing of potential Internet sites).*
- Become knowledgeable of the local LGBT inclusive community media. Media and communications can be a valuable resource in identifying the media sources.
- Develop a comprehensive listing of other points of access for reaching diverse communities, i.e., places of worship, community centres, social clubs, etc.
- Develop effective and inclusive formal and informal working relationships with diverse community groups and organizations.
- Engage with the Community Care Access Centre, hospital discharge planners, Ministry of Health and Long-Term Care, Local Health Integration Network, advocacy organizations and other community support service agencies in the local community that will promote awareness and understanding about the home and the LGBT initiative.
- In collaboration with Media and Communications, communicate the homes plans with media and websites serving the LGBT community.
- Engage the leadership of the Residents Council and Family Council to explore opportunities for supporting and welcoming LGBT residents and family members or in establishing a gay-straight alliance.

- Include articles about LGBT issues, services and programs in newsletters and public reports and the strategies the home has or is implementing in supporting the initiative. *(Please see Appendix Q as an example of a submission that was used in the residents' newsletters).*
- LGBT positive signs and symbols and artwork are displayed within the home, this could include special displays celebrating Pride. Ensure that leisure and social programs are profiled within the services and programs that the home offers.
- LGBT materials, such as newspapers, magazines and brochures are easily accessible and available in common spaces within the home, i.e., lobby sitting area, library, etc.
- In collaboration with Media and Communications, seek publicity for the LGBT Welcoming Communities Initiative through various media, i.e. press releases, interviews, notice of special events, participation at Pride Celebrations etc.
- Identify local LGBT neighbours and businesses and explore possible partnerships and linkages.
- Meet with LGBT residents and family members (who have self-disclosed) at the home and explore engagement opportunities, i.e., interest in being active on the Residents' Council or the Family Committee, etc.
- Meet with LGBT staff members who have self-identified as LGBT.
- Meet with LGBT volunteers who have self-disclosed.
- Explore opportunities with LGBT groups or agencies that LGBT residents and family/friends have already established and opportunities that might strengthen these linkages.
- Promotional materials for the home are adapted to be LGBT inclusive, i.e., material that can be used for public tours of the home, informational brochures, etc.
- In collaboration with Media and Communications, advertise through LGBT organizations and networks, such as special events, community outreach, volunteer opportunities, staff recruitment, etc.
- Plan and strategically participate in community networks that increase awareness and promote LGBT cultural competency and which strengthens and integrates services available to the larger LGBT community.
- Include LGBT people and their families/friends in all outreach and health promotion activities initiated by the home, i.e. adult day programs, convalescent care, respite care, etc.



## ***Measuring Success Within the Organizational Culture***

- All members of the organization have opportunities for involvement in evaluating the progress made in the areas of diversity, equity and inclusion, which includes LGBT care and service provision.
- The environment is safe for members of the Home Advisory, staff, residents, family/friends and volunteers to be "out."
- LGBT members are actively recruited for the Home Advisory, staff and volunteers.
- A working alliance is established with local union representatives who support the LGBT initiative within the home.
- The Home Advisory Committee has a mechanism in place to be informed of any resident/family/staff/volunteer complaint related to discrimination/harassment related to sexual orientation and sexual identity.
- Responsive to LGBT issues and cultural diversity and designs programs and services that reflect the needs of this resident population.
- The home is recognized as a reputable resource within the LGBT community.
- The home seeks out opportunities that will include the LGBT community, i.e., making meeting space available while promoting an "open and receptive" environment.
- And finally, the home is encouraged to celebrate the accomplishments and successes they have achieved within the LGBT initiative.



# *Appendices*

*Diversity  
Our  
Strength*

## **Appendix: A**

### ***An Overview of LGBT History From the 1900s to Present day***

#### **1903**

In New York, on February 21, 1903, New York police conducted the first United States recorded raid on a gay bathhouse, the Ariston Hotel Baths. Twenty-six men were arrested and 12 brought to trial on sodomy charges; seven men received sentences ranging from four to 20 years in prison.

#### **1907**

Adolf Brand, the activist leader of the Gemeinschaft der Eigenen, working to overturn Paragraph 175, publishes a piece "outing" the imperial chancellor of Germany, Prince Bernhard von Bülow. The Prince sues Brand for libel and clears his name; Brand is sentenced to 18 months in prison.

#### **1910**

Emma Goldman first begins speaking publicly in favour of homosexual rights.

#### **1913**

The word faggot is first used in print in reference to gays in a vocabulary of criminal slang published in Portland, Oregon: "All the fagots (sissies) will be dressed in drag at the ball tonight."

#### **1917**

The October Revolution in Russia repeals the previous criminal code in its entirety, including Article 995.

#### **1920**

The word gay is used for the first time in reference to homosexuals in the Underground.

#### **1921**

In England, an attempt to make lesbianism illegal for the first time in Britain's history fails.

#### **1922**

A new criminal code comes into force in the USSR officially decriminalizing homosexual acts.

#### **1924**

The first homosexual rights organization in America is founded in Chicago – The Society for Human Rights. The movement exists for a few months before being ended by the police. Panama, Paraguay and Peru legalize homosexuality.

#### **1928**

The Well of Loneliness by Radclyffe Hall is published in the United States. This sparks great legal controversy and brings the topic of homosexuality to public conversation.

#### **1929**

May 22 – Katharine Lee Bates, author of America the Beautiful dies.

October 16 – a Reichstag Committee votes to repeal Paragraph 175. The Nazis' rise to power prevents the implementation of the vote.

**1930**

New Danish penalty law decriminalizes homosexuality. It comes into effect in 1933.

**1932**

The new Polish Criminal Code decriminalizes homosexuality in the whole of Poland.

**1933**

The National Socialist German Workers Party bans homosexual groups. Homosexuals are sent to concentration camps. Nazis burn the library of Magnus Hirschfeld's Institute for Sexual Research, and destroy the Institute.

Denmark and Philippines decriminalizes homosexuality.

Homosexual acts are recriminalized in the USSR.

**1934**

Uruguay decriminalizes homosexuality.

**1936**

Federico García Lorca , Spanish poet, is shot at the beginning of the civil war.

**1937**

The first use of the pink triangle for gay men in Nazi concentration camps.

**1940**

Iceland decriminalizes homosexuality.

**1941**

Transsexuality was first used in reference to homosexuality and bisexuality.

**1942**

Switzerland decriminalizes homosexuality, with the age of consent set at 20.

**1944**

Sweden decriminalizes homosexuality, with the age of consent set at 20 and Suriname legalizes homosexuality.

**1945**

Upon the liberation of Nazi concentration camps by Allied forces, those interned for homosexuality are not freed, but required to serve out the full term of their sentences under Paragraph 175.

Portugal decriminalizes homosexuality for the second time in its history.

**1946**

"COC" (Dutch acronym for "Center for Culture and Recreation"), one of the earliest homophile organizations, is founded in the Netherlands. It is the oldest surviving LGBT organization.

### **1947**

Vice Versa, the first North American LGBT publication, is written and self-published by Edith Eyde in Los Angeles.

### **1948**

"Forbundet af 1948" ("League of 1948"), a homosexual group, is formed in Denmark. The communist authorities of Poland make age 15 the age of consent for all sexual acts, homosexual or heterosexual.

### **1950**

The Swedish Federation for Lesbian, Gay, Bisexual and Transgender Rights (RFSL) is formed in Sweden.

East Germany partially abrogates the Nazis' emendations to Paragraph 175.

The Mattachine Society, the first American homosexual group, is founded in Los Angeles. 190 individuals in the United States are dismissed from government employment for their sexual orientation, commencing the Lavender scare.

### **1951**

Greece decriminalizes homosexuality.

### **1952**

Dale Jennings successfully uses the defense of entrapment against charges of solicitation; ONE, Inc. is founded in California.

### **1954**

June 7, Alan Turing dies from cyanide poisoning, 18 months after being given libido-reducing hormone treatment for a year as a punishment for homosexuality.

Arcadie, the first homosexual group in France, is formed.

### **1955**

Daughters of Bilitis founded in San Francisco, California.

### **1956**

Thailand decriminalizes homosexual acts.

### **1957**

The word "Transsexual" is coined by U.S. physician Harry Benjamin; The Wolfenden Committee's report recommends decriminalizing consensual homosexual behaviour between adults in the United Kingdom; Psychologist Evelyn Hooker publishes a study showing that homosexual men are as well adjusted as non-homosexual men, which becomes a major factor in the American Psychiatric Association removing homosexuality from its handbook of disorders in 1973.

### **1958**

The Homosexual Law Reform Society is founded in the United Kingdom; Barbara Gittings founds the New York chapter of Daughters of Bilitis.

### **1961**

Czechoslovakia and Hungary decriminalize sodomy.

The Vatican declare that anyone who is "affected by the perverse inclination" towards homosexuality should not be allowed to take religious vows or be ordained within the Roman Catholic Church.

Jose Sarria becomes the first openly gay candidate in the world when he ran for the San Francisco Board of Supervisors.

### **1962**

Illinois becomes first U.S. state to remove sodomy law from its criminal code.

### **1963**

Israel decriminalizes de-facto sodomy and sexual acts between men by judicial decision against the enforcement of the relevant section in the old British-mandate law from 1936 (which in fact was never enforced).

### **1966**

The National Planning Conference of Homophile Organizations is established (to become NACHO – North American Conference of Homophile Organizations – in 1967).

The Compton's Cafeteria riot occurred.

### **1967**

Chad decriminalizes homosexuality.

The Sexual Offences Act 1967 decriminalizes male homosexual behaviour in England and Wales.

The book "Homosexual Behavior Among Males" by Wainwright Churchill breaks ground as a scientific study approaching homosexuality as a fact of life and introduces the term "homoerotophobia," a possible precursor to "homophobia".

The Oscar Wilde Bookshop, the world's first homosexual-oriented bookstore, opens in New York City.

"Our World" ("Nuestro Mundo"), the first Latino-American homosexual group, is created in Argentina.

A raid on the Black Cat Bar in San Francisco, CA prompts homosexual rights activity.

The Student Homophile League at Columbia University is the first institutionally recognized gay student group in the United States.

### **1968**

Paragraph 175 is ceased in East Germany decriminalizing homosexual acts over the age of 18; Bulgaria decriminalizes adult homosexual relations.

### **1969**

Homosexual behavior is legalized in Canada, with an Age of Consent of 21 for sodomy, and 14 for non-sodomy.

The Canadian Prime Minister is quoted as saying: "The government has no business in the bedrooms of the nation".

The Stonewall riots occur in New York.

Paragraph 175 is eased in West Germany.

Poland decriminalizes homosexual prostitution.

An Australian arm of the Daughters of Bilitis forms in Melbourne and is considered Australia's first homosexual rights organization.

### **1970**

The first Gay Liberation Day March is held in New York City.

The first Gay Freedom Day March is held in Los Angeles.

The first "Gay-in" is held in San Francisco.

CAMP (Campaign Against Moral Prosecution) is formed in Australia.

### **1971**

Society Five (a homosexual rights organization) is formed in Melbourne Victoria.

Homosexuality is decriminalized in Austria, Costa Rica and Finland.

Colorado and Oregon repeal sodomy laws.

Idaho repeals the sodomy law – then re-instates the repealed sodomy law because of outrage among mormons and catholics.

The Netherlands changes the homosexual age of consent to 16, the same as the straight age of consent.

The U.S. Libertarian Party calls for the repeal of all victimless crime laws, including the sodomy laws.

Dr. Frank Kameny becomes the first openly gay candidate for the United States Congress.

The University of Michigan establishes the first collegiate LGBT programs office, then known as the "Gay Advocate's Office."

### **1972**

Sweden becomes first country in the world to allow transsexuals to legally change their sex, and provides free hormone therapy.

Hawaii legalizes homosexuality.

In Australia, the Dunstan Labor government introduces a consenting adults in private type defence in South Australia. This defence was initiated as a bill by Murray Hill, father of former Defence Minister Robert Hill, and later repealed the state's sodomy law in 1975.

Norway decriminalizes homosexuality.

East Lansing and Ann Arbor, Michigan and San Francisco, California become the first cities in United States to pass a homosexual rights ordinance.

Jim Foster, San Francisco and Madeline Davis, Buffalo, NY, first gay and lesbian delegates

to the Democratic Convention in Miami and McGovern give the first speeches advocating a gay rights plank in the Democratic Party platform.

"Stonewall Nation," the first gay anthem is written and recorded by Madeline Davis and is produced on 45 rpm records by the Mattachine Society of the Niagara Frontier.

Lesbianism 101, first lesbianism course in the U.S. taught at the University of Buffalo by Margaret Small and Madeline Davis.

### **1973**

The American Psychiatric Association removes homosexuality from its Diagnostic and Statistical Manual of Mental Disorders (DSM-II), based largely on the research and advocacy of Evelyn Hooker.

Malta legalizes homosexuality.

In West Germany, the age of consent is reduced for homosexuals to 18 (though it is 14 for heterosexuals).

### **1974**

Kathy Kozachenko becomes the first openly homosexual American elected to public office when she wins a seat on the Ann Arbor, Michigan city council.

Ohio repeals sodomy laws. Robert Grant founds American Christian Cause to oppose the "gay agenda", the beginning of modern Christian politics in America.

In London, the first openly LGBT telephone help line opens, followed one year later by the Brighton Lesbian and Gay Switchboard.

After performing a song on amateur night called, "I Enjoy Being a Dyke," four women are asked to leave a bar in Toronto, Ontario, called the Brunswick Tavern. They refuse, and the Brunswick Four are arrested on January 5th, 1974. This incident of Lesbophobia galvanizes the Toronto Lesbian and Gay community.

### **1975**

Elaine Noble becomes the second openly homosexual American elected to public office when she wins a seat in the Massachusetts State House.

South Australia becomes the first state in Australia to make homosexuality legal between consenting adults in private.

Panama is the second country in the world to allow transsexuals who have gone through gender reassignment surgery to get their personal documents reflecting their new sex.

### **1976**

Robert Grant founds the Christian Voice to take his anti-homosexual-rights crusade national in United States.

The Homosexual Law Reform Coalition and the Gay Teachers Group are started in Australia. The Australian Capital Territory decriminalizes homosexuality between consenting adults in private and equalizes the age of consent.

Denmark equalizes the age of consent.



### **1977**

Harvey Milk is elected city-county supervisor in San Francisco, becoming the third "out" American elected to public office.

Dade County, Florida enacts a Human Rights Ordinance; it is repealed the same year after a militant anti-homosexual-rights campaign led by Anita Bryant.

Quebec becomes the first jurisdiction larger than a city or county in the world to prohibit discrimination based on sexual orientation in the public and private sectors.

Croatia, Montenegro, Slovenia and Vojvodina legalizes homosexuality.

### **1978**

San Francisco Supervisor Harvey Milk and Mayor George Moscone are assassinated by former Supervisor Dan White.

The Sydney Gay and Lesbian Mardi Gras for the first time.

The rainbow flag is first used as a symbol of homosexual pride.

Sweden establishes a uniform age of consent.

Samois, the earliest known lesbian-feminist BDSM organization is founded in San Francisco.

Well-known members of the group include Pat Califia and Gayle Rubin; the group is among the very earliest advocates of what came to be known as sex-positive feminism.

### **1979**

The first national homosexual rights march on Washington, DC is held.

Harry Hay issues the first call for a Radical Faerie gathering in Arizona.

Cuba and Spain decriminalize homosexuality.

### **1980**

The Democratic National Convention becomes the first major political party in America to endorse a homosexual rights platform plank.

Scotland decriminalizes homosexuality.

David McReynolds becomes the first openly GLBT individual to run for President of the United States, appearing on the Socialist Party U S A ticket.

The Human Rights Campaign Fund is founded by Steve Endean, an advocate for gay, lesbian, bisexual and transgender equality.

### **1981**

The European Court of Human Rights in *Dudgeon v. United Kingdom* strikes down Northern Ireland's criminalization of homosexual acts between consenting adults, leading to Northern Ireland decriminalizing homosexual sex the following year.

Victoria, Australia and Colombia decriminalize homosexuality with a uniform age of consent.

The Moral Majority starts its anti-homosexual crusade; Norway becomes the first country in the world to enact a law to prevent discrimination against homosexuals.

Hong Kong's first sex-change operation is performed.

## **1982**

France equalizes the age of consent.

The first Gay Games is held in San Francisco, attracting 1,600 participants.

Northern Ireland decriminalizes homosexuality.

Wisconsin becomes the first US state to ban discrimination against homosexuals.

New South Wales becomes the first Australian state to outlaw discrimination on the basis of actual or perceived homosexuality.

## **1983**

Massachusetts Representative Gerry Studds reveals he is a homosexual on the floor of the House, becoming the first openly homosexual member of Congress.

Guernsey (Including Alderney, Herm and Sark) and Portugal decriminalizes homosexuality.

AIDS is described as a "gay plague" by Reverend Jerry Falwell.

## **1984**

The lesbian and gay association "Ten Percent Club" is formed in Hong Kong.

Massachusetts voters reelect representative Gerry Studds, despite his revealing himself as homosexual the year before.

New South Wales and the Northern Territory in Australia make homosexual acts legal.

Chris Smith, newly elected to the UK parliament declares: "My name is Chris Smith. I'm the Labour MP for Islington South and Finsbury, and I'm gay", making him the first openly out homosexual politician in the UK parliament.

The Argentine Homosexual Community (Comunidad Homosexual Argentina, CHA) is formed uniting several different and preexisting groups.

Berkeley, California becomes the first city in the U.S. to adopt a program of domestic partnership health benefits for city employees.

## **1985**

France prohibits discrimination based on lifestyle (moeurs) in employment and services.

The first memorial to gay Holocaust victims is dedicated; Belgium equalizes the age of consent.

## **1986**

Homosexual Law Reform Act passed in New Zealand, legalizing sex between males over 16.

In *Bowers v. Hardwick* case, U.S. Supreme Court upholds Georgia law forbidding oral or anal sex, ruling that the constitutional right to privacy does not extend to homosexual relations but it did not state whether the law could be enforced against heterosexuals.

## **1987**

ACT UP stages its first major demonstration, 17 protesters are arrested.

U.S. Congressman Barney Frank comes out.

Homomonument, a memorial to persecuted homosexual opens in Amsterdam.

### **1988**

Sweden is the first country to pass laws protecting homosexual regarding social services, taxes, and inheritances.

Section 28 passes in England and Wales; Scotland enacts almost identical legislation.

Canadian MP Svend Robinson comes out.

Canada lowers the age of consent for sodomy to 18.

Belize and Israel decriminalize (de jure) sodomy and sexual acts between men (the relevant section in the old British-mandate law from 1936 was never enforced in Israel).

### **1989**

Western Australia legalizes male homosexuality.

Liechtenstein legalizes homosexuality.

Denmark is the first country in the world to enact registered partnership laws (like a civil union) for same-sex couples, with most of the same rights as marriage (excluding the right to adoption and the right to marry in a church).

### **1990**

OutRage!, an LGBT rights direct action group, forms in the UK.

Czechoslovakia equalizes the age of consent.

Jersey legalizes homosexual acts.

Justin Fashanu is the first professional footballer to come out in the press.

### **1991**

Bahamas, Hong Kong, Ukraine and Queensland in Australia decriminalize sodomy.

The red ribbon is first used as a symbol of the campaign against HIV/AIDS.

### **1992**

The World Health Organization removes homosexuality from its ICD-10.

Australia allows homosexuals to serve in the military for the first time.

Isle of Man, Estonia and Latvia legalize homosexuality.

Iceland, Luxembourg and Switzerland all equalize the age of consent.

Nicaragua recriminalizes homosexuality (then decriminalizes homosexuality again in March 2008).

### **1993**

Brandon Teena, a transgender man, is raped and murdered.

The third homosexual rights march on Washington, DC is held.

Sodomy laws are repealed in Norfolk Island and the Republic of Ireland.

Gibraltar and Russia decriminalizes consensual male sodomy (with the exception of the Chechen Republic).

Lithuania legalizes homosexuality.

Norway enacts registered partnership civil union laws that grant same-sex couples the same rights as married couples, except for the right to adopt or marry in a church.

### **1994**

Bermuda, Serbia (including Kosovo) and South Africa legalize homosexuality.  
The United Kingdom reduces the age of consent for homosexual men to 18.  
The American Medical Association denounces supposed cures for homosexuality.  
Canada grants refugee status to homosexuals fearing for their well-being in their native country.  
Paragraph 175 is repealed in Germany.  
Israel's supreme court defines homosexual couple's rights as the same as any common-law-couple's rights.

### **1995**

Sweden legalizes registered partnerships.  
The Supreme Court of Canada rules that sexual orientation is a prohibited reason for discrimination under the Canadian Charter of Rights and Freedoms.  
Albania and Moldova decriminalize homosexuality; The Human Rights Campaign drops the word fund from their title and broadens their mission to promote "an America where gay, lesbian, bisexual and transgender people are ensured equality and embraced as full members of the American family at home, at work and in every community."

### **1996**

The age of consent is equalized in Burkina Faso.  
Iceland legalizes registered partnerships.  
Hungary recognizes same-sex partners in unregistered domestic partnerships.  
Romania decriminalizes homosexuality that is not scandalous.  
Macedonia decriminalizes homosexuality.

### **1997**

South Africa becomes the first country to prohibit explicitly discrimination based on sexual orientation in its constitution and comes into force.  
The UK extends immigration rights to same-sex couples akin to marriage.  
Fiji becomes the second country to protect explicitly against discrimination based on sexual orientation in its constitution.  
Laws prohibiting private homosexual acts are finally repealed in Tasmania, Australia, the last Australian state to do so, as well as in Ecuador.  
Russia equalizes the age of consent.

### **1998**

Matthew Shepard, a gay man, is murdered, bringing attention to the issue of hate crime legislation at the state and federal levels in the United States.  
The Employment Equality Act is introduced in Ireland, covering wrongful dismissal based on the grounds of sexual orientation.  
Ecuador is the third country in the world to explicitly prohibit discrimination on the basis of sexual orientation.  
Bosnia and Herzegovina, Chile, Kazakhstan, Kyrgyzstan and Tajikistan legalize homosexuality.

Croatia and Latvia equalize the age of consent.  
Cyprus decriminalizes homosexuality.

### **1999**

California adopts a domestic partnership law.  
France enacts civil union laws.  
The "Queer Youth Alliance" is founded in the UK.  
Israel's supreme court recognizes a lesbian partner as another legal mother of her partner's biological son.  
Finland equalizes the age of consent.

### **2000**

The United Kingdom's ban on homosexuals serving in the armed forces is abolished and Clause 2A is repealed in Scotland.  
The former USSR states of Azerbaijan and Georgia legalize homosexual acts.  
Gabon decriminalize homosexuality.  
The age of consent is equalized in the United Kingdom, Belarus, and Israel.  
The Bundestag officially apologizes to gays and lesbians persecuted under the Nazi regime, and for "harm done to homosexual citizens up to 1969."  
Vermont becomes the first U.S. state to legalize civil unions.  
Israel recognizes same-sex relations for immigration purposes for a foreign partner of an Israeli resident.

### **2001**

The state of Arizona repeals its sodomy law.  
Albania and Liechtenstein equalize the age of consent.  
Same-sex marriage is legalized in the Netherlands, making it the first country to do so.  
Germany enacts registered partnership legislation.  
Protesters disrupt the first Pride march in Belgrade and the rest of the United Kingdom's territories legalize homosexuality.

### **2002**

Austria, Bulgaria, Cyprus, Estonia, Hungary, Moldova, Romania and Western Australia all equalize their age of consent.  
Romania repeals article 200, which was used to punish "scandalous sodomy."  
Sweden legalizes adoption for same-sex couples.  
Zurich extends marriage-like rights to same-sex couples.  
Openly gay Dutch politician Pim Fortuyn is assassinated by Volkert van der Graaf.  
Homosexuality is decriminalized in China.  
A civil unions law is passed in Buenos Aires, making it the first Latin-American city to legalize same-sex unions.

### **2003**

Belize recriminalizes homosexuality.

Section 28 is repealed in England and Wales.

The U.S. Supreme Court strikes down remaining state sodomy laws.

Armenia decriminalizes male homosexual sodomy.

Lithuania, the Northern Territory and New South Wales all equalize their age of consent.

Same-sex marriage in Belgium is legalized; Germany's Supreme Court upholds the country's civil union.

### **2004**

In Tasmania, the Relationships Act 2003 providing a registered partnership becomes affective from January 1, 2004.

Cape Verde and Marshall Islands legalize homosexuality.

Portugal is the fourth country in the world to protect people from discrimination on the basis of sexual orientation in their Constitution.

Massachusetts legalizes same-sex marriage, while eleven other U.S. states ban the practice through public referendums.

Domestic partnerships are legalized in New Jersey.

Rio Grande do Sul, Brazil accepts civil unions.

Australia bans same-sex marriage on August 13, 2004.

New Zealand passes a civil union bill; Luxembourg introduces civil partnerships.

Same-sex marriages in Belgium get adoption rights and are equal to marriage.

### **2005**

New Zealand is the first nation in the world to outlaw hate crimes and employment discrimination on the basis of gender identity.

Puerto Rico repeals anti-sodomy law.

Hong Kong's age of consent equalized through legal ruling.

Uganda and Latvia amend their constitutions to prohibit same-sex marriage.

Same-sex marriage is legalized in Spain and Canada (together with adoption).

Andorra recognizes same-sex partners in "Stable Unions".

Two gay male teenagers, Mahmoud Asgari and Ayaz Marhoni, are executed in Iran.

Switzerland votes in favour of extending rights for registered same-sex couples.

South Africa's Supreme Court rules that it is unconstitutional to ban gay marriages, legalizing same-sex marriage effective December 1, 2006.

André Boisclair is chosen leader of the Parti Québécois, becoming the first openly homosexual man elected as the leader of a major political party in North America.

UK introduces civil partnerships with rights all but equal to marriage.

Maine adds sexual orientation and gender identity to existing anti-discrimination laws.

## **2006**

Serbia and Isle of Man equalized the age of consent. Illinois outlaws sexual orientation discrimination. Washington adds sexual orientation to its existing anti-discrimination laws.

Missouri legalizes homosexuality between consenting adults.

The first homosexual pride march in Moscow ends with violence.

The first regional Eastern European Pride is held in Zagreb, Croatia.

The United States Senate fails to pass the Federal Marriage Amendment.

The International Conference on LGBT Human Rights is held in Montreal.

The Czech Republic and Slovenia introduce civil partnerships.

Mexico City introduces civil unions.

South Africa legalizes same-sex marriage.

The Israeli High Court orders Israeli law to recognize same-sex marriages performed abroad.

Fiji legalizes consensual homosexuality and Germany includes gender identity in anti-discrimination law.

South Australia is the last state in Australia to enact most laws that includes all couples;

Another section 28 "successfully repealed" in Isle of Man and the Faroe Islands make sexual orientation discrimination illegal by a narrow vote of 17:15.

Human Rights Campaign, 2006 Summary of legislative issues in each state of USA

## **2007**

Registered partnership takes effect in Switzerland.

Age of consent equalized in Jersey.

In New Jersey and Coahuila, Mexico civil unions law come into effect.

The first ever gay pride parade in a Muslim country was held in Istanbul, Turkey.

Domestic partnership law comes into effect in South Australia on June 1, 2007 and in Washington state on July 22, 2007.

Equality Act 2006 comes into force for the UK (with provisions protecting people from discrimination in goods and services on the grounds of sexual orientation and establishing the Commission for Equality and Human Rights).

Oregon, Colorado, Ohio, and Iowa ban discrimination based on sexual orientation or gender identity in the private sector.

On August 9, 2007, the Logo cable channel hosts the first presidential forum in the United States focusing specifically on LGBT issues. Six Democratic Party candidates participate in the event. GOP candidates were asked to attend but turned it down.

Nepal make homosexuality legal, by Supreme Court orders.

Portugal and South Africa equal age of consent come into force from a new Penal Code.

## **2008**

The "civil union" law comes into effect in New Hampshire and Uruguay on January 1, 2008 and also a "domestic partnership" legislation in Oregon comes into effect on February 4 – lots of couples sign up for these.

Nicaragua re-legalizes homosexuality (with an equal age of consent), under a new Penal Code on March 1, 2008.

Kosovo declares to be an international country with a new constitution that includes "sexual orientation" the first of its kind in Eastern Europe.

The Registered partnership legislation called the Relationships Act 2008 will come into effect on December 1, 2008 in Victoria, Australia.

## **2009**

Hungary's "Registered partnership" law goes into effect on January 1, 2009.

"Unregistered co-habitation" has been provided since 1996 and Northern Cyprus legalizes male homosexuality by a new Criminal Code, effective on January 1 2009.

Austria, Ireland and the Australian Capital Territory introduce "civil partnerships" which all come into effect on December 1, 2009.

*Source: Wikipedia ([www.wikipedia.org](http://www.wikipedia.org)).*

*Note: This appendix is not intended to represent an extensive history, but rather a brief overview and offer possible suggestions for additional material that could be researched.*



## **Appendix: B**

### ***Recommended Steps to Inclusivity***

Steps to Inclusivity should include:

#### 1. Preparing for Change

- ◆ Raise the issue
- ◆ Address any initial opposition
- ◆ Make the commitment
- ◆ Document the commitment
- ◆ Communicate the commitment
- ◆ Establish a Steering Committee (Terms of Reference, Shared Understanding and Vision, Leadership, Involvement, Education and Training).

#### 2. Research and Assessment

- ◆ Review the literature
- ◆ Create a community (demographic profile)
- ◆ Conduct a survey of the community
- ◆ Assess your organization

#### 3. Planning for Change

- ◆ Develop your plan
- ◆ Create a Communications Strategy

#### 4. Making it Happen

- ◆ Implement the plan
- ◆ Continue to deal with opposition

#### 5. Evaluation

- ◆ Track your progress
- ◆ Evaluate the outcomes
- ◆ Reflect on the process

*Source: Adapted from Inclusive Community Organizations:  
A Tool Kit- Ontario Health Communities Coalition. October 2004.*

## **Appendix: C**

### ***Principles of a Collaborative Service Model***

While not limited to this initiative, leading practices demonstrates that successful engagement of both the internal and external communities by the long-term care home would most optimally employ and ascribe to a collaborative service model that demonstrates the principles of:

- ◆ Understanding and respect for the traditions and values of the “linked” group being engaged. This will facilitate success in achieving person-centred care;
- ◆ Leadership, shared values and common objectives;
- ◆ Building buy-in and trust between the long-term care home, the “linked” community and the community at large;
- ◆ Meaningful and ongoing engagement with community groups – working and evaluating together;
- ◆ Staff training and awareness building regarding cultures served;
- ◆ Finding “program champions” or “allies” within the staff and the community partners to guide the models’ success; and
- ◆ Revising and realigning processes, resources or the environment to improve quality of life.

## **Appendix: D**

### ***Toronto Long-Term Care Homes and Services LGBT Diversity Initiative***

LGBT Steering Committee  
Terms of Reference  
November 2006

#### **Purpose:**

Toronto Long-Term Care Homes and Services is committed to provide care and service in a manner that respects the sexual orientation and gender identity of all applicants, residents and clients. The LGBT Steering Committee has been established to build on the successes achieved to date in establishing a gay-positive culture within Toronto Long-Term Care Homes and Services, to provide advice in enhancing and sustaining this culture and approach and to develop multi-level strategies to expand this culture and approach to other long-term care homes.

#### **Fundamental Principle:**

To celebrate the diversity and the unique lives of residents living in Toronto Long-Term Care Homes and Services.

#### **LGBT Diversity Initiative Goals:**

- ◆ To provide leadership, support and encouragement in the continuing implementation of LGBT responsive (gay-positive) services in Toronto Long-Term Care Homes and Services;
- ◆ To promote full and equal access to services for LGBT individuals who require long-term care;
- ◆ To create an atmosphere of openness and affirmation for LGBT individuals applying to or residing in Toronto Long-Term Care Homes and Services;
- ◆ To create environments where it is "safe" to be "out" for people who live, work and volunteer at Toronto Long-Term Care Homes and Services;
- ◆ To create support groups for LGBT residents, their partners and families;
- ◆ To continue to research and develop strategies for the provision of culturally competent service for LGBT individuals;
- ◆ To plan, develop, coordinate and implement care and service protocols that respect LGBT culture, traditions and social networks; and
- ◆ To create a "tool kit" to guide the provision of LGBT responsive (gay-positive) care and service.

### **LGBT Steering Committee Objectives:**

- ◆ To plan, develop, coordinate and implement administrative practices that facilitate the demonstration of LGBT responsive (gay-positive) care and service;
- ◆ To provide advice and input into the creation of LGBT responsive (gay-positive) care, service and environment and quality improvement processes;
- ◆ To develop effective linkages for LGBT referrals;
- ◆ To continue to build an effective volunteer program with connections to the LGBT community;
- ◆ To continue to develop processes to maintain effective community engagement;
- ◆ To develop a "tool kit" for the provision of LGBT responsive (gay-positive) services for Toronto Long-Term Care Homes and Services, making it available to other long-term care homes;
- ◆ To provide advice regarding the provision of staff orientation, training and education regarding LGBT responsive (gay-positive) services, thus contributing to cultural competence;
- ◆ To develop indicators to evaluate LGBT responsive (gay-positive) services; and
- ◆ To develop a gay-straight alliance of interested residents, their partners, families and staff.

### **LGBT Steering Committee Membership:**

Anna Travers – Sherbourne Health Centre

Dick Moore – The 519 Community Centre

Matt Hughes – Community Member and Member of Fudger House Advisory Committee

Gay Thomson – Concerned Friends

Jack Harmer – Member of the Advisory Committee on Toronto Long-Term Care Homes and Services

Pat Prentice – Ontario Association of Residents' Councils'

Mary Diamond – Ministry of Health and Long-Term Care

Maylin Poon – Toronto Central Community Care Access Centre

Sandra lafrate – Toronto Central Community Care Access Centre

Catherine Anastakis – Toronto Central Local Health Integration Network

Brian Nicholson – Fudger House

Patty Carnegy – Toronto Long-Term Care Homes and Services

Sally Martin – Fudger House

Doreen Calvin – Toronto Long-Term Care Homes and Services

Greg O'Grady – True Davidson Acres

Erin Mulcahey-Abbott – Toronto Long-Term Care Homes and Services

Bob Petrushewsky – Kipling Acres

Sandra Pitters – Toronto Long-Term Care Homes and Services

Michael Saunders – Toronto Long-Term Care Homes and Services

Timeframe:

- ◆ LGBT Steering Committee to begin in November 2006;
- ◆ Meetings to be scheduled for every other month;
- ◆ Proposed timeframe for completion of the initiative to be 12-18 months; and
- ◆ Detailed work to be completed through a series of work groups, led by individual members of the LGBT Steering Committee

Authority:

- ◆ Advisory in nature, providing advice to the General Manager, Toronto Long-Term Care Homes and Services; and
- ◆ Forwarding an eight-month and final report to the Advisory Committee on Long-Term Care Homes and Services.

Work Groups:

The following work groups were established by the LGBT Steering Committee at its November 2006 meeting. All work groups will report back to the LGBT Steering Committee with draft plans and deliverables. Each work group will be led by a member of the LGBT Steering Committee and will establish its own work plan, based on the approved LGBT Steering Committee Work Plan. Work Groups may augment their membership with others, based on the tasks to be done.

- ◆ Welcoming Environment;
- ◆ Administrative Processes;
- ◆ Programs & Services in the Home;
- ◆ Nursing & Personal Care in the Home;
- ◆ Staff & Volunteers in the Home; and
- ◆ Community Engagement.

## Appendix: E

### *LGBT Inclusiveness – Personal Assessment Tool*

Please check appropriate box

Yes	No	In Progress	Not Sure	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I have an equal rights statement posted in my work area (i.e., "positive space" sticker).
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I am honest about the limits of my understanding of sexual orientation and gender diversity.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I endeavor to use inclusive language such as "partner" instead of "girlfriend/boyfriend" or "wife/husband".
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	When providing individual or group services, I use questions and comments that are inclusive of all sexual orientations and gender identities.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I treat people of all sexual orientations and gender identities as individuals with many roles and identities.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I ask questions to understand the personal lived realities of others.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I review forms, histories, posters, etc., regularly for inclusivity and appropriate language.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I keep a list of resources for people who are LGBT or questioning.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I post positive images and posters of sexual orientation minorities and gender diverse people.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I am comfortable working with co-workers of all sexual orientations and gender identities.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I am comfortable working with clients and communities of all sexual orientations and gender identities.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I would feel comfortable if my manager were LGBT.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I utilize opportunities for ongoing training on sexual orientation and gender identity issue.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I monitor my attitudes, values, behaviours and practice for discrimination based on sexual orientation or gender identity.

## ***LGBT Inclusiveness – Personal Assessment Tool***

Please check appropriate box

Yes	No	In Progress	Not Sure	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I recognize that a person's appearance, actions or words may not be reflective of that person's sexual orientation or gender identity and I avoid making assumptions based on these characteristics.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I can recognize discrimination by association. (i.e., discrimination against heterosexuals who support the rights of sexual minorities).
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I have been/or would be accepting of an LGBT person coming out to me.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I am aware of the laws and personnel policies concerning sexual orientation and gender diversity.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I am aware that the presenting problems of LGBT and questioning clients may not be related to sexual orientation or gender identity.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I advocate for policies that include non-discrimination related to sexual orientation minorities and gender diverse persons.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I encourage education about sexual orientation and gender identity in my workplace.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I work to safeguard the rights of sexual orientation and gender diverse minorities.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I confront statements and jokes that discriminate or make fun of LGBT people or communities.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I challenge gender stereotypes.

## **Appendix: F**

### ***Glossary and Definitions***

*Changes in thinking and attitudes toward sexual orientation and gender identity are continually taking place in society as a whole and within the LGBT communities. These terms and definitions are not standardized and may be used differently by different people and in different regions.*

***Asexual:*** a word describing a person who is not sexually and/or romantically active, or not sexually and/or romantically attracted to other people.

***Autosexual:*** a word describing a person whose significant sexual involvement is with oneself or a person who prefers masturbation to sex with a partner.

***Biphobia:*** irrational fear or dislike of bisexuals. Bisexuals may be stigmatized by heterosexuals, lesbians and gay men.

***Bi-positive:*** the opposite of biphobia. A bi-positive attitude is one that validates, affirms, accepts, appreciates, celebrates and integrates bisexual people as unique and special in their own right.

***Bisexual:*** a word describing a person whose sexual orientation is directed toward men and women, though not necessarily at the same time.

***Coming out:*** the process by which LGBT people acknowledge and disclose their sexual orientation or gender identity, or in which transsexual or transgendered people acknowledge and disclose their gender identity, to themselves and others (See also "Transition"). Coming out is thought to be an ongoing process. People who are "closeted" or "in the closet" hide the fact that they are LGBT. Some people "come out of the closet" in some situations (i.e., with other gay friends) and not in others (i.e., at work).

***Crossdresser:*** A person who dresses in the clothing of the other sex for recreation, expression or art, or for erotic gratification. Formerly known as "transvestites." Cross-dressers may be male or female, and can be straight, gay, lesbian or bisexual. Gay/bisexual male crossdressers may be "drag queens" or female impersonators; lesbian/bisexual female crossdressers may be "drag kings" or male impersonators.

***Dyke:*** a word traditionally used as a derogatory term for lesbians. Other terms include lezzie, lesbo, butch, bull dyke and diesel dyke. Many women have reclaimed these words and use them proudly to describe their identity.

***Fag:*** a word traditionally used as a derogatory term for gay men. Other terms include fruit, faggot, queen, fairy, pansy, sissy and homo. Many men have reclaimed these words and use them proudly to describe their identity.

***Family of choice:*** the circle of friends, partners, companions and perhaps ex-partners with which many LGBT people surround themselves. This group gives the support, validation and sense of belonging that is often unavailable from the person's family of origin.

***Family of origin:*** the biological family or the family that was significant in a person's early development.



**Gay:** a word to describe a person whose primary sexual orientation is to members of the same gender or who identifies as a member of the gay community. This word can refer to men and women, although many women prefer the term "lesbian."

**Gay-positive:** the opposite of homophobia. A gay-positive attitude is one that affirms, accepts, appreciates, celebrates and integrates gay and lesbian people as unique and special in their own right.

**Gender conforming:** abiding by society's gender rules, i.e., a woman dressing, acting, relating to others and thinking of herself as feminine or as a woman.

**Gender identity:** a person's own identification of being male, female or intersex; masculine, feminine, transgendered or transsexual. Gender identity most often corresponds with one's anatomical gender, but sometimes people's gender identity doesn't directly correspond to their anatomy. Transgendered people use many terms to describe their gender identities, including: pre-op transsexual, post-op transsexual, non-op transsexual, transgenderist, crossdresser, transvestite, transgendered, two-spirit, intersex, hermaphrodite, fem male, gender blender, butch, manly woman, diesel dyke, sex radical, androgynist, female impersonator, male impersonator, drag king, drag queen, etc.

**Genderqueer:** this very recent term was coined by young people who experience a very fluid sense of both their gender identity and their sexual orientation, and who do not want to be constrained by absolute or static concepts. Instead, they prefer to be open to relocate themselves on the gender and sexual orientation continuums.

**Gender role:** the public expression of gender identity. Gender role includes everything people do to show the world they are male, female, androgynous or ambivalent. It includes sexual signals, dress, hairstyle and manner of walking. In society, gender roles are usually considered to be masculine for men and feminine for woman.

**Gender transition:** the period during which transsexual persons begin changing their appearance and bodies to match their internal identity.

**Genderism:** the belief that the binary construct of gender, in which there are only two genders (male and female), is the most normal, natural and preferred gender identity. This binary construct does not include or allow for people to be intersex, transgendered, transsexual or genderqueer.

**Hate crimes:** offences that are motivated by hatred against victims based on their actual or perceived race, colour, religion, national origin, ethnicity, gender, disability or sexual orientation.

**Heterosexism:** the assumption expressed overtly and/or covertly, that all people are or should be heterosexual. Heterosexism excludes the needs, concerns, and life experiences of lesbian, gay and bisexual people, while it gives advantages to heterosexual people. It is often a subtle form of oppression that reinforces silence and invisibility for lesbian, gay and bisexual people.

**Heterosexual:** term used to describe a person whose primary sexual orientation is to members of the opposite gender. Heterosexual people are often referred to as "straight."

**Heterosexual privilege:** the unrecognized and assumed privileges that people have if they are heterosexual. Examples of heterosexual privilege include: holding hands or kissing in public without fearing threat, not questioning the normalcy of your sexual orientation, raising children without fears of state intervention or worries that your children will experience discrimination because of your heterosexuality.

**Homophobia:** irrational fear, hatred, prejudice or negative attitudes toward homosexuality and people who are gay or lesbian. Homophobia can take overt and covert, as well as subtle and extreme, forms. Homophobia includes behaviours such as jokes, name-calling, exclusion, gay bashing, etc.

**Homosexual:** a term to describe a person whose primary sexual orientation is to members of the same gender. Most people prefer to not use this label, preferring to use other terms, such as gay or lesbian.

**Identity:** how one thinks of oneself, as opposed to what others observe or think about one.

**Internalized homophobia:** fear and self-hatred of one's own sexual orientation that occurs for many lesbians and gay men as a result of heterosexism and homophobia. Once lesbians and gay men realize that they belong to a group of people that is often despised and rejected in our society, many internalize and incorporate this stigmatization, and fear or hate themselves.

**Intersex:** a person who has some mixture of male and female genetic and/or physical sex characteristics. Formerly called "hermaphrodites." Many intersex people consider themselves to be part of the trans community.

**Lesbian:** a female whose primary sexual orientation is to other women or who identifies as a member of the lesbian community.

**LGBTTIQ:** a common acronym for lesbian, gay, bisexual, transsexual, transgendered, two-spirit, intersex and queer individuals/communities. This acronym may or may not be used in a particular community. For example, in some places, the acronym LGBT (for lesbian, gay, bisexual and transgendered/transsexual) may be more common.

**MSM:** refers to any man who has sex with a man, whether he identifies as gay, bisexual or heterosexual. This term highlights the distinction between sexual behaviour and sexual identity (i.e., sexual orientation). A person's sexual behaviour may manifest itself into a sexual identity, but the reverse is not always true; sexual orientation is not always reflective of sexual behaviour. For example, a man may call himself heterosexual but may engage in sex with men in certain situations (i.e., prison, sex work).

**Out or out of the closet:** varying degrees of being open about one's sexual orientation or gender identity.

**Passing:** describes transgendered or transsexual people's ability to be accepted as their preferred gender. The term refers primarily to acceptance by people the individual does not know or who do not know that the individual is transgendered or transsexual. Typically, passing involves a mix of physical gender cues (i.e., clothing, hairstyle, voice), behaviour, manner and conduct when interacting with others. Passing can also refer to hiding one's sexual orientation, as in "passing for straight."

**Polysexual:** an orientation that does not limit affection, romance or sexual attraction to any one gender or sex and that further recognizes there are more than just two sexes.

**Queer:** traditionally, a derogatory and offensive term for LGBT people. Many LGBT people have reclaimed this word and use it proudly to describe their identity. Some transsexual and transgendered people identify as queers; others do not.

**Questioning:** people who are questioning their gender identity or sexual orientation and who often choose to explore options.

**Sexual behaviour:** what people do sexually. Not necessarily congruent with sexual orientation and/or sexual identity.

**Sexual identity:** one's identification to self (and others) of one's sexual orientation. Not necessarily congruent with sexual orientation and/or sexual behaviour.

**Sexual minorities:** include people who identify as LGBT.

**Sexual orientation:** a term for the emotional, physical, romantic, sexual and spiritual attraction, desire or affection for another person. Examples include heterosexuality, bisexuality and homosexuality.

**Significant other:** a life partner, domestic partner, lover, boyfriend or girlfriend. It is often equivalent to the term "spouse" for LGBT people.

**Straight:** a term often used to describe people who are heterosexual.

**Trans and transpeople:** are non-clinical terms that usually include transsexual, transgendered and other gender-variant people.

**Transgendered:** a person whose gender identity is different from his or her biological sex, regardless of the status of surgical and hormonal gender reassignment processes. Often used as an umbrella term to include transsexuals, transgenderists, transvestites (crossdressers), and two-spirit, intersex and transgendered people.

**Transgenderist:** someone who is in-between being a transsexual and a transgendered person on the gender continuum, and who often takes sex hormones, but does not want genital surgery. Transgenderists can be born male (formerly known as "she-males") or born females (one called he/shes"). The former sometimes obtain breast implants and/or electrolysis.

**Transition:** the process (which for some people may also be referred to as the "gender reassignment process") whereby transsexual people change their appearance and bodies to match their internal (gender) identity, while living their lives full-time in their preferred gender role.

**Transphobia:** irrational fear or dislike of transsexual and transgendered people.

**Transpositive:** the opposite of transphobia. A transpositive attitude is one that validates, affirms, accepts, appreciates, celebrates and integrates transsexual and transgendered people as unique and special in their own right.

**Transsensual:** a term for a person who is primarily attracted to transgendered or transsexual people.

**Transsexual:** a term for a person who has an intense long-term experience of being the sex opposite to his or her birth-assigned sex and who typically pursues a medical and legal transformation to become the other sex. There are transmen (female-to-male transsexuals) and transwomen (male-to-female transsexuals). Transsexual people may undergo a number of procedures to bring their body and public identity in line with their self-image, including sex hormone therapy, electrolysis treatments, sex reassignment surgeries and legal changes of name and sex status.

**Transvestite:** see "Crossdresser."

**Two-spirit:** an English term coined to reflect specific cultural words used by First Nation and other indigenous peoples for those in their cultures who are gay or lesbian, are transgendered or transsexual, or have multiple gender identities. The term reflects an effort by First Nation and other indigenous communities to distinguish their concepts of gender and sexuality from those of Western LGBT communities.

**WSW:** refers to any woman who has sex with a woman, whether she identifies as lesbian, bisexual or heterosexual. This term highlights the distinction between sexual behaviour and sexual identity (i.e., sexual orientation). For example, women who identify as lesbian can also have sex with men and not all wsw identify as lesbian or bisexual.

*Source: Adapted from the Centre for Addictions and Mental Health (CAMH) 2007.*

## **Appendix: G**

### ***Residents Rights and Responsibilities***

Residents of long-term care homes deserve to be cared for in a respectful and compassionate way. They can and should expect their lives to be free from abuse and neglect.

Resident rights include:

- ◆ The residents' right to be treated with courtesy and respect;
- ◆ The right to be adequately sheltered, fed, clothed, groomed and cared for, according to one's needs;
- ◆ The right to privacy in treatment and the tending to one's personal needs;
- ◆ The right to be informed of one's medical condition, treatment and proposed treatment;
- ◆ The right to consent to or refuse treatment, and to obtain an independent medical opinion;
- ◆ The right to have medical records and other aspects of one's treatment kept confidential;
- ◆ The right to receive visitors; and
- ◆ The right, when a resident's death appears to be near, to have family members present 24 hours a day.

*Source: Adapted from Ministry of Health and Long-Term Care website.*

## Appendix: H

### *Ethics and Research Committee Policy*

Toronto Long-Term Care Homes & Services  
Administration Manual

AD-0102-04

<b>Division</b> Introduction	<b>Policy</b>  Ethics/Research Committee	<b>Page</b>  1 of 6		
<b>Applicability</b> All Management Staff		<b>Day</b> 01	<b>Month</b> 12	<b>Year</b> 2008
<b>Approval History</b> Original: 01-03-04; Revised: 01-07-05, 01-11-05, 01-02-08, 01-08-08, 01-12-08		<b>Next Review Date</b> 01-12-2011		

#### POLICY:



The Long-Term Care Homes and Services Division shall have a process to address ethical issues/concerns and to review/approve applied research proposals.

#### PREAMBLE:



The primary purpose of the Ethics/Research Committee is to provide support and recommendations to the division's management and staff regarding their respective ethical responsibilities and to review/recommend approval of research proposals that are congruent with the division's vision, mission statement and values.

#### DEFINITIONS:

For the purpose of this policy, a research proposal is defined as any request from an individual or agency to collect, analyze, and publish data related to resident/client care and service within the division. This includes studies involving interventions and treatments, and also the simple collection of data from divisional files.

*Applied Research:* Work which develops or tests existing knowledge. It is primarily directed towards either specific practical objectives or the evaluation of policies or practices. Work which involves the routine application of established techniques on routine problems is unlikely to constitute research. *New Zealand Qualifications Authority (1998).*

#### PURPOSE:

The interdisciplinary Ethics/Research Committee exists to:



1. improve ethical decisions in resident/client care by providing advice to care teams to ensure that decisions are thoroughly reasoned and balance competing values, wishes and preferences;
2. provide support to residents/clients and families in addressing issues that have ethical implications;
3. review research proposals submitted to the division and evaluate the appropriateness of all proposed research projects in a long-term care setting;
4. protect the legal and human rights of residents;
5. recommend action on proposed research projects to the General Manager;
7. ensure that all approved research projects comply with the requirements of the *Municipal Freedom of Information and Protection of Privacy Act (MFIPPA)* and the *Personal Health Information Protection Act 2004 (PHIPA)*;

<b>Division</b> Introduction	<b>Policy</b>  Ethics/Research Committee	<b>Page</b>  2 of 3		
<b>Applicable to</b> All Management Staff		<b>Day</b> 01	<b>Month</b> 12	<b>Year</b> 2008
<b>Approval History</b> Original: 01-03-04; Revised: 01-07-05, 01-11-05, 01-02-06, 01-03-08, 01-12-08		<b>Next Review Date</b> 01-12-2011		

**PURPOSE:** (Cont'd)



8. monitor the progress of all approved research projects, providing interim and final reports and instituting any remedial action required; and
9. be an integral part of Quality Improvement.



**MEMBERSHIP - ETHICS/RESEARCH COMMITTEE:**

- |  |  |
|--|--|
| 1. Co-ordinator of Medical Services                  | 8. Resident/Client Advocate                                |
| 2. Director of Resident Care                         | 9. Manager Clinical Nutrition Services                     |
| 3. Administrator                                     | 10. Assistant Administrator                                |
| 4. Director of Resident Services (Chairperson)       | 11. Supervisor Staff Education                             |
| 5. General Manager (Ex-Officio)                      | 12. Director of Nursing/Care                               |
| 6. Management Representation from Community Programs | 13. Additional disciplines/outside consultants as required |
| 7. Manager, Programs & Services                      |  |

**NOTE:** To expedite the review of research proposals, the Chairperson shall call an Ad Hoc meeting with 4 members of the Ethics/Research Committee.

**TERMS OF REFERENCE:**

1. to act as a consultative team to the Home/Program in clarifying and advising on both clinical and organizational ethical issues;
2. to identify gaps in knowledge and recommend education/training;
3. to respond to requests to assist staff, residents, and families address issues that have ethical implications;
4. to recommend revision/changes in policy and procedures to ensure ethical practices and decision making improve both the quality of life and quality of the environment for residents/clients, families and staff;
5. to review and complete the Research Proposal Criteria Checklist for research proposals submitted to the division;
6. to recommend action to the General Manager for research proposals that are simple data collection and analysis and are non-diagnostic and non-treatment in nature utilizing the Ethics/Research Committee Recommendation Form. Research proposals that include a diagnostic or treatment component would continue to be referred to City Council for prior approval.

Section Introduction	Policy  <b>Ethics/Research Committee</b>	Page 3 of 6		
Application All Management Staff		Day 01	Month 06	Year 2008
Approval History Original: 01-03-04; Revised: 01-07-05, 01-11-05, 01-02-06, 01-06-08		Next Review Date 01-06-2011		

**ADMINISTRATION:**

1. Meetings shall be held a minimum of four (4) times per year. Additional Ad Hoc meetings will be held at the call of the Chair to expedite the review of research proposals.
2. All approved research projects will be reported to the Advisory Committee on Long-Term Care Homes and Services.
3. The Administrator of the home/program where the proposed research is being considered shall:
  - complete Research Proposal Criteria Checklist and submit to the chair of the Ethics/Research Committee two weeks prior to the Ethics/Research Committee meeting
  - for incomplete research proposals, the Administrator of the Home/Program will contact the researcher for any outstanding information. Once all information is received, the Administrator of the home/program will submit to Chair of Ethics/Research Committee
  - provide quarterly interim reports throughout the duration of the project and a final report to the Chair of the Ethics/Research Committee for inclusion/discussion and recommendations at the next Ethics/Research Committee meeting.
4. The Ethics/Research Committee will forward appropriate recommendations based on the final report to the Long-Term Care Homes and Services Management Committee for consideration.
5. The final report shall be summarized for presentation to the Advisory Committee on Long-Term Care Homes and Services for information.
6. Final research reports shall be retained in the divisional library.
7. Written minutes shall be distributed to:
  - Committee Members
  - Long-Term Care Homes and Services Management Committee
  - General Manager

**ACCOUNTABILITY:**

General Manager

**CRITERIA FOR APPROVAL OF RESEARCH PROJECTS:**

1. Current scientific and ethical approval from an accredited university, teaching hospital, or national granting agency. The researcher is responsible for maintaining and submitting approval extensions to the Chair of the Ethics/Research Committee during the project.



Section Introduction	Policy  Ethics/Research Committee	Page  4 of 6		
Application All Management Staff		Day 01	Month 12	Year 2008
Approval History Original: 01-03-04; Revised: 01-07-05, 01-11-05, 01-02-06, 01-03-08, 01-12-08		Next Review Date 01-12-2011		

**CRITERIA FOR APPROVAL OF RESEARCH PROJECTS: (Cont'd)**

2. Support of senior management at the site proposed by the research team prior to recommendation for approval by the Ethics/Research Committee.
3. Evidence that the project will cause minimal disruption to residents/clients, families, and staff.
4. Evidence of potential future benefit to residents and caregivers.
5. No cost to the City of Toronto.
6. Agreement to gain individual residents' consent in a manner that complies with MFIPPA and PHIPA requirements.
7. Execution of a Research Agreement with the Long-Term Care Homes and Services Division that complies with MFIPPA and PHIPA requirements.
8. Agreement to include a statement in the final report and related published articles acknowledging the collaboration with and support of the City of Toronto Long-Term Care Homes and Services Division in the completion of the project.

**GUIDELINES FOR PREPARING A RESEARCH PROPOSAL:**

The Municipal Freedom of Information and Protection of Privacy Act, governs how institutions collect, use and disclose an individual's personal information. It sets out rules for protecting individual privacy and establishes criteria under which research may be conducted. The Act establishes in law objective standards which have normally been part of research agreements by custom and practice.

The Personal Health Information Protection Act 2004 (PHIPA) requires even more stringent confidentiality of the personal health information of any Ontario citizen held by a "health information custodian". A "health information custodian" (HIC) is a person or organization who needs to know personal health information for the purpose of delivering health care.

To facilitate compliance with the legislation and streamline the approval process, a Long-Term Care Homes and Services Ethics/Research Committee will review all applications to conduct research involving the personal information of others. The Chair of Ethics/Research Committee may consult with the Legal Department to ensure the proposals do not contravene the Acts. Researchers must provide the following documentation to the Ethics/Research Committee to assist in evaluating the proposed research project:

Section Introduction	Policy  <b>Ethics/Research Committee</b>	Page 5 of 6		
Application All Management Staff		Day 01	Month 06	Year 2008
Approval History Original: 01-03-04; Revised: 01-07-05, 01-11-05, 01-02-06, 01-06-08		Next Review Date 01-06-2011		

**GUIDELINES FOR PREPARING A RESEARCH PROPOSAL:** (Cont'd)

- general description of the research proposal and design;
- the objectives of the research project;
- the proposed method of analysis;
- an explanation of why the research cannot be accomplished without individually identifiable information;
- stating the time at which the personal identifiers will be removed;
- outlining the benefits to be derived from the research project as proposed;
- the names and positions of all those who will have access to and use of the personal information (i.e. research assistant). Such access must be limited and specific.

The principal researcher must provide the Ethics/Research Committee with a curriculum vitae. All others having access and use of the personal information requested must also provide their curriculum vitae outlining:

- education;
- research experience;
- knowledge of subject and proposed analytical methodology;
- three references.

This information is required by the Ethics/Research Committee to evaluate and determine the researcher's ability, judgement and competence to responsibly access personal information.

**Terms and Conditions**

The following terms and conditions must be agreed to before access can be granted:

1. The **original** records disclosed under this agreement can only be consulted in the homes or the Archives and Record Centre.
2. **COPIES** can be made of the original records disclosed. The researcher may take notes or enter the information onto a computer disk.
3. The researcher is responsible for ensuring that all measures have been taken to ensure the confidentiality of the original documents both on the premises and in copies of information in their own offices.

<b>Section</b> Introduction	<b>Policy</b>  Ethics/Research Committee	<b>Page</b>		
<b>Application</b> All Management Staff		G of G		
		<b>Day</b>	<b>Month</b>	<b>Year</b>
		01	12	2008
<b>Approval History</b> Original: 01-03-04; Revised: 01-07-05, 01-11-05, 01-02-06, 01-06-08, 01-12-08		<b>Next Review Date</b> 01-12-2011		

**Terms and Conditions (Cont'd)**

4. Once the research project is completed and the agreement has expired, the researcher **must** destroy all copies and notes containing any personal information or identifiers, both hard copy and disk. The destruction of such notes must follow the destruction guidelines of the Long-Term Care Homes and Services Division (i.e. shredding).
5. The researcher may not make any data linkages other than those specified and agreed to under the terms and conditions of the research agreement.
6. Individually identifiable information may not be transmitted by means of any telecommunication device (i.e. fax machines).
7. The researcher may not contact any individual to whom personal information relates directly or indirectly without the prior written authority of the Long-Term Care Homes and Services Division.
8. The researcher must immediately notify the Ethics/Research Committee in writing if the person becomes aware that any of the conditions set out in these terms/conditions have been breached.
9. Consultation with Legal Department will occur to determine the proper steps to prevent any further disclosure of personal information. The research agreement is a legal document and the researcher will be held liable for any breach of the outlined terms and conditions.

**NOTE:** Should the research project involve general records, the requested records must first be reviewed for exemptions under MFIPPA and PHIPA before the researcher is granted access to all or part of the records. A review is a time and labour-intensive process and, depending on the volume of records, must be taken into account when determining a research completion date.

### Research Proposal Criteria Checklist

Home: \_\_\_\_\_  
 Date: \_\_\_\_\_  
 Title of Proposal: \_\_\_\_\_



Submission includes the following criteria:	Yes	No
General description of research proposal		
Design of research proposal		
Objectives		
Proposed method of analysis		
Explanation of research requiring individual identifiable information		
States time personal identifiers will be removed		
Outlines benefits to be gained		
Names and positions of those who will have access to personal information including research assistants		
Access will be limited and specific. Data will be secured during study and storage.		
Curriculum vitae (CV) of principal researcher		
CV of others having access and use of personal information		
Ethical approval from accredited university, teaching hospital or national granting agency		
Ethical approval current		
Project to cause minimal disruption to residents/clients, families, staff		
Evidence of potential future benefit to residents and caregivers		
No cost to the City of Toronto		
There is no monetary benefits to City of Toronto employees or residents/clients		
Agreement to gain individual resident's/client's/staff's consent		
Consent for residents/clients meets MFIPPA, PHIPA requirements		
Researcher agrees to execution of a Research Agreement with the division that complies with MFIPPA and PHIPA		
Researcher agrees to include statement in final report, related published articles acknowledging collaboration with the division in the completion of the project		

Administrator recommends approval of the research proposal.  Yes  No

Administrator will forward quarterly interim reports and a final report to Ethics/Research Committee.

Administrator's Signature: \_\_\_\_\_

Ethics/Research Committee Member Signature: \_\_\_\_\_

### Ethics/Research Committee Recommendation

Memo to: General Manager  
Toronto Long-Term Care Homes and Services

From: Ethics/Research Committee

Date: \_\_\_\_\_

1. The Ethics/Research Committee has received and reviewed the research proposal entitled:

\_\_\_\_\_

Brief Description: \_\_\_\_\_

\_\_\_\_\_

2. This research proposal has been forwarded and being supported from: \_\_\_\_\_  
Home/Program

The home/program currently is involved in \_\_\_\_\_ other research proposals.  
Number

3. The research proposal is simple data collection and analysis, and is non-diagnostic and non-treatment in nature.

Yes  No  \*N.B. Diagnostic or treatment components require City Council approval.

4. Copies of the Ethics/Research member review is attached.

Yes  No

5. The Ethics/Research members are recommending that the research proposal:

- Receive approval  
 Not receive approval

Reason for not recommending approval: \_\_\_\_\_

\_\_\_\_\_

6. General Manager Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Statement: Research Agreement will be sent to the Administrator/Director of Program for completion prior to implementation of the research program.

Date \_\_\_\_\_

**Memo to:**

**From:** Ethics/Research Committee

**Re:** Research Proposal Entitled \_\_\_\_\_

- We are pleased to inform you that the Research Proposal has been reviewed by the Ethics/Research Committee and approved by the General Manager. Please contact the Researcher and complete the Research Agreement. Once completed, the researcher may proceed with their research project.

We look forward to your interim and final reports.

- We have received the research proposal you submitted and have withheld recommendation for approval for the following reason(s):

---

---

---

---

---

---

Our recommendations have been reviewed and supported by the General Manager.

Please contact the researcher and inform them of the Ethics/Research Committee decision.

Thank you for the opportunity of reviewing this proposal.

Sincerely,

Doreen Calvin  
Chair, Ethics/Research Committee

# Appendix: I

## *Intimacy and Sexuality*

Homes for the Aged  
**Resident Care Manual**

**RC-0309-00**

Section Residents' Rights	Policy  <b>Intimacy and Sexuality</b>	Page  1 of 2		
Application All Staff		Day 01	Month 11	Year 2007
Approval History New		Next Review Date 01-11-2010		

### **POLICY:**

The Home shall develop and maintain a decision-making process for use in residents' expression of intimacy and sexuality.

Management of intimacy and sexuality will demonstrate respect for the dignity and autonomy of the residents' involvement in the context of residing in a communal living environment and recognizing the needs of others that may be uncomfortable or embarrassed by open expression of intimacy and sexuality.

### **PREAMBLE:**

Intimacy and sexuality is a basic human need and a normal part of life that is integral to who we are as human beings.

Intimacy, sexuality and the opportunity to form meaningful relationships with others are important needs for all adults at all levels of functioning. There are many different ways where residents can express their interest in affection and intimate relationships, including but not limited to holding hands, dancing closely together, hugging and kissing, intimate caressing, masturbation and sexual intercourse.

There are many different situations and issues that arise in caring for residents in long-term care situations. Simple single acts like masturbation or shared intimacy such as sitting together, holding hands and hugging are rarely problematic in the long-term care home environment. However, when intimacy takes on a sexual nature like shared sexual touching or intercourse, the issues are often more serious, difficult and complex given the characteristics and profiles of the residents in our care.

### **DEFINITIONS:**

- Intimacy** - a shared, private experience, which may or may not be physical
- Sexuality**
  - concept of self and expression of love and affection
  - incorporates physical, emotional, social, spiritual and psychological well-being
  - involves need, drive and desire both at a conscious and sub-conscious level
- Capacity to Consent**
  - the ability to consent to sexual intimacy and/or activity and may be demonstrated by lack of resistance or objection, and by willing participation
  - often referred to as competency
  - "the resident is able to understand what is relevant in making a decision and is able to appreciate the reasonable foreseeable consequences of a decision or lack of decision" [adapted from the Health Care Consent Act reference 4. (1)]

Section Residents' Rights	Policy  <b>Intimacy and Sexuality</b>	Page  2 of 2		
Application All Staff		Day 01	Month 11	Year 2007
Approval History New		Next Review Date 01-11-2010		

**PURPOSE:**

To promote the resident's bill of rights as it relates to intimacy and sexuality and ensure each resident's rights to freedom, privacy, confidentiality and dignity. Residents who are assessed as being competent have the right to make their own informed decisions and choices. These individual decisions and choices must not comprise other residents' rights.

**PROCEDURE:**

1. Upon report of resident expression of intimacy and sexuality, refer to Decision-Making Tree for the management of intimacy and sexuality to support the following roles and responsibilities:

RN/RPN:

- assess competency of both residents;
- assess situation taking into consideration physical, psychological and emotional outcomes of the episode of intimacy and sexuality;
- obtain medical interventions as required;
- notify management based on assessed risk;
- ensure care plan current and co-ordinate communication to all team members;
- provide clear direction to PCA/CT on actions when encountering an episode of intimacy and sexuality.

Physician:

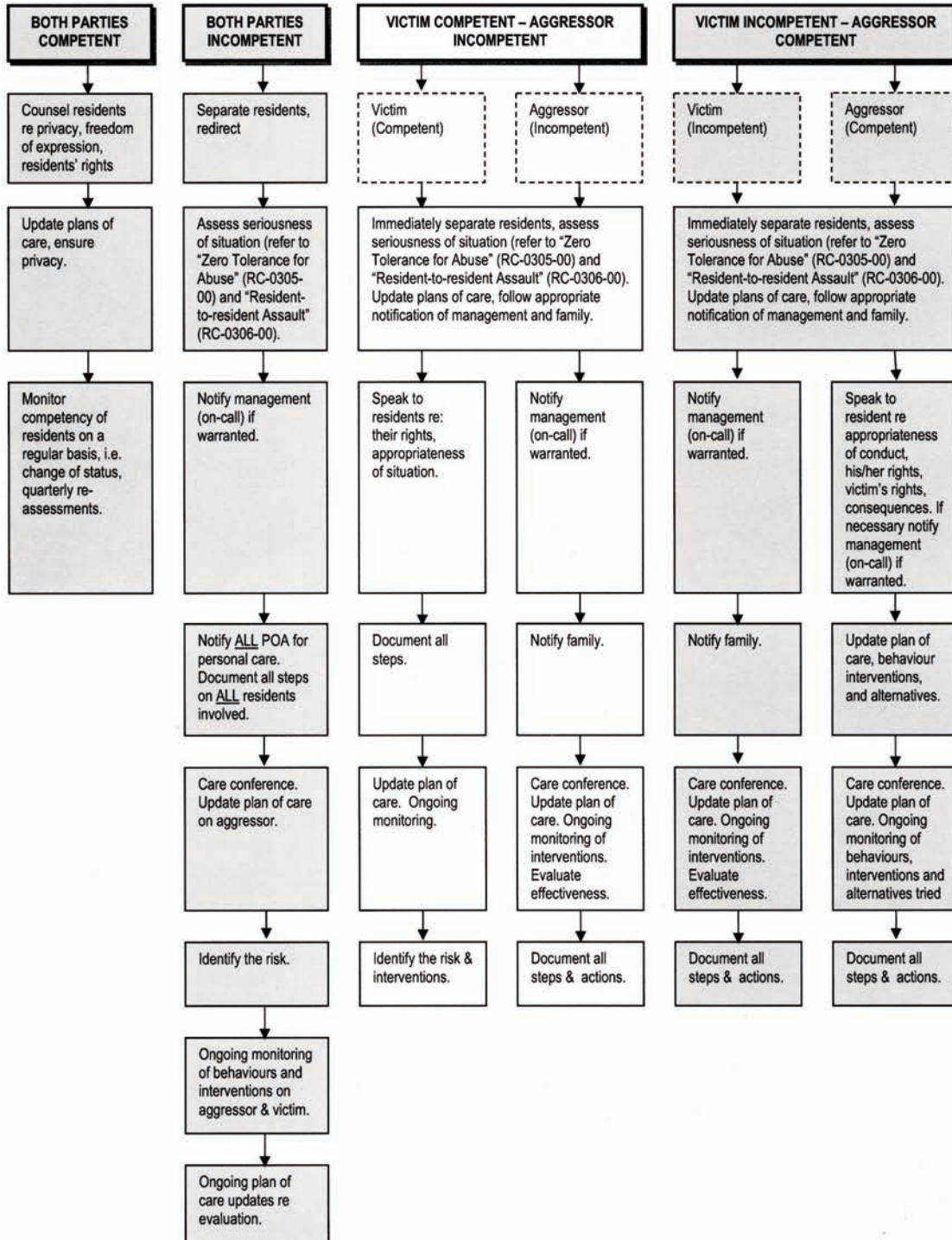
- based on nursing assessment provide treatment as indicated in particular with episodes of sexual aggression;
- provide health teaching and counselling to residents on sexually transmitted diseases (STDs) as required; and
- support and provide leadership in support of Care Team's understanding of intimacy and sexuality.

Counsellor:

- support competent residents and confirm informed consent;
- support and educate POA (family) on incompetent residents' expression and meaning of intimacy and sexuality behaviour;
- assess need for ongoing POA (family) counselling as required and update care plan;
- update care team as to the counsellor involvement;
- document strategies on care plan; and
- collaborate with the Nurse Manager in considering staff education needs that would support the care team's understanding and skill in managing residents' intimacy and sexuality and communicate these learning needs to the appropriate resources within the Home.



**DECISION-MAKING TREE FOR MANAGEMENT OF INTIMACY AND SEXUALITY**



## Appendix: J

### *LGBT Training Plan for Fudger House, True Davidson Acres and Kipling Acres*



## Memorand

**Homes for the Aged**  
Metro Hall, 11<sup>th</sup> Floor  
55 John Street  
Toronto, Ontario M5V 3C6

**Tel:** (416) 392-8906  
**Fax:** (416) 392-4180

**Date:** December, 2007

**To:** HFA Management

**From:** Patty Carney  
Co-ordinator of Staff Education

**Re:** **LGBT Training Plan for Fudger House, TDA, Kipling and (Seven Oaks)**

The following is the LGBT educational plan for Fudger House, True Davison Acres, Seven Oaks and Kipling Acres. Implementation for 2007 and 2008 is as described below.

Target Group	Content	Delivered by	Date & Length	Cost/ Location of AV Materials	Group size
<b>Fall, 2007</b>					
Managers and Social Work Counselors	<b>“Asking the Right Questions”</b>	CAMH	One day training (2 days total)	\$2000.00	25 each  Fudger House
<b>2008</b>					
Staff at Fudger House, Kipling Acres and Seven Oaks	<b>Understanding Human Sexuality</b> Video: 30 minutes  Journal Article: “Sex and Intimacy” Nursing Homes, February 2003	Supervisor of Staff Education	Inservice: 45 minutes	Seven Oaks	Front-line staff
Staff at Fudger House, Kipling Acres and Seven Oaks	<b>Intimacy, Sexuality and Aging</b> Video: 32 minutes  Policy: Intimacy and Sexuality	Supervisor of Staff Education	Inservice: 45 minutes	Head Office	Front-line staff

Staff at Fudger House, Kipling Acres and Seven Oaks	<b>Project Visibility</b> Video: 28 minutes  Definitions list from CAMH	Supervisor of Staff Education	Inservice: 45 minutes	Head Office	Front-line staff
Staff at Fudger House, Kipling Acres and Seven Oaks	<b>HIV:</b>  Video: Understanding HIV  Policy: Routine Practices	Supervisor of Staff Education	Inservice: 45 minutes	Head Office	Front-line staff
Staff at Fudger House, Kipling Acres and Seven Oaks	<b>Rewriting the Script: A Love Letter To Our Families.</b> Video = 48 minutes.  A documentary that explores the loves, lives and sexualities of "Queer South Asians" and their families of origin.	Supervisor of Staff Education	Inservice: 45 minutes	Kipling Acres	Front-line staff

Details will be confirmed by the Supervisor of Staff Education in each Home as they are available.

Thank you,

Patty Carnegy,  
Co-ordinator of Staff Education

## **Appendix: K**

### ***Training Resources - Educational LGBT Videos***

#### **Understanding Healthy Relationships and Sexuality**

Films for Humanities and Sciences

Allan and Bacon

Princeton, New Jersey

1998, 30 minutes

Good for staff as an introduction to the requirements for a healthy relationship and that LGBT is one of them.

#### **Creating a Welcoming Space for GLBT Patients**

Rainbow Access Initiative, Mautner Program,

Gay Lesbian Medical Association.

[www.rainbowaccess.org](http://www.rainbowaccess.org)

A short video for healthcare professionals concerned about providing the best care for patients who are LGBT.

#### **Project Visibility**

Boulder County Aging Services Division

PO Box 471

Boulder CO, 80306

2004, 30 minutes

[www.projectvisibility.org](http://www.projectvisibility.org)

Seniors expressing their views on aging and LGBT sexuality.

\$165.00 – 2 films and one training manual

#### **Intimacy, Sexuality and Aging**

Video: 32 minutes

#### **Rewriting the Script: A Love Letter to Our Families.**

Lesbian and Gay Community Appeal and City of Toronto

Access and Equity Program, Heritage Canada.

Home Sales - Toronto Women's Book Store.

This is a new documentary that explores the loves,

lives and sexualities of "Queer South Asians" and their families of origin.

#### **Open Secrets**

Story of gay men in World War II

National Film Board of Canada

Directed by: José Torrealba

Produced by: Germaine Ying Gee Wong. 2003, 52 minutes

Good for Veteran's Day

\$65.00

## Appendix: L

### Policy Recommendations



### Policy Recommendations and Best Practices for Agencies Working Towards Trans Accessibility

#### Policy Recommendations

- 1 Trans access should be considered as part of a larger anti-oppression framework and policies regarding trans service users should be consistent with policies regarding other marginalized groups accessing services.
- 2 A policy of inclusion: ensure that the mandate of the organization specifically includes trans people in advertising, outreach materials, web sites, flyers and posters.
- 3 Include gender identity and expression in existing non-discrimination policies and/or anti-oppression policies and training.
- 4 Trans people can be accommodated in women and men's services according to their self-defined needs and gender identity.
- 5 Ongoing training for staff, volunteers and counselors by members of the TS/TG community and ongoing outreach to the trans community.
- 6 Staff, boards, volunteers: reflect the diversity of your service users in all aspects of the organization by recruiting and hiring trans people as well as members of other marginalized groups.

#### Best Practices

- 1 Respect: demonstrate respect towards all people on the trans spectrum. Use pronouns that are consistent with the person's stated preference or gender expression; if preference is not known, respectfully ask.
- 2 Privacy/confidentiality: trans status is to be kept confidential unless permission is given by the person to disclose. Allow TS/TG staff or clients to choose if, when, and to whom to disclose their trans status. If someone is inadvertently or accidentally outed, let them know.
- 3 Personal Questions: Refrain from asking questions of an intimate physical nature (such as asking about genital surgery) other than what is relevant and necessary to best serve the client.
- 4 Intake conversations: let service users know that your organization works with people from diverse backgrounds including trans people, this allows them to make an informed decision to use the service and creates an environment where trans people may be more likely to disclose and get their needs met.
- 5 Advocacy: Assistance and advocacy with trans specific goals: changing ID, keeping medical appointments related to transitioning, attending trans support groups.
- 6 Referrals: If referrals are necessary, work with other agencies to develop an appropriate referral plan.

Last Updated: Oct-30-2007

**For more Info. Contact: Alec Butler, Trans Policy Consultant,  
trans\_policy@yahoo.ca, 416-392-6878 x315  
<http://www.the519.org/programs/trans/>**

## **Appendix: M**

### ***Top Gay Films*** (March 2008)

#### **The Adventures of Felix (France)**

*Sami Bouajila, Patachou, Ariane Ascaride, Pierre-Loup Rajot, Charly Sergue*

#### **The Adventures of Priscilla, Queen of the Desert (Australian)**

*Terence Stamp, Guy Pearce, Hugo Weaving, Bill Hunter, Sarah Chadwick*

#### **All Over the Guy (U.S.A.)**

*Dan Bucatinsky, Richard Ruccolo, Adam Goldberg, Sasha Alexander, Doris Roberts*

#### **Angels in America (USA)**

*Meryl Streep, Al Pacino, Emma Thompson, Justin Kirk, Jeffrey Wright*

#### **Another Country (Great Britain)**

*Rupert Everett, Colin Firth, Cary Elwes*

#### **Another Gay Movie (USA)**

*Michael Carbonaro, Jonathan Chase, Jonah Blechman, Mitch Morris, Scott Thompson*

#### **Bear Cub (Spain)**

*José Luis García Pérez, David Castillo, Diana Cerezo, Arno Chevrier, Empar Ferrer*

#### **Beautiful Thing (Great Britain)**

*Linda Henry, Glen Barry, Scott Neal, Tameka Empson*

#### **Before Night Falls (USA)**

*Javier Bardem, Olivier Martinez, Johnny Depp, Andrea Di Stefano, Sean Penn*

#### **Bent (Great Britain)**

*Clive Owen, Lothaire Bluteau, Mick Jagger, Ian McKellen, Rupert Graves*

#### **Big Eden (USA)**

*Arye Gross, Eric Schweig, George Coe, Louise Fletcher, Nan Martin*

#### **Billy's Hollywood Screen Kiss (USA)**

*Sean Hayes, Brad Rowe, Meredith Scott Lynn, Paul Bartel, Holly Woodlawn*

#### **Brokeback Mountain (USA)**

*Heath Ledger, Jake Gyllenhaal, Michelle Williams, Linda Cardellini, Anne Hathaway*

#### **Brother to Brother (USA)**

*Anthony Mackie, Roger Robinson, Larry Gilliard Jr., Daniel Sunjata, Aunjanue Ellis*

#### **Burnt Money (Argentina)**

*Eduardo Noriega, Ricardo Piglia, Leonardo Sbaraglia, Leticia Bredice*

#### **Capote**

*Phillip Seymour Hoffman (USA)*

#### **In and Out**

*Kevin Klein, Tom Selleck, Matt Dillion (USA)*

**Infamous**

*Sandra Bullock (USA)*

**Les Cage aux Folles (France)**

*Michael Serrault, Ugo Tognazzi*

**Lan Yu (China)**

*Liu Ya, Hu Jun*

**Like It Is (Great Britain)**

*Dani Behr, Ian Rore, Steve Bell*

**Love! Valour! Compassion! (USA)**

*Jason Alexander, John Glover*

**Making Love (USA)**

*Michael Outkean, Kate Jackson, Harry Hamlin*

**Maurice (Great Britain)**

*James Wilby, Hugh Grant Rupert Graves*

**Philadelphia**

*Tom Hanks, Denzel Washington (USA)*

**The Bird cage**

*Robin Williams, Nathan Lane (USA)*

**The Black Dahlia**

*Hillary Swank (USA)*

**The Object of My Affection (USA)**

*Jennifer Aniston, Paul Rudd*

**To Wong Foo Thanks for Everything, Julie Newmar (USA)**

*Patrick Swayze*

**Transamerica (USA)**

*Felicity Hoffman*

**Trash (USA)**

*Joe Dallesandro, HollyWoodlawn*

**Total Eclipse (Great Britain)**

*Leonardo DiCaprio, David Thewlis*

**Velvet Goldmine (Great Britain)**

*Ewan McGregor, Jonathan Rhys Meyers, Christian Bale*

**Victor/Victoria (USA)**

*Julie Andrews, Robert Preston, James Garner*

**Others:**

**La Vie En Rose**

**Appendix: N**

***“TOOL KIT” Activities Program Template***

Staff Name: \_\_\_\_\_

Discipline: \_\_\_\_\_

Date: \_\_\_\_\_ Time/Place: \_\_\_\_\_

Start Date: \_\_\_\_\_ Review Date: \_\_\_\_\_

Activity/Program Type: \_\_\_\_\_

Specialty: \_\_\_\_\_

Integrative: \_\_\_\_\_

Revised: \_\_\_\_\_

LGBT Activity/Program: \_\_\_\_\_

Needs Assessment: \_\_\_\_\_

Goal: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Program Design: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Indicators for Evaluation: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Supplies and Budget Required: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



## **Appendix: O**

### ***Program Evaluation and Possible Indicators***

INDICATORS - DATA - OUTCOMES MEASUREMENT - PLANNING - SUSTAINABILITY

**1.**

# \_\_\_\_\_ of residents that have demonstrated positive behavioural changes  
\_\_\_\_\_ x 100 = %

# \_\_\_\_\_ of residents in program

**2.**

# \_\_\_\_\_ of residents demonstrating positive program interaction  
\_\_\_\_\_ x 100 = %

# \_\_\_\_\_ of residents in program

**3.**

# \_\_\_\_\_ of residents who have improved previous negative program intervention  
\_\_\_\_\_ x 100 = %

# \_\_\_\_\_ of residents in program

**4.**

# \_\_\_\_\_ of residents who have communicated program satisfaction  
\_\_\_\_\_ x 100 = %

# \_\_\_\_\_ of residents in program

**5.**

# \_\_\_\_\_ of residents currently attending the program  
\_\_\_\_\_ x 100 = %

# \_\_\_\_\_ of residents initially involved in program

**6.**

# \_\_\_\_\_ of residents demonstrating decrease in agitation  
\_\_\_\_\_ x 100 = %

# \_\_\_\_\_ of residents involved in program

**7.**

# \_\_\_\_\_ of residents who have demonstrated increase program enthusiasm or participation  
\_\_\_\_\_ x 100 = %

# \_\_\_\_\_ of residents in program

### **Other Activity and Program Indicators**

as identified by the service provider Means of Evaluation

- ◆ Discipline Specific Program Evaluation Indicator Tool
- ◆ Resident Feedback
- ◆ Audit
- ◆ Observation of participation
- ◆ Activity Evaluation (required)
- ◆ Attendance
- ◆ Other - i.e. questionnaire, staff/family feedback

### **Other Activity and Program Indicators**

as identified by the service provider Note:

Activity/Program Evaluations are to have the following information attached:

- ◆ list of program participants names and folstein scores
- ◆ identified goals for each individual program participant
- ◆ whether the individual participant identified goal(s) were achieved
- ◆ an explanation as to why the identified individual participant goal(s) were not achieved

## **Appendix: P**

### ***Internet Sites***

The Internet can be a useful tool and resource for information about LGBT people, issues and ideas. We have listed some of these for your reference. In connecting with these sites, there are often additional links to other sites that you may find helpful.

***Canadian Rainbow Health Coalition***

[www.rainbowhealth.ca](http://www.rainbowhealth.ca)

***EGALE- Equality for Gays and Lesbians Everywhere***

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

***PFLAG Canada- Parents and Friends of Lesbians and Gays***

[www.pflag.ca](http://www.pflag.ca)

***Gender Education and Advocacy Inc.***

[www.gender.org](http://www.gender.org)

***Gay and Lesbian Medical Association***

[www.glma.org](http://www.glma.org)

***National Day to End Homophobia***

[www.homophobiaday.org](http://www.homophobiaday.org)

***Ontario Rainbow Health Resource Centre***

[www.rainbowhealthnetwork.ca](http://www.rainbowhealthnetwork.ca)

***Coalition for Lesbian and Gay Rights in Ontario***

[www.web.ca/clgro](http://www.web.ca/clgro)

***Gay Seniors, Canada***

[www.gaynorfolk-net.norfolk.on.ca](http://www.gaynorfolk-net.norfolk.on.ca)

***Human Rights Campaign***

[www.hrc.org](http://www.hrc.org)

***Gay, Lesbian and Straight Educators Network***

[www.glsen.org](http://www.glsen.org)

***National Gay and Lesbian Task Force***

[www.thetaskforce.org](http://www.thetaskforce.org)

***Children of Gay and Lesbians Everywhere***

[www.colage.org](http://www.colage.org)

***International Foundation for Gender Equality***

[www.ifge.org](http://www.ifge.org)

***Transgender at Work***

[www.tgender.net](http://www.tgender.net)

*Outlive-Canadian Rainbow Health Campaign*

[www.outlive.ca](http://www.outlive.ca)

*Gay Grief*

[www.GayandLesbianWidows.com](http://www.GayandLesbianWidows.com)

*Grief Therapy*

[www.gaypsychotherapy.com](http://www.gaypsychotherapy.com)

*Lesbian and Gay Aging Issues Network*

[www.asaging.org](http://www.asaging.org)

*LGBT Online Caregiver Group*

[www.caregiver.org](http://www.caregiver.org)

*Services and Advocacy for LGBT Elders*

[www.sageusa.org](http://www.sageusa.org)

*Transgender Aging Network*

[www.forge-forward.org](http://www.forge-forward.org)

*Queer people of South Asian heritage*

[www.trikone.org](http://www.trikone.org)

*Asian Community AIDS Service*

[www.acas.org](http://www.acas.org)

*Gay Latinos*

[www.the519.org](http://www.the519.org)

*Ontario Rainbow Alliance of the Deaf*

[www.geocities.com](http://www.geocities.com)

*Lesbian and Gay Immigration Task Force*

[www.legit.ca](http://www.legit.ca)

*Resources for bisexual people living with disabilities*

[www.bi.org](http://www.bi.org)

*Two-Spirited People of the First Nations*

[www.2spirits.com](http://www.2spirits.com)

*Ottawa GLBT Seniors*

[www.pinktriangle.org](http://www.pinktriangle.org)

*Queer Muslims*

[www.salaamcanada.com](http://www.salaamcanada.com)

*L/G/B/Ts on the WWW*

[www.qrd.org](http://www.qrd.org)

*National Gay and Lesbian Task Force, United States*

[www.thetaskforce.org](http://www.thetaskforce.org)

*Intersex Society of North America*

[www.isna.org](http://www.isna.org)

*Toronto Bisexual Network*

[www.torontobinet.org](http://www.torontobinet.org)

*Info On Resources For Transpeople Across Ontario*

[www.the519.org](http://www.the519.org)

*The 519 Church Street Community Centre*

[www.the519.org](http://www.the519.org)

*LGBT Health Matters manual*

[www.lgtbcentrevancouver.com](http://www.lgtbcentrevancouver.com)

*LGBT Communities and Substance Abuse -*

*What Health Has to Do With It! report*

[www.vch.ca](http://www.vch.ca)

*Canadian Centre on Substance Abuse's LGBTTTTIQ page*

[www.ccsa.ca](http://www.ccsa.ca)

*National Association of Gay and Lesbian Addiction Professionals*

[www.nalgap.org](http://www.nalgap.org)

*Online Magazine of Health and Fitness*

*for Transsexual and Transgendered People*

[www.trans-health.com](http://www.trans-health.com)

*Health care information and resources*

[www.mcmaster.ca](http://www.mcmaster.ca)

*The Women's Addiction Foundation's document:*

*Lesbian and Bisexual Women and Substance Use*

[www.womenfdn.org](http://www.womenfdn.org)

*Sherbourne Health Centre*

[www.sherbourne.on.ca](http://www.sherbourne.on.ca)

*Citizens Against Homophobia*

[www.actwin.com](http://www.actwin.com)

*Family Pride Canada*

[www.uwo.ca](http://www.uwo.ca)

*LGBT parenting*

[www.fsatoronto.com](http://www.fsatoronto.com)

## **Appendix: Q**

### ***“Ask the Advocate” Resident Newsletter Submission***

One of the mechanisms used by Toronto Long-Term Care Homes and Services of promoting information and awareness was to include an article in the residents' newsletter entitled “Ask the Advocate”. The “Ask the Advocate” submission is a regular feature in each of the newsletters.

#### ***An example of this is from the Spring 2007 submission:***

**Question:** *Why is Toronto Long-Term Care Homes and Services working to establish positive welcoming communities for Lesbian, Gay, Bisexual and Transgendered (LGBT) individuals?*

**Answer:** Actually the work to establish positive welcoming environments for LGBT people requiring long-term care began back in 2004 at Fudger House.

At that time, the Division became aware that there was significant evidence that the needs of LGBT seniors were not well served in the mainstream health care system, and certainly not being addressed in the long-term home system itself.

A vast majority of the LGBT seniors over the age of 65 years have lived most of their lives in an environment of overt discrimination and hostility. For many, given the times and societal views, they have experienced different forms of abuse as a result of their sexual orientation. And for many, it was impossible to be openly gay and to feel safe.

Now, at a different time in their life where perhaps they require the services and programs offered within a long-term care home, many LGBT seniors report heightened fear and anxiety should they disclose their sexual orientation to service providers within both health and social service agencies and have little faith and confidence that they would not experience further victimization.

Once Toronto Toronto Long-Term Care Homes and Services became aware of this disparity in service provision, the division saw this as a unique opportunity in establishing positive and welcoming communities within our homes that would respond to this gap and also improve residents' quality of life. Similar to some of the other “programs” that Toronto Long-Term Care Homes and Services offers, such as Young Adults with Health Issues or Intellectual Disabilities, Behavioral Support, Language/Cultural alliances to name a few, the division has engaged in a successful collaborative relationship with both the 519 Church Street Community Centre and the Sherbourne Health Centre, who have provided expert advice, consultation, collaboration and first hand experiences that has guided and continues to bring value added to the ongoing work within this initiative.

While significant inroads with this initiative have been implemented within Toronto Long-Term Care Homes and Services, we are not completely “there” yet in fully evolving this program.

Toronto Long-Term Care Homes and Services has broadened the scope since the initial beginnings in 2004. Today, the division has expanded this program to include two additional homes (Kipling Acres and True Davidson Acres). And more recently, has created a vibrant Steering Committee with representation from staff, families, community advocates, consumers and LGBT colleagues which will continue to guide our endeavors in continuing to create welcoming environments for LGBT people who require long-term care.

## Appendix: R

### *Health and Social Services Needs of Gay and Lesbian Elders*

#### **The health and social service needs of gay and lesbian elders and their famil...**

Shari Brotman; Bill Ryan; Robert Cormier  
*The Gerontologist*; Apr 2003; 43, 2; Research Library Core  
pg. 192

*The Gerontologist*  
Vol. 43, No. 2, 192-202

Copyright 2003 by The Gerontological Society of America

## The Health and Social Service Needs of Gay and Lesbian Elders and Their Families in Canada

Shari Brotman, PhD,<sup>1</sup> Bill Ryan, MEd, MSW,<sup>1</sup> and Robert Cormier, MSW<sup>1</sup>

**Purpose:** This article reports the findings of a study, undertaken in 2000, whose purpose was to gather information about the experiences and realities of gay and lesbian seniors and their families from across Canada in accessing a broad range of health and social services in the community, and to examine the role of health care and social service organizations in shaping access and service delivery. **Design and Methods:** This study used a qualitative exploratory design based on focus group interviews. Perspectives of older gay men and lesbians and their families involved in organizations addressing these issues, as well as professionals from both gay and lesbian health organizations and mainstream elder care organizations were sought. **Results:** Specific reference was made to the impact of discrimination on the health and access to health services of these populations. Issues relating to invisibility, historic and current barriers to care, and the nature of service options are identified. **Implications:** Recommendations for change are highlighted, including those related to best practice programs and policies in the long-term care sector.

**Key Words:** *Sexual orientation, Aging, Health care, Access, Long-term care*

It has been well documented that gays and lesbians of all ages face considerable discrimination in health and social service systems. This discrimination has been identified as homophobia (fear or hatred) and heterosexism (assumption of all forms of sexuality other than heterosexuality as deviant). Because gay men and lesbians have historically been socially defined within medical terms as mentally ill,

the health care system has been one of the primary arenas through which control over their lives was exerted. As such, health professionals were often charged with the task of "healing" gay and lesbian people from their so-called unhealthy same-sex attractions through such means as electroshock therapy or aversion therapy (Daley, 1998; Dunlap, 1994). Although the American Psychiatric Association removed homosexuality from its classification of mental disorders in 1973, many health care providers continue to consider homosexuality as a mental disorder (Harrison & Silenzio, 1996; Jones & Gabriel, 1999). Gay and lesbian patients of all ages still report negative reactions from service providers. These include embarrassment, anxiety, inappropriate reactions, direct rejection of the patient or exhibition of hostility, harassment, excessive curiosity, pity, condescension, ostracism, refusal of treatment, detachment, avoidance of physical contact, or breach of confidentiality (Aranson, 1995; Berkman & Zimberg, 1997; Dardick & Grady, 1980; Harrison, 1996; Harrison & Silenzio, 1996; Kaufman, Ford, Pranger, & Sankar-Mistry, 1997; Morrissey & Rivers, 1998; Nystrom, 1997; Peers & Demczuk, 1998; Randall, 1989; Schatz & O'Hanlon, 1994; Smith, 1993; Stevens, 1992; Stevens & Hall, 1990; Tievsky, 1988; Van Soest, 1996).

Discrimination in health care is particularly salient for today's gay and lesbian elders (Beeler, Rawls, Herdt, & Cohler, 1999; Boxer, 1997; Cahill, South, & Spade, 2001). Many of these people lived their youth and young adult lives in very hostile environments, prior to the development of the modern day gay liberation movement that began in the late 1960s in Canada and the United States. The current cohort of gay and lesbian elders is commonly referred to as "preliberation" as a means of calling attention to their particular reality. It cannot be understated that gay and lesbian elders who grew up prior to the era of gay liberation face considerable obstacles to accessing health care. Many have lived through enforced medical interventions and/or have experienced overt discrimination on the part of professionals and the public. This has resulted in feelings of great stigma and shame (Chamberland,

The authors acknowledge the Social Sciences and Humanities Research Council, le Conseil Québécois de Recherche Sociale, CLSC René-Cassin, and McGill University for their support of this work.

Address correspondence to Shari Brotman, PhD, McGill School of Social Work, 3506 University Street, Montreal, Quebec, Canada H3A 2A7. E-mail: shari.brotman@staff.mcgill.ca

<sup>1</sup>McGill School of Social Work, Montreal, Quebec, Canada.

1996; Kaufman & Raphael, 1996), which continue to shape their lives, often requiring them to keep their sexual orientation hidden as a strategy of survival. This need to stay hidden for fear of discrimination has remained a prominent coping mechanism in the lives of many older gay men and lesbians (Bonneau, 1998; Cook-Daniels, 1997; Harrison, 1996; Harrison & Silenzio, 1996; Kochman, 1997; Krauss Whitbourne, Jacobo, & Munoz-Ruiz, 1996; Rosenfeld, 1999; Saunders, Tupac, & MacCulloch, 1988).

Older gay men and lesbians who have come out to others often find themselves having to go back into hiding when they begin to require health care services. *Coming out* is a term used to describe the process of identification as a gay or lesbian individual. Some research has documented that homophobia and heterosexism are even more common in elder care systems than within the health care system generally. This is partially because the aging network has largely gone unchallenged with respect to its attitudes and practices toward gay and lesbian elders. In addition, sectors of the aging network in which elders work (voluntary or social support organizations), or live alongside each other (congregate housing), often expose gay men and lesbians to further marginalization from contemporaries who continue to hold discriminatory attitudes reminiscent of the preliberation era (Daley, 1998; Krauss Whitbourne et al., 1996; Peterson & Bricker-Jenkins, 1996).

The health impacts of exposure to discrimination are far-reaching (Appelby & Anastas, 1998; Brotman, Ryan, & Rowe, 2001; Cabaj & Stein, 1996). The risks of coming out in hostile or intolerant environments cause significant stress on gay men and lesbians, and often forces them to focus more on assessing the safety of environments rather than on developmental achievements (e.g., education, employment, family, social networks, etc.; Appelby & Anastas, 1998; Brotman et al., 2001; Demczuk, 1998). It also contributes to lower life satisfaction and self-esteem. Research has also documented that managing stigma over long periods of time results in higher risks of depression and suicide, addictions, and substance abuse (Bradford & Ryan, 1989; Gillow & Davis, 1987; Rothblum, 1994; Russel & Joyner, 2001). Because of the length of time that elderly gay men and lesbians have been managing stigma, health care professionals should be particularly concerned about potential effects on their health status. This is made more problematic because older gay men and lesbians are less likely to seek out health care services or identify themselves as gay or lesbian to health care professionals when they do (Harrison & Silenzio, 1996; Owen, 1996; Risdon, 1998; Robertson, 1998). This makes outreach efforts and adapting practices to meet their needs more challenging (Conolly, 1996; Jacobs, Rasmussen, & Hohman, 1999).

Another major area of concern for gay and lesbian

elders is the way in which notions of “the family” are constructed in elder care services. From the perspective of heterosexual elders, families have become an increasingly visible and important partner in the elder care network over the past decade. Health care professionals, policy makers, and researchers have pointed to the essential role of families in providing care and support and in participating in decision making with regard to care plans. However, prioritizing of the “biological family” has reinforced the experience of marginalization and exclusion among gay and lesbian elders. First, gay and lesbian elders may be less linked to their biological families or families of origin. Although many do receive support from their biological families (siblings, parents, etc.), many do not. In addition, although many older gay men and lesbians have children and grandchildren, largely through previous heterosexual relationships experienced prior to coming out, many do not (Barranti & Cohen, 2000). In these instances, health care professionals who come into contact with gay and lesbian elders with few or no ties to biological family simply assume that they have no one to support them. This is not true in most cases. Research on gay and lesbian elders have demonstrated that often these elders have larger social networks than their heterosexual counterparts. Having faced rejection from the biological family, gay and lesbian people have often had to seek out friends with whom they can be themselves, be out, and be affirmed. These friends become family, or “fictive kin” (Barranti & Cohen, 2000). The “myth” of the older gay man or lesbian as isolated and lonely is simply a myth (Ehrenberg, 1996; Friend, 1990). Older gay men and lesbians often have “fictive kin” networks made up of partners and friends who act as family (Barranti & Cohen, 2000). It is not that these families do not exist, it is that they are unrecognized by health care professionals and systems. In the health care field, partners and friends of gay and lesbian people requiring health care services have pointed time and again to the lack of rights/recognition given them in relation to visiting, decision making, and caregiving for their loved one (Irving, Bor, & Catalan, 1995; Kaufman et al., 1997; Ryan, Hamel, & Cho, 1998; Simkin, 1993; Turner & Catania, 1997). To make matters worse, health care professionals will often call on biological family to make health care decisions because of a lack of rights/recognition afforded to “fictive kin.” However, these family members may have little support for the elder’s identity and may even exhibit hostility toward the elder and/or his or her partner (Barranti & Cohen, 2000). These practices result in further isolation of the gay or lesbian elder. That isolation may be a factor in the lives of older gay men and lesbians, and must be taken into consideration in outreach and care plans.

Unfortunately, because of invisibility and discrimination, there continues to be almost no recogni-



tion of the specific needs of gay and lesbian elders and their families in health and social services (Auger, 1992; Berger & Kelly, 1996; Slusher, Mayer, & Dunkle, 1996). This is reinforced by a lack of affirmative research (Berger, 1984; Cook-Daniels, 1997; Cruikshank, 1991; Hamburger, 1997; Humphreys & Quam, 1998; Kochman, 1997). This enforced invisibility both results from and has contributed to a continued lack of exposure to gay and lesbian issues and experiences, and the lack of commitment to developing gay-positive policies and practices directed toward elders themselves (Kochman, 1997; Metz, 1997) and their caregivers (Aranson, 1998). It has also resulted in increased stress on both elderly gay or lesbian people and their families (Fredriksen, 1999).

This article reports the results of a Phase 1 exploratory study undertaken between 2000–2001 in Canada on the experiences and realities facing gay and lesbian seniors in accessing the health care and social service system. The aim of the study was to generate understanding about the health and social service needs of gay and lesbian elders and their caregivers through an exploration of the perceptions of various professional and activist stakeholders in the community—namely those representing gay and lesbian health community organizations, gay and lesbian seniors organizations, community health and homecare organizations, and elder care policy bodies. The study examined how key informants from both the gay and lesbian network and the mainstream elder care network understand and talk about need and current responses. The project investigated an area of health equity studies that has been, to date, largely unexplored. Also, this study supported building partnerships between key stakeholders to facilitate development of a large national study on access and equity among gay and lesbian elders and their families.

This study is limited to analyses based on gay and lesbian sexual orientation, meaning that the experiences of bisexual and transgender people are not included in the current study. Although the issues facing these communities are essential to address and have often been identified alongside those of gay men and lesbians, the points of view of both bisexual and transgender people are unique enough to warrant a distinct and separate enquiry. Often times, research that claims to include bisexual and transgender populations alongside gay and lesbian populations is actually focused almost entirely on the experiences of the latter groups. This reinforces the marginalized and invisible status of bisexual and transgender people. Given the limited funding available for this study, emphasis was placed on exploring the issues facing gay men and lesbians, both with respect to review of the literature and participant identification. In this context, including bisexual and transgender issues would contribute to a process of tokenization. This study was preliminary in nature,

and it is hoped that additional funding can be sought to expand our exploration with bisexual and transgender people in the future.

## Methods

A focus group design was used to explore the perceptions and understandings of the experiences and realities facing gay and lesbian seniors in Canada from the perspectives of a variety of community stakeholders. Four focus groups were undertaken in three locations across Canada to ensure a national scope to the project: One in Quebec, one in Nova Scotia, and two in British Columbia. Focus groups were composed of gay and lesbian activists working within the community, namely those representing organizations made up of gay and lesbian seniors and their families, health care providers and policy makers within the public health system, and members of various mainstream senior groups, including those representing caregivers.

Current research aimed to develop relationships with local organizations to advance a partnership agenda for future work in the area. Intended as a Phase I endeavor, only those people with organizational or group affiliation were invited to attend the focus group discussions. The discussions that resulted were based both on participants' own experiences and perspectives, and those of organizations, agencies, or groups in which they were involved. Participants were recruited in each location using a snowball sampling technique (Neuman, 1997). Those representing gay and lesbian organizations, including gay and lesbian seniors groups, were identified through contact with key informants reinforced through identification in local and national gay and lesbian directories. The researchers, themselves active in local and national gay and lesbian research and activist projects, had had much prior contact with many of the individuals approached, which expedited trust-building. Participants representing mainstream long-term care and other health care organizations—including public health departments, homecare agencies, seniors groups, and voluntary sector aging and caregiver organizations and institutions—were identified through key informants in each local setting. Key informants from gay and lesbian sectors, both locally and nationally, have had much contact with policy and public health bodies, and these contacts were used to identify those who might be willing to participate in focus groups on gay and lesbian aging. Once these “publicly supportive” people were contacted, researchers used snowball techniques to identify others who, key informants felt, could make an important contribution or who would be open to discussing these issues. All potential participants in focus group discussions were provided with a letter of introduction and information about the project. A number of organizations did refuse to

participate, mostly sighting that they did not work with gay or lesbian elders or that sexual orientation was not an important consideration for their agency.

Focus group theory asserts that disparate groups need to be separated out, one from the other, when undertaking focus group discussions. This is particularly important when there is a power differential between these groups that might lead to exposure of marginalized people to further discrimination by those people with more power or control (Bryman, 2001). At first glance, one might conclude that the design undertaken in the current study is problematic. Two issues are important to consider in response to this concern. First, although participants from the mainstream elder care sector might have had little familiarity with the issue, these individuals had at least recognized that the issue of accessibility was an important and often ignored issue that needed to be addressed. This suggests some openness to rethinking their particular positions. Second, because organizational representation was a necessary precursor to inclusion in the study, those gay and lesbian people who participated were already identified as willing and able to speak publicly about their experiences in a wide range of environments. This considerably diminished the risk of exposure in the context of this study. In fact, gay and lesbian participants were eager to have the opportunity to engage in discussion across groups, both to exchange information and broaden understanding. All of the gay and lesbian groups or organizations that researchers contacted for inclusion in the study identified a representative to participate. Informal feedback from participants suggested that they were satisfied with the model used. However, there are still several limitations to the mixed-group study design. The potential exposure inherent in mixing gay and lesbian people with people from mainstream elder care sectors might have resulted in a refusal to participate by those who might feel risk in speaking out. This includes gay and lesbian elders or their caregivers who fear being remarginalized or oppressed by professionals or policy makers from the mainstream elder care network and also professionals who are less aware or who harbor negative feelings about the subject matter who fear being challenged by gay and lesbian activists. Second, the content of the focus groups may have been limited because of the mixed nature of the groups so that, even though people agreed to participate in the mixed setting, they may have shaped their responses in consideration of the safety of the environment. Still, given these limitations, the substance of the discussions were rich and complex.

Overall, 32 people participated in all four focus groups [8 in Quebec, 6 in Nova Scotia, 9 in Location 1 (midsized center) in British Columbia, and 9 in Location 2 (large urban center)]. Within the four focus groups, 7 participants were from gay and lesbian seniors groups (being seniors them-

selves), 9 were from gay and lesbian health organizations, 3 were from voluntary mainstream organizations (including caregiver groups), 8 were from public sector service delivery organizations or institutions, and 5 were from governmental policy bodies. Twenty-one were identified as gay or lesbian. Other demographic data were not collected in this study, and we are not able to identify any other information about participants aside from what is described. At the time, the focus of analysis was limited to organizational representation as the main interest of this study. This was justified because the goal of the project was to build understanding of organizational or professional perceptions of the issues to substantiate the need for further inquiry. Stemming from this focus on representation, it was decided that identification of sexual orientation would be entirely voluntary.

Participants engaged, with investigators, in a tape-recorded group discussion of approximately 2 hr. Informed consent was received from all participants in the study. The discussion questions were semi-structured and designed to cover specific aspects of gay and lesbian elders' experience of health, their particular health needs, and access/service delivery issues. The focus group questions and emerging themes were designed to be broad-based and exploratory at this stage. These questions included what services are needed by gay and lesbian elders and their families, how they go about finding these services, what stops people from getting services, and whether or not services meet their needs. Focus group discussions centered on: (1) the perspectives of allies and activists as to the needs and issues facing gay and lesbian seniors and their families, (2) the perspectives of mainstream policy and practice organizations with respect to their knowledge about or current practice with gay and lesbian seniors, and (3) the sharing of gay and lesbian elders' and their families' experiences of care. This final theme emerged out of discussions and was not pursued directly by research interviewers. This attests to the level of comfort within focus groups that facilitated disclosure of personal experiences.

Data collection and analysis were consistent with that developed by Morgan (1997), who articulates a distinctive qualitative methodology for focus group inquiry. Focus group discussions were transcribed and then analyzed with the intent of developing common and divergent themes. This analysis proceeded through an iterative process, beginning first with a reading of each full transcript independently to uncover overarching themes that emerged from the text. Then, each transcript was analyzed section by section, maintaining the integrity of the speakers' comments to code the data. A final run-through, moving line by line, allowed the researchers to uncover both locations of connection and divergence of themes/codes within the text. Once themes were explored to their fullest and sections from the text

identified that highlighted these themes, all four focus groups were compared and contrasted in an iterative process of identification and analysis, in Phase 3. This was done to ensure that findings were grounded first in local and then in national perspectives. This was also done to facilitate feedback from participants with respect to the local focus groups in which they were involved. Intercoder reliability testing was undertaken throughout these phases of analysis. At each phase, at least two members of the research team reviewed transcripts and data coding. The research coordinator undertook preliminary data coding, which was reviewed and verified by at least one of the principal investigators on an ongoing basis. This included having the principal investigators reread the original transcripts to verify the coding and analysis process. This ensured consistency and reliability. Finally, preliminary description of themes were brought back to participants for validation and reflection. Each participant was sent a draft document of the analysis (including theme areas, comments on those themes in bullet form, and quotes that related to these themes) from their particular geographic region for feedback. Feedback suggested that the themes emerging and quotes identified to justify these themes were accurate. This process of member-checking was important to ensure authenticity.

## Results

Although several issues arose from the four focus group discussions, the one theme that emerged repeatedly and most frequently was the profound marginalization experienced by older gays and lesbians in all aspects of social and political life. From this theme of marginalization emerged five critical issues that help to deepen our understanding of gay and lesbian seniors, including: (1) historical experiences of discrimination; (2) homophobia within present-day context; (3) the profound invisibility of gay and lesbian seniors in all segments of society; (4) long-term care services; and (5) gay and lesbian support networks. The final section of this analysis will include several recommendations that were brought forward by participants in an attempt to address the present health care and social service needs of these aging populations.

### *Historical Experiences of Discrimination*

Participants in this study confirmed that older gay men and lesbians often mistrust the health and social service network as a result of life-long experiences of marginalization and oppression. Many gay and lesbian elders who experienced the pervasive social stigma that existed prior to the advent of the gay liberation movement maintain a sense of extreme caution with respect to whether or not societal attitudes have really changed.

... we're coming out of an experience of being badly treated in society, and there's no sense that that treatment is going to get any better when you get older and more vulnerable within the system ...

... for most people who didn't have the support of various organizations or were part of some kind of social movement, the scarring is pretty deep ...

The painful wounds of being socially marginalized and the deep scarring that resulted from these experiences remind older gays and lesbians that it is unwise to place trust in individuals and social systems that have historically persecuted them, particularly as they confront the potential of becoming physically dependent on others as they grow older. In this regard, the historical experiences of oppression and related trauma continue to figure importantly in the lives of many lesbians and gay men of older generations.

### *Homophobia Within the Present Social Context*

Although gay and lesbian seniors are deeply affected by their historical experiences of discrimination, they continue to be victims of discrimination within their present social environments. Despite recent changes in social policy in Canada that have resulted in increased recognition of the rights of gay men and lesbians (the most important of these is the passing of federal and provincial legislation recognizing same-sex couples as equivalent to common-law couples outside of family law), discrimination continues to be apparent in many social and institutional environments. This represents an important threat to the health and well-being of gay and lesbian seniors and their families. Whereas many focus group participants acknowledged that attitudes had changed in recent years for gays and lesbians living in Canada, many reported incidences of overt homophobia directed toward the elderly lesbian and gay male populations.

In light of this reality, the possibility of one day having to be reliant on the health care system, on a nursing home facility, or any other social institution understandably provokes anxiety and fear in aging lesbians and gay men. Many gay and lesbian elders who fear being victimized or discriminated against in these systems may avoid accessing services all together, even when their health, safety, and security depend on it.

... but their fear is where they are at, and until they see that the system is inclusive, I think there are some people who are not going to access services when they really could benefit from them until it may be too late.

### *Profound Invisibility of Older Gays and Lesbians*

Past and current experiences of stigma reinforce, in the minds of many lesbian and gay seniors,

a vigilance in maintaining secrecy over their sexual orientation. Other seniors may feel it necessary to deny a same-sex relationship for fear of being badly treated in the long-term care network. Many seniors are very cautious about disclosing their sexual orientation. Consequently, they remain profoundly invisible in most segments of society. Older gays and lesbians are hardly ever seen in mainstream senior networks, in health care institutions, and in society.

What I am hearing around the table is that the word invisibility keeps coming up in one way or another . . . in the network, in workers' caseloads, all around us . . .

Because of the absolute invisibility of gays and lesbians in senior care networks, physicians, nurses, psychologists, social workers, and volunteers working within the health care system often overlook the possibility that some of their aging clients may be gay or lesbian. This oversight promotes and further marginalizes these seniors and their care providers.

The invisibility of older gays and lesbians in the health care and social service systems not only helps keep these seniors marginal within social systems, but also creates important barriers to the development of a social and political voice. Historically, gay and lesbian seniors have been excluded from all discussion, planning, and programming processes both in mainstream senior networks, as well as in gay and lesbian organizations. When the needs of gay and lesbian seniors are raised at national seniors' meetings and conferences, the most prominent reaction is one of discomfort. Most often, there is a lack of willingness to place the issues of gay and lesbian seniors on the agenda for discussion.

There was a consensus among focus group participants that the issues of gay and lesbian seniors are poorly understood by academics, lesbian and gay communities, and by health care professionals. Their needs are hardly ever addressed, and their profound invisibility obstructs any possibility of developing sensitive and appropriate health, social service, and long-term care alternatives for them.

#### *Long-Term Care Services for Older Gays and Lesbians*

The question remains as to how gay and lesbian elders can begin to trust in a system in which their needs are not clearly expressed or understood. Older lesbians and gay men have learned to survive negative social climates by being cautious and suspicious of public health care services and of professionals working within these systems. When professionals conduct assessments with these seniors, important aspects of their social lives are often overlooked. Most health care professionals are completely unaware of the specific needs of this population.

Issues of sexuality are often overlooked when these clients are assessed by health care providers.

The discomfort that many professionals experience around discussing issues of sexuality with their aging clients, coupled with these clients' need to remain invisible to protect themselves from discrimination, promotes and reinforces a vicious cycle of oppression for aging gay and lesbian populations. For example, outward expressions of affection may represent major impediments to the health and well-being of older lesbians and gay men who reside in long-term care facilities.

One woman told me that she would just like to know that if she ever has to go into a facility, that she can hold hands with her partner in the tv room.

Given the discomfort exhibited by health care professionals with respect to addressing issues of sexuality, even the simplest outward signs of affection between gay or lesbian couples living within long-term care facilities would cause conflict within most institutions currently operating in Canada.

Seniors who require care need to be assured that the values of agencies, institutions, and professionals respect and reflect who they are and their unique needs. Relying on others for health care as a result of failing health is a profoundly frightening experience for most seniors. For lesbians and gay men, the fear is even greater because they are forced to depend on networks and social institutions that have traditionally been known to be intolerant of them.

Most people are terrified of going into any of the care facilities, and having to be hidden, losing their lovers, their partners, their friends . . . so it is a huge question and a tremendous loss of power when you're not mobile anymore.

The profound lack of visibility and awareness of the needs of older gays and lesbians within the health care system has sometimes resulted in tragic situations for these seniors. For example, one participant recounted the story of a lesbian couple who, after living together for several decades, were separated with the help of health care professionals and family members who were unaware of the nature of their partnership.

Finally, it must be stressed that remaining invisible has been a strategy of survival for today's older gay men and lesbians—a strategy that has often resulted in an increased capacity for resilience against the onslaught of additional forms of discrimination they experience as elders. Historical experiences of victimization have led many older lesbians and gay men to develop skills that keep them safe from or help them deal with all kinds of hostile environments.

I heard a story once that one lesbian couple . . . one of the partners changed her last name to her partner's last name so that they would be taken for sisters. To be put in the same room.

### *Gay and Lesbian Communities and Their Aging Members*

Older gays and lesbians not only confront obstacles when accessing services from mainstream senior networks, but also face important barriers within lesbian and gay communities. Even though gay and lesbian organizations are well positioned to develop and provide advocacy and support services for their aging members, the needs of seniors are poorly understood within these networks and are now only beginning to be addressed.

In recent decades, gay and lesbian communities have spent a lot of energy articulating and responding to the needs of its younger members, but have done much less in an effort to develop services for its senior members. Few services or programs presently exist in Canada for older gays and lesbians, despite the potential benefits they could bring to this profoundly marginal population.

For gay and lesbian communities that have been willing to develop and offer services to senior members, one important challenge for them has been to access these older members and to entice them to come out and participate in various activities. The high degree of invisibility that currently characterizes these populations makes the challenge even greater.

Another important challenge for these communities is to change their youth-focused image, which makes it troublesome for groups to reach out to its aging members and, more importantly, makes it difficult for seniors to reach out to gay and lesbian organizations. As one participant emphasized, the youth centered culture of many lesbian and gay communities represents an important impediment for senior members. Older lesbians and gay men feel they cannot relate to the younger members of these communities.

Older gays and lesbians are often confronted with negative attitudes toward them because of their age. Several participants raised concerns about ageist attitudes that dominate gay and lesbian communities and culture. Ageism, beauty, and youthfulness are values that reign supreme within most gay and lesbian communities, making it difficult for older members to feel like they belong.

Perhaps it is worth the effort to underline the ageism that we find in the gay community. And perhaps it is an additional reason that older gay men and lesbians are so invisible . . . it's the ageism within our community. Because in the community, one has to also say, as in society at large . . . beauty, youthfulness, these are the primary values . . . there was an older lesbian who told me "Look, I've gained weight, I've gotten older, I'm not visible anymore!" and she no longer goes out . . .

### *Recommendations: Education and Raising Awareness*

Some participants questioned whether senior-serving organizations and caregiver networks are in a state of readiness to be offering services to aging lesbians and gay men. People are having to adjust their views and thinking about these marginalized populations. Other participants believed that education and awareness-raising campaigns are critically important in terms of improving services and service access for aging lesbians and gay men.

Educating health care professionals has also been identified as an important way of raising awareness and improving services for aging gays and lesbians. Participants addressed a variety of issues related to educational initiatives and adapted practice. The most frequently mentioned issues were those related to the development of supportive and safe environments and improvements to the ways in which professionals collect information. It was felt that improving communication and support would best facilitate trust-building for gay and lesbian seniors.

Finally, it was suggested that older lesbians and gay men would benefit immensely from the added protection of policy initiatives that incorporate homophobia as a grounds of elder abuse. One participant suggested that the time has come to expand the definition of elder abuse to include sexual harassment based on sexual orientation, because the knowledge of one's same-sex orientation could easily be used to intimidate, harass, humiliate, or shame an elderly individual living within a long-term care institution.

I think that what a lot of people feel is that fear that they can't be out, that it won't be safe to be out, that what is required in order to create a kind of safety is some proactive reassurance that this is an open climate.

A policy initiative that incorporates homophobia as a grounds of elder abuse could benefit gay and lesbian seniors greatly by entrenching it as a category of potential discrimination within the elder care network. This would provide impetus for embedding the notion of freedom from harassment or injury based upon sexual orientation as a legitimate right. This would, in turn, force institutions and organizations to prepare themselves better to work with gay and lesbian elders and respond proactively to potential threats of discrimination against them.

### **Discussion**

Several issues have been identified in this study. First, there is the profound invisibility of gay and lesbian seniors, both within gay and lesbian communities and mainstream long-term care services. This finding was consistent across all geographic

regions and within both midsized and large urban centers. Even in locations in which there are high proportions of seniors and/or a sizeable infrastructure of gay and lesbian organizations and services, gay and lesbian elders remain invisible. The reasons for this are complex and directly related to the experiences of homophobia and heterosexism faced by gay and lesbian elders across the life span. Gay and lesbian elders have learned to cope with discrimination by hiding their sexual orientation. They do this in a variety of ways, including: (1) avoiding identification of their sexual orientation to others; (2) avoiding identification of their partners to others; (3) avoiding identification with gay and lesbian communities; and (4) avoiding services altogether. In light of the overt homophobia that they faced throughout their lives, particularly during the years prior to the advent of the gay liberation movement, this strategy of hiding must be seen as an important coping mechanism for survival.

Developing resilience in the face of discrimination has helped many gay and lesbian seniors become expert in dealing with adversity, facing change, and learning how to take care of themselves. This adaptive capacity follows them into old age so that, although unable to rely on public services, elderly gays and lesbians have developed a unique capacity to do for themselves and for each other. These adaptive coping strategies, as forms of resilience and resistance, have been well documented in the research (Barranti & Cohen, 2000; Berger, 1980; Berger & Kelly, 1986; Friend, 1980, 1990; Humphreys & Quam, 1998; Kimmel, 1978). This research suggests that older gay men and lesbians adjust to age more successfully than their heterosexual counterparts.

Older gay men and lesbians' ability to cope and survive on their own in hostile environments does have a downside, however. These populations have learned to adjust to loss and stigma so well that they may delay seeking medical attention even though they need it, relying on their own resources far beyond the limits of their functional capacity because this is what they have always had to do. This means that older gays and lesbians may arrive at the doors of the health care system and long-term care network in a more advanced state of risk than their heterosexual counterparts, or not at all.

It is important to emphasize that discrimination continues to be present in health care and social services in the field of aging. This contributes to a continued discomfort with and lack of trust in the system. Older gays and lesbians, their families, and allies have identified the incredible fear experienced by gay and lesbian elders when confronted with these services and systems. At worst, the system continues to be hostile. At best, there is a pervasive ignorance about gay and lesbian elders and their unique needs in the elder care network.

Given the current reality, health and social service

providers must begin to ask themselves profound questions about how to transform the system to enhance equity. The participants made several suggestions in this study that are important to highlight. First, we must not blame seniors for their lack of visibility in the system. Health care professionals must understand the roots of gay and lesbian seniors' mistrust and must see the strategy of hiding as an understandable outcome of facing ongoing and pervasive discrimination. Health care providers must also be able to identify this and other coping mechanisms as signs of resilience and capacity. This invariably means understanding and identifying the role of the health care system in the oppression of gay and lesbian people. Institutional practices must reflect this understanding through the development of unique programs designed to redress discrimination. Developing outreach strategies, adapting assessment tools, improving communication, and creating open and supportive environments are all necessary changes to better meet the needs of gay and lesbian seniors within the current system. Entrenching homophobia as a category of elder abuse in aging policy would go a long way to enforce institutional change. The difficulty in undertaking change in an environment in which older gays and lesbians are profoundly silent cannot be underestimated.

It is inherently difficult to reconcile the silence of older gays and lesbians because of their historical and current realities with the need to engage with these elders so that they can be seen and heard. This conflict will not change overnight. Making room for older gay men's and lesbians' voices to be heard in elder care sectors will require beginning the change process from within, sometimes without their inclusion, as a beginning phase. Institutions and organizations that have been historically oppressive to these individuals will not be able to simply invite participation without first engaging in a trust-building process. Trust-building takes time and great effort. Once again, outreach programs are essential, as is beginning with where individuals are in the process. Elder care organizations, including voluntary sector ones, must begin by learning about the issues facing older gay men and lesbians and their families through the development of staff and volunteer training, inviting gay and lesbian organizations to speak to them, sitting on boards and committees and to review methods of practice, and evaluating their own values and assumptions about gay and lesbian people. Institutional policy changes, such as recognizing and supporting the rights of partners and fictive kin to participate in care plans, are another way to create a welcoming environment for gay and lesbian elders. Finally, once the transformation work is done, organizations and institutions must advertise the gay affirmative nature of their settings by reaching out and participating in gay and lesbian community events, posting informa-

tion, and opening their doors through such events as open houses to invite gay and lesbian communities into their settings. Although this may only reach those that are already out, it would create an atmosphere of partnership with gay and lesbian organizations and people that would help facilitate spreading the word. Finally, it cannot be understated that part of the job of creating a gay affirmative elder care sector includes making these spaces affirmative for gay and lesbian professionals working in them. Whereas these people should not be the only ones involved in the change process in these settings, they must be included as essential participants. After all, if gay and lesbian employees and volunteers are not visible, it is more likely that elders will not be comfortable in being visible. Once environments are made more open, then older gay and lesbian populations, as well as their families, are more likely to trust, find space, and make their voices heard.

Another important aspect addressed briefly by participants in this study is the importance of rendering the issue of sexuality more open in elder care sectors. It is less likely that sexual orientation will be addressed in environments in which discussions of sexuality in general remain taboo. Many myths currently exist surrounding sexuality in old age. Despite the fact that research has shown that elders can and do participate in sexual activity and that desire continues throughout our lives, ageism has reinforced the perception that sex is only for the young; that older people lack the interest or capacity to be sexually active (Gibson, 1992; Kaye, 1993). Prejudicial beliefs about elders' experience of sexuality, as well as repressive attitudes that make discussions about sex and sexuality uncomfortable for workers, contribute to making sexuality an ignored and often feared subject in elder care settings (Scrutton, 1999). This also filters up to the level of policy. Many organizational settings, for example, place little significance on privacy, and actively discourage sexual activity between residents or clients. Although enabling discussions of sexuality does not guarantee increased openness to the issues and needs of gay and lesbian elders, it certainly will not do harm. Where sexuality is understood as a normal and healthy aspect of older people's lives, arguments for the inclusion of sexual orientation gain credibility. Making the sexual needs and identities of older people a mandatory part of assessment and care plans will facilitate understanding of the concerns facing older gay and lesbian clients.

The role of gay and lesbian communities in change efforts cannot be understated. Gay and lesbian community activists would be well placed to advocate for changes to the health, social service, and long-term care systems and to provide education. They have worked for decades on documenting and addressing homophobia and heterosexism in society and can advance an agenda for institutional change, particularly in light of the current appre-

hension of gay and lesbian seniors to identify to the system because of increased vulnerability. However, before community organizations and activists can adequately and appropriately take on this advocacy role, they need to engage in more dialogue with gay and lesbian elders themselves. This means addressing ageism within the gay and lesbian community so that space can be opened for gay and lesbian elders to identify themselves and participate as equals in change efforts. In doing so, gay and lesbian communities will also be better placed to provide gay- and lesbian-specific services across the long-term care network. Although efforts must be made to create equity in the public system, gay- and lesbian-specific services need to be available as an option for those people who are more comfortable in culturally specific environments.

Finally, a brief discussion on possible cohort differences between the current population of gay and lesbian elders and those who will be coming of age over the next 15–20 years is warranted in the current context. Although gay and lesbian elders today grew up in harsh conditions of discrimination that existed before the advent of the gay liberation movement, resulting in particular strategies of hiding to survive, tomorrow's gay and lesbian elders have potentially had a quite different experience. Tomorrow's elders will have grown up in an environment of political and social solidarity that emerged out of the gay liberation movement. This cohort will have more likely identified themselves with a cultural community and had the opportunity to participate in a variety of organizations designed to promote their health and well-being, challenge discriminatory law and policy, and celebrate a sense of pride in their identity. This is, of course, more likely in larger urban centers, in which a critical mass of gay and lesbian people have been able to come together. The past few decades in Canada have seen major changes in attitudes toward and law protecting the rights of gay and lesbian people. All jurisdictions in Canada have included sexual orientation as a grounds of discrimination under federal and provincial charters of rights, and this has led the way for challenges to many aspects of legislation, including family, insurance, and pension law in favor of same-sex couples. In light of this, gay and lesbian people growing old with the experience of solidarity and community, and who have a sense of their rights and entitlements, will be less likely to accept going back into invisibility to receive elder care services. They will also be less likely to stand back while services are designed and delivered without their interests in mind, whether this be done within the mainstream elder care sector or the gay and lesbian community sector. This cohort of gay and lesbian people are already beginning to identify the need to re-examine and address the interplay of ageism and homophobia that may hinder their visibility and participation in the future. There are also several informal projects

underway across Canada, made up of middle-aged gay men and lesbians, to develop residential services that are gay and lesbian exclusive or affirmative.

Engaging in advocacy strategies, training, and outreach will ensure that today's gay and lesbian elders, as well as tomorrow's gay and lesbian elders, will be able to locate appropriate and adequate services to meet their needs in environments of safety and security. Providing gay- and lesbian-affirmative services must be seen as a priority to ensure that gay and lesbian elders can live out their latter years free of the discrimination and exclusion they have been forced to manage for most of their lives.

#### References

- Appleby, G., & Anastas, J. (1998). *Not just a passing phase: Social work with gay, lesbian and bisexual people*. New York: Columbia University Press.
- Aronson, J. (1995). Lesbians in social work education: Processes and puzzles in claiming visibility. *Journal of Progressive Human Services*, 6, 5-26.
- Aronson, J. (1998). Lesbians giving and receiving care: Stretching conceptualizations of caring and community. *Women's Studies International Forum*, 21, 505-519.
- Auger, J. (1992). Living in the margins: Lesbian aging. *Canadian Woman Studies/Les Cahiers de la femme*, 12, 80-84.
- Barranti, C., & Cohen, H. (2000). Lesbian and gay elders: An invisible minority. In Schneider, R., Kropp, N., & Kisor, A. (Eds.), *Gerontological social work: Knowledge, service settings and special populations* (2nd ed., pp. 343-367). Belmont, CA: Wadsworth/Thompson Learning.
- Becler, J., Rawls, T., Herdt, G., & Cohler, B. (1999). The needs of older lesbians and gay men in Chicago. *Journal of Gay and Lesbian Social Services*, 9, 31-49.
- Berger, R. (1980). Psychological adaptation of the older homosexual male. *Journal of Homosexuality*, 5, 161-175.
- Berger, R. (1984). Realities of gay and lesbian aging. *Social Work*, 29, 57-62.
- Berger, R., & Kelly, J. (1986). Working with homosexuals of the older population. *Social Casework*, 67, 203-210.
- Berger, R., & Kelly, J. (1996). Gay men and lesbians grown older. In R. Cabaj & T. Stein (Eds.), *Textbook of homosexuality and mental health* (pp. 305-316). Washington, DC: American Psychiatric Press.
- Berkman, C. S., & Zimberg, G. (1997). Homophobia and heterosexism in social workers. *Social Work*, 42, 319-332.
- Bonneau, M. (1998). L'affirmation lesbienne en milieu régional: Une visibilité problématique. In I. Demczuk (Ed.), *Des droits à reconnaître—Les lesbiennes face à la discrimination* (pp. 167-192). Montreal, Quebec, Canada: Les Éditions du Remue-ménage.
- Boxer, A. (1997). Gay, lesbian and bisexual aging into the twenty-first century: An overview and introduction. *Journal of Gay, Lesbian and Bisexual Identity*, 2, 187-196.
- Bradford, J., & Ryan, C. (1989). *National Lesbian Health Care Survey*. Final report. Washington, DC: National Lesbian and Gay Health Foundation.
- Brotman, S., Ryan, B., & Rowe, B. (2001). *Equity in health service delivery to gay and lesbian patients*. Montreal, Quebec, Canada: McGill School of Social Work.
- Bryman, A. (2001). *Social research methods*. Oxford, UK: Oxford University Press.
- Cabaj, R. P., & Stein, T. S. (1996). *Textbook of homosexuality and mental health*. Washington, DC: American Psychiatric Press.
- Cahill, S., South, K., & Spade, J. (2001). *Outing age: Public policy issues affecting gay, lesbian, bisexual and transgender elders*. New York: National Gay and Lesbian Task Force Foundation.
- Chamberland, L. (1996). *Mémoires lesbiennes. L'expérience du lesbianisme à Montréal entre 1950 et 1972*. Montréal, Quebec, Canada: Les Éditions du Remue-ménage.
- Conolly, L. (1996). Long-term care and hospice: The special needs of older gay men and lesbians. *Journal of Gay and Lesbian Social Services*, 5, 77-91.
- Cook-Daniels, L. (1997). Lesbian, gay male, bisexual and transgendered elders: Elder abuse and neglect issues. *Journal of Elder Abuse and Neglect*, 9, 35-49.
- Cruikshank, M. (1991). Lavender and gray: A brief survey of lesbian and gay aging studies. In J. A. Lee (Ed.), *Gay midlife and maturity* (pp. 77-87). New York: The Hayworth Press.
- Daley, A. (1998). Lesbian invisibility in health care services. Heterosexual hegemony and strategies for change. *Canadian Social Work Review/Revue Canadienne de Service Social*, 15, 57-95.
- Dardick, L., & Grady, K. E. (1980). Openness between gay persons and health professionals. *Annals of Internal Medicine*, 93, 115-119.
- Demczuk, I. (1998). Enquête sur la violence vécue par les lesbiennes. In I. Demczuk (Ed.), *Des droits à reconnaître—Les lesbiennes face à la discrimination* (pp. 199-212). Montreal, Quebec, Canada: Les Éditions du Remue-ménage.
- Dunlap, D. W. (1994, December 25). AMA states new policy on sexuality. *New York Times*, p. 30.
- Ehrenberg, M. (1996). Aging and mental health: Issues in the gay and lesbian community. In C. J. Alexander (Ed.), *Gay and lesbian mental health: A sourcebook for practitioners* (pp. 189-209). Binghamton, NY: Harrington Park Press.
- Fredriksen, K. (1999). Family caregiving responsibilities among lesbians and gay men. *Social Work*, 44, 142-155.
- Friend, R. (1980). Gayging: Adjustment and the older gay male. *Alternative Lifestyle*, 3, 231-248.
- Friend, R. (1990). Older lesbian and gay people: A theory of successful aging. *Journal of Homosexuality*, 20, 99-117.
- Gibson, H. (1992). *The emotional and sexual lives of older people*. London: Chapman and Hall.
- Gilow, K. E., & Davis, L. L. (1987). Lesbian stress and coping methods. *Journal of Psychosocial Nursing and Mental Health*, 25, 28-32.
- Hamburger, L. (1997). The wisdom of non-heterosexually based senior housing and related services. *Journal of Gay and Lesbian Social Services*, 6, 11-25.
- Harrison, A. E. (1996). Primary care of lesbian and gay patients: Educating ourselves and our students. *Family Medicine*, 28, 10-23.
- Harrison, A. E., & Silenzio, V. M. B. (1996). Comprehensive care of lesbian and gay patients and families. *Primary Care: Models of Ambulatory Care*, 23, 31-46.
- Humphreys, N., & Quam, J. (1998). Middle-aged and old gay, lesbian, and bisexual adults. In G. A. Appleby & J. W. Anastas (Eds.), *Not just a passing phase: Social work with gay, lesbian, and bisexual people* (pp. 245-267). New York: Columbia University Press.
- Irving, G., Bor, R., & Catalan, J. (1995). Psychological distress among gay men supporting a lover or partner with AIDS: A pilot study. *AIDS Care*, 7, 605-617.
- Jacobs, R., Rasmussen, L., & Hohman, M. (1999). The social support needs of older lesbians, gay men, and bisexuals. *Journal of Gay and Lesbian Social Services*, 9, 1-30.
- Jones, M. A., & Gabriel, M. A. (1999). Utilization of psychotherapy by lesbians, gay men and bisexuals: Findings from a nationwide survey. *American Journal of Orthopsychiatry*, 68, 209-219.
- Kaufman, G., & Raphael, L. (1996). *Coming out of shame: Transforming gay and lesbian lives*. New York: Doubleday.
- Kaufman, H., Ford, P., Pranger, T., & Sankar-Mistry, P. (1997). Women who have sex with women: Linking HIV, hepatitis B and C infection with risk behaviours. *Social Work*, 65, 77-86.
- Kaye, R. (1993). Sexuality in the later years. *Ageing and Society*, 13, 415-426.
- Kimmel, D. C. (1978). Adult development and aging: A gay perspective. *Journal of Social Issues*, 34, 113-120.
- Kochman, A. (1997). Gay and lesbian elderly: Historical overview and implications for social work practice. *Journal of Gay and Lesbian Social Services*, 6, 1-10.
- Krauss Whitbourne, S., Jacobo, M., & Munoz-Ruiz, M. T. (1996). Adversity in the lives of the elderly. In R. Feldman (Ed.), *The psychology of adversity* (pp. 160-175). Boston, MA: University of Massachusetts Press.
- Metz, P. (1997). Staff development for working with lesbian and gay elders. *Journal of Gay and Lesbian Social Services*, 6, 35-44.
- Morgan, D. (1997). *Focus groups as qualitative research*. Thousand Oaks, CA: Sage.
- Morrissey, M., & Rivers, I. (1998). Applying the Mims-Swenson Sexual Health Model to nurse education: Offering an alternative focus on sexuality and health care. *Nurse Education Today*, 18, 488-495.
- Neuman, W. L. (1997). *Social research methods*. Boston, MA: Allyn and Bacon.
- Nystrom, N. (1997). *Mental health experiences of gay men and lesbians*. Paper presented at the Symposium on Assessing Health Needs of Gay Men and Lesbians, American Association for the Advancement of Sciences, Houston, TX.
- Owen, W. F. (1996). Gay men and bisexual men and medical care. In R. P. Cabaj & T. S. Stein (Eds.), *Textbook of homosexuality and mental health* (pp. 673-685). Washington, DC: American Psychiatric Press, Inc.
- Peers, L., & Demczuk, I. (1998). Lorsque le respect ne suffit pas: Intervenir auprès des lesbiennes. In I. Demczuk (Ed.), *Des droits à reconnaître—*



- Les lesbiennes face à la discrimination* (pp. 77–116). Montreal, Quebec, Canada: Les Éditions du Remue-ménage.
- Peterson, J., & Bricker-Jenkins, M. (1996). Lesbians and the health care system. *Journal of Gay and Lesbian Social Services*, 5, 33–47.
- Randall, C. E. (1989). Lesbian phobia among BSN educators: A survey. *Journal of Nursing Education*, 28, 302–306.
- Risdon, C. (1998). Lesbian and bisexual women—Challenging our heterosexist assumptions. *Canadian Family Physician*, 44, 1567–1568.
- Robertson, A. E. (1998). The mental health experiences of gay men: A research study exploring gay men's health needs. *Journal of Psychiatric and Mental Health Nursing*, 5, 33–40.
- Rosenfeld, D. (1999). Identity work among lesbian and gay elderly. *Journal of Aging Studies*, 13, 121–144.
- Rothblum, E. D. (1994). Introduction to the special section: Mental health of lesbians and gay men. *Journal of Consulting & Clinical Psychology*, 62, 211–212.
- Russell, S. T., & Joyner, K. (2001). Adolescent sexual orientation and suicide risk: Evidence from a national study. *American Journal of Public Health*, 91, 1276–1281.
- Ryan, B., Hamel, M. A., & Cho, C. (1998). Multiple loss and mourning within the gay male community. In W. Rowe & B. Ryan (Eds.), *HIV and social work: The Canadian experience* (pp. 210–232). Toronto: Oxford University Press.
- Saunders, J. M., Tupac, J. C. D., & MacCulloch, B. (1988). *A lesbian profile: A survey of 1000 lesbians*. West Hollywood, CA: Southern California Women for Understanding.
- Schatz, B., & O'Hanlan, K. (1994). Anti-gay discrimination in medicine: Results of a national survey of lesbian, gay and bisexual physicians. San Francisco: American Association of Physicians for Human Rights.
- Scrutton, S. (1999). *Counselling older people* (2nd ed.). London: Arnold Publishing.
- Simkin, R. (1993). Creating openness and receptiveness with your patients: Overcoming heterosexual assumptions. *The Canadian Journal of Obstetric/Gynecology Women's Health Care*, 5, 485–489.
- Slusher, M., Mayer, C., & Dunkle, R. (1996). Gays and lesbians older and wiser: A support group for older gay people. *The Gerontologist*, 36, 118–123.
- Smith, G. B. (1993). Homophobia and attitudes toward gay men and lesbians by psychiatric nurses. *Archives of Psychiatric Nursing*, VII, 377–384.
- Stevens, P. E. (1992). Lesbian health care research: A review of the literature from 1970 to 1990. *Health Care for Women International*, 13, 91–120.
- Stevens, P. E., & Hall, J. M. (1990). Abusive health care interactions and experiences by lesbians: A case of institutional violence in the treatment of women. *Response to the Victimization of Women and Children*, 13, 23–27.
- Tievsy, D. L. (1988). Homosexual clients and homophobic social workers. *Journal of Independent Social Work*, 2, 51–62.
- Turner, H., & Catania, J. (1997). Informal caregiving to persons with AIDS in the United States: Caregiver burden among Central city residents eighteen to forty-nine years old. *American Journal of Community Psychology*, 25, 35–59.
- Van Soest, D. (1996). The influence of competing ideologies about homosexuality on nondiscrimination policy: Implications for social work education. *Journal of Social Work Education*, 32, 53–64.

Received February 28, 2002

Accepted July 22, 2002

Decision Editor: Laurence G. Branch, PhD

## Appendix: S

### Coming Out to Care

The Gerontologist  
Vol. 47, No. 4, 490-500

Copyright 2007 by The Gerontological Society of America

## Coming Out to Care: Caregivers of Gay and Lesbian Seniors in Canada

Shari Brotman, PhD,<sup>1</sup> Bill Ryan, MSW,<sup>1</sup> Shannon Collins, MSW,<sup>2</sup>  
Line Chamberland, PhD,<sup>2</sup> Robert Cormier, MSW,<sup>1</sup> Danielle Julien, PhD,<sup>3</sup>  
Elizabeth Meyer, PhD,<sup>4</sup> Allan Peterkin, MD,<sup>5</sup> and Brenda Richard, PhD<sup>6</sup>

**Purpose:** This article reports on the findings of a study whose purpose was to explore the experiences of caregivers of gay and lesbian seniors living in the community and to identify issues that emerged from an exploration of access to and equity in health care services for these populations. **Design and Methods:** The study used a qualitative methodology based upon principles of grounded theory in which open-ended interviews were undertaken with 17 caregivers living in three different cities across Canada. **Results:** Findings indicated several critical themes, including the impact of felt and anticipated discrimination, complex processes of coming out, the role of caregivers, self-identification as a caregiver, and support. **Implications:** We consider several recommendations for change in light of emerging themes, including expanding the definition of caregivers to be more inclusive of gay and lesbian realities, developing specialized services, and advocating to eliminate discrimination faced by these populations.

**Key Words:** Gay and lesbian aging, Caregiving, Health care, Access and equity, Home care, Elderly

Discrimination faced by gay and lesbian seniors and their caregivers in the health care system has only recently begun to receive attention within the field of gerontology (Brotman, Ryan, & Cormier, 2003). In Canada, a growing interest in gay and lesbian aging has resulted in several community-led initiatives documenting older gay and lesbian realities and challenging health care practitioners to respond to homophobic and heterosexist discrimination and to adapt their services to these populations. *Homophobia* is the fear, hatred, or mistrust of gays and lesbians often expressed in overt displays of discrimination. *Heterosexism* is the privileging of heterosexuality over all other sexual orientations and identities, although it is often subtle and invisible, heterosexism effectively works to create obstacles to achieving full equality for gays and lesbians (Brotman, Ryan, & Meyer, 2006).

Two notable Canadian organizations run by gay and lesbian community groups are the 519 Community Centre in Toronto and The Centre in Vancouver, both of which have highly organized and advanced programs for gay and lesbian seniors and their caregivers. Yet despite their efforts, policies and practices addressing issues facing gay and lesbian seniors in Canada continue to be marginal, particularly within mainstream health and social service agencies.

Given this reality, it is no surprise to find that identification of and responsiveness to those providing informal, unpaid caregiver support to these seniors is even further removed from the health care agenda. Faced with many of the same emotional and physical strains that often accompany caring for any disabled senior regardless of sexual orientation, caregivers of lesbian and gay seniors in Canada also experience unique challenges to identify themselves and receive appropriate care in an environment often marked by intolerance and avoidance. As a result, caregivers may experience a sense of isolation and invisibility in their attempts both to provide care to their loved ones and to identify

We wish to acknowledge the Canadian Institutes of Health Research, the Social Sciences and Humanities Research Council of Canada, and the Centre de Santé et de Services Sociaux, Concordia University Affiliated Research Centre in Social Gerontology for their support of this research. We also wish to thank Kristen Carron for her hard work and dedication to the project over five years.

Address correspondence to Shari Brotman, McGill University School of Social Work, 3309 University Street, 300, Montreal, QC H3A 2A7, Canada; E-Mail: shari.brotman@mcgill.ca

<sup>1</sup>McGill University School of Social Work, Montreal, Quebec, Canada.

<sup>2</sup>Université de Québec à Montréal, Canada.

<sup>3</sup>Department of Psychology, Université du Québec à Montréal, Canada.

<sup>4</sup>McGill University Department of Education, Montreal, Quebec, Canada.

<sup>5</sup>Department of Psychiatry, Mount Sinai Hospital, Toronto, Ontario, Canada.

<sup>6</sup>School of Social Work, Dalhousie University, Halifax, Nova Scotia, Canada.

support for their own needs. Because of the added burden of exposure to discrimination, caregivers may experience the challenges of providing care in the context of reduced support, rejection by family and society, and invisibility. Individuals who provide informal care support to gay and lesbian seniors remain hidden from view. If health care providers are to develop best practices to address the unique realities of gay and lesbian seniors, then the experiences of informal, unpaid family and friend caregivers must also receive adequate attention. For these caregivers, the experience of "coming out to care" must be given voice.

This article highlights the experiences and perceptions of caregivers to gay and lesbian seniors that emerged from a study exploring health care access and equity issues facing gay and lesbian seniors in Canada. The study addressed the issues facing gay and lesbian seniors living in the community who experience a loss of autonomy from the perspectives of three distinct groups: (a) gay and lesbian seniors; (b) their informal, unpaid family and friend caregivers; and (c) providers of community and home care health services. Using qualitative exploratory interviews with caregivers that were undertaken between 2002 and 2006, we explored some of the critical themes that emerged in the interviews, including self-identity as a caregiver, the impact on caregivers of real and anticipated discrimination faced by gay and lesbian seniors in the health care system, coming out and the role of caregivers, and the need for specialized caregiver support services. (The term *coming out* refers to the process of identifying oneself to others as gay or lesbian.) This article addresses the unique perspectives of caregivers themselves and is an initial attempt to articulate issues from the standpoint of this population. Further explorations of data emerging from the standpoints of seniors and service providers are currently underway, and we hope, as a research team, to follow up this analysis with future articles comparing and contrasting perspectives and experiences in and between cohorts of participants (Brotman et al., 2003; Brotman et al., 2006). Hence, this article will draw exclusively from the voices of caregiver participants in the larger study. Finally, we consider recommendations for change in light of emerging themes expressed by caregivers.

The literature focused on individuals (regardless of their sexual orientation) caring for gay and lesbian seniors is limited. Rather than consider the experience of caring for a gay or lesbian older adult, the literature tends to approach the issue from the perspective of gay and lesbian caregivers, many of whom, admittedly, care for their gay or lesbian partners, friends, or, more rarely, parents (Cantor, Brennan, & Shippy, 2004; Cantor, Shippy, & Brennan, 2002; Coon, 2004; Frederiksen, 1999; Hash, 2001; Hash & Cramer, 2003; Moore, 2002; Shippy, Brennan, & Cantor, 2003; Shippy, Cantor, &

Brennan, 2004). The majority of the literature that describes caregiving to gay and lesbian people focuses specifically upon HIV/AIDS caregiving and centers around the physical, psychological, emotional, social, and financial strains involved with caregiving for a partner with HIV/AIDS (e.g., Irving & Bor, 1995; Wight, Aneshensel, & LeBlanc, 2003). Apart from those in Shippy, Brennan, and Cantor's seminal work on HIV caregiving experiences among lesbian and gay elders, the individuals receiving care in most of studies on HIV and caregiving represent largely a young adult population (generally younger than 50 years old), and thus their usefulness for understanding the experiences of those caring for gay and lesbian seniors is limited. We were also unable to uncover any published research focusing on the experiences of children caring for ailing gay or lesbian parents. As a result, we know very little about their unique care experiences.

Overall, research on caregiving to gay and lesbian seniors is just beginning to emerge in the United States and Canada. Although researchers have explored a variety of issues and factors, the literature has demonstrated that discrimination plays a key role in the capacity for seniors and their caregivers to access health care services (Brotman et al., 2003; Brotman et al., 2006; Cahill & South, 2002; Hunter, 2005; Johnson, Jackson, & Arnette, 2005). Both the anticipation of discrimination and actual experiences of discrimination in health care services contribute to great tension and represent a challenge to the possibility of coming out to health care providers in order to receive appropriate care. This represents a significant challenge to seniors and their spousal/partner caregivers. Several key authors who have published in the area have stressed the importance of expanding beyond the focus on burden and strain in order to examine the unique and positive aspects of caregiving and post-caregiving for this population (Frederiksen, 1999; Hash, 2001; Hash & Cramer, 2003; Moore, 2002; Shippy et al., 2004). The available scholarship has also reported that there exists significant experiences of heterosexist and/or homophobic discrimination at individual, social, economic, policy, and institutional levels (Coon, 2004; Hash, 2001; Hash & Cramer, 2003; Hunter, 2005; Moore, 2002; Wenzel, 2002).

The few studies on gay and lesbian caregiving have pointed to common issues consistent with the general literature on caregiving, including managing caregiving responsibilities, experiencing emotional and physical strains, feeling tension in partner relationships, and experiencing conflicts with employment responsibilities (Hash, 2001; Hash & Cramer, 2003; Moore, 2002; Shippy et al., 2003). Many respondents also noted positive aspects of caregiving, including the fact that caregiving gave them the opportunity to show love and maintain a commitment to a significant other (Hash, 2001; Shippy et al., 2003). Research has also highlighted

the challenges of navigating the disclosure or hiding of their same-sex relationship to family, friends, and coworkers during both the caregiving and post-caregiving periods (Cantor et al., 2002; Hash, 2001; Hash & Cramer, 2003; Moore, 2002).

In these studies, most caregivers dealt with family members, friends, and professionals who did not provide them with the support they needed (Cantor et al., 2002; Cantor et al., 2004; Coon, 2004; Hash, 2001; Hash & Cramer, 2003). Support or lack thereof (if for reasons of not accepting respondents' relationships) seemed to greatly affect the caregiving processes (Hash, 2001; Hash & Cramer, 2003). Supportive family, friends, and professionals often served as buffers to caregiver strain, yet this support was not generally anticipated and respondents seemed to expect insensitive and unsupportive individuals (Hash, 2001).

Shippy and colleagues' (2004) more recent findings differed somewhat in that their examination of gay male caregivers presented a picture wherein caregivers received significant support from biological family members. This challenged the myth of the isolated gay male senior. Shippy and colleagues found that caregivers had both friends and family with whom they were close. Respondents asserted that, when present, biological family members were accepting and maintained contact. Nevertheless, the majority of respondents stated that, when in need of help, they were most likely to call on their partners followed by their friends. Remarkably, however, one third of the respondents expressed the need for more adequate emotional support, and most called for the gay and lesbian community to fill the important role of caring for their elders.

Other work by the latter researchers echoed the call for psychological and emotional support for elder caregivers within gay and lesbian communities (Cantor et al., 2004; Shippy et al., 2003). In their groundbreaking research on caregiving among middle-aged and older gay, lesbian, bisexual, and transgendered New Yorkers, Cantor and colleagues (2004) found that of 341 participants who answered a mail survey, 46% had provided care to a family-of-origin member or a family-of-choice member during the past 5 years. In all, 24% of those individuals reported having cared for a person not related by blood. More than half of those caring for family-of-choice members were caring for a partner or a significant other. Apart from the expressed desire for more psychological support, one third of the respondents also highlighted the need for more organized social activities for older lesbians, gays, bisexuals, and transgendered people (Cantor et al., 2004).

Respondents in many studies reported the commonality of homophobia and heterosexism visible either in attitudes of staff or in policies and practices (Coon, 2004; Hash, 2001; Hash & Cramer, 2003; Moore, 2002). Some caregivers expressed anger and hurt at how they were repeatedly denied acknowl-

edgement as family within policies such as visiting hours or parking (Moore, 2002). Often professionals would look to biological family members to relay information or discuss issues that arose (Hash, 2001). Respondents generally expected to face insensitive individuals and did not anticipate support from others (Hash & Cramer, 2003; Moore, 2002). Caregivers were apprehensive about seeking support from health professionals and services (such as groups or home care services; Hash, 2001). In light of this, respondents recommended policy changes and improved training in health and human services organizations (Hash & Cramer, 2003).

Studies have found that the majority of caregivers were apprehensive about disclosing the status of their relationship to health care professionals and that they would use generalized language hoping that, if professionals caught on, they would be alright with it (Hash, 2001; Moore, 2002). Finally, participants expressed that coping can be severely hampered due to the fact that partnerships cannot be openly acknowledged, shared, or disclosed. For example, in one study, caregivers expressed negative experiences with prior support groups wherein they felt unsafe or uncomfortable disclosing their same-sex relationship. Many expressed that their survival up to that point had been largely based on concealing their relationships and/or sexual orientation, making communication of feelings and thoughts impossible in the context of support groups (Moore, 2002).

In conclusion, several themes exist in the small literature currently available on caregiving to gay and lesbian seniors. These themes include anticipated and experienced forms of heterosexism and homophobic discrimination in the delivery of health care resources to gay and lesbian seniors and their caregivers; the challenges of identifying oneself as gay or lesbian, or as the caregiver of a gay or lesbian senior, in the context of receiving health care services; the management of caregiving responsibilities; the experience of emotional and physical strains; and the positive aspects of caregiving, including those related to a demonstration of commitment and the impact of informal support on the well-being of seniors and their caregivers. Previous research has also concluded that professionals currently know little about caregivers to gay and lesbian seniors because of the paucity of studies that address their unique needs and realities. These conclusions point to the need for further research on these often invisible populations.

## Methods

The findings presented in this article emerged from a larger study that investigated many aspects of accessing health and social services for gay and lesbian seniors in three cities across Canada. We

developed a 3-year participatory qualitative research program that used an adapted grounded theory methodology (Glaser & Strauss, 1967; Strauss & Corbin, 1998) to uncover the multiple experiences of care that were reflected in service access and delivery with gay and lesbian seniors and their caregivers. The focus on seniors, their caregivers, and health and social service providers facilitated understanding of the potential dilemmas, gaps, similarities, and differences between the experiences of seniors and their caregivers and the ways in which service providers understand and make sense of that experience.

We determined research processes in conjunction with our local and national partner organizations, including those representing gay and lesbian community organizations, health policy bodies, home care organizations and caregiver groups. We established an advisory group made up of 10 national partner organizations from the onset of the study in order to enhance the trustworthiness (Denzin & Lincoln, 1998; Lincoln & Guba, 1985) and authenticity of the research (Erlanson, Harris, Skipper, & Allen, 1993). Our partner organizations were specifically involved in participant identification and recruitment, development of interview guides, review of data analysis, and member checking themes and patterns that emerged. Several separate meetings of local team members provided the research team in local areas with opportunities to undertake more in-depth regional outreach and analysis and to plan knowledge transfer strategies. We designed this research process to be a change process, and we intended that the involvement of an advisory group would move investigators' and participants' understandings toward change (educative and analytic authenticity). This was generally thought to be achieved.

Issues of sampling are particularly relevant in studies addressing sexual orientation (Brotman et al., 2003). The history of silence around discussions about the needs and realities of gay and lesbian seniors on the part of health care and social service providers as well as the reticence of seniors and their caregivers to come out to providers may have made some people hesitant to participate and often made recruitment quite challenging. This is particularly true for the current cohort of gay and lesbian seniors, who have a unique historical experience regarding oppression that is different from the experience of middle-aged and younger gays and lesbians today. Many older gays and lesbians lived their youths and young adult lives in very hostile environments prior to the development of the gay liberation movement that began in the late 1960s in Canada and the United States (Brotman et al., 2003). We cannot understate that gay and lesbian elders who grew up prior to the era of gay liberation faced considerable obstacles to coming out. Many experienced overt discrimination in their private and public lives. This has resulted in the need to stay hidden and has

remained a prominent coping mechanism in the lives of many older gay men and lesbians (Bonneau, 1998; Cook-Daniels, 1997; Harrison, 1996; Harrison & Silenzio, 1996; Kochman, 1997; Krauss Whitbourne, Jacobo, & Munoz-Ruiz, 1996; Rosenfeld, 1999; Saunders, Tupac, & MacCulloch, 1988). This is particularly relevant in the context of health care research initiatives, which may have historically centered around the development of "curative" strategies designed to "fix" gay and lesbian people of their same-sex attractions (Brotman, Ryan, Jalbert, & Rowe, 2002). As such, recruitment efforts in the current study emphasized the importance of addressing this information and stressing the confidentiality of interview processes in order to respond to potential participants' concerns.

As is common in qualitative research methods, we employed a snowball sampling technique as the primary method of finding participants for the study (Bogdan & Taylor, 1994; Bryman, 2001; Neuman, 1997; Pulice, 1994). Snowballing techniques can be effective when a sample of interest is difficult to identify (Grinnell, 1993). This is pertinent with respect to gay and lesbian populations who, because of past and current experiences of discrimination, have remained largely invisible in health and social service environments. Unfortunately, one of the weaknesses of this technique is the risk that the sample will result in a relatively homogenous group of participants (e.g., friends refer friends, clients come from the same agency, or key informants suggest similar people). This emerged in the current study, with many participants coming from referrals from a small number of agencies or from within the same community or circle of people. For example, our female participants were largely activist in orientation, having come from an experience of feminist community organizing. Also, our participant group was relatively young. Still, caregiver participants represented a wide range of people with different relationships to the senior they were caring for (partner, child, friend, other relative), living arrangements (with and away from the care receiver), gender, and sexual orientation, and with a variety of caregiving tasks and frequencies and durations of support (see Table 1). We placed special attention on establishing a climate of confidence to facilitate participant involvement. This included engaging in a prolonged manner both in the field (through partner agencies) and in the interview process itself (Lincoln & Guba, 1985, p. 301).

Overall, recruitment proved to be very challenging throughout the research process, particularly in Halifax, where we succeeded in interviewing only 2 caregivers. In Montreal, we identified only 5 caregivers for participation in the study. This directly points to the level of invisibility of this population and the variation of support in different parts of Canada. In Vancouver, for example, where a unique organization directed toward the needs of

Table 1. Demographic and Relational Chart

Interview	Gender	Age	Sexual Orientation	Relationship to CR	CR	CR's Health Status	CG's Relationship Status	Form of Caregiving	Frequency	Duration
Montréal 1	M	41	Gay	Child	Gay father	Recovering from stroke	Single	Hospital visits	Daily	1 year
Montréal 2	M	60	Gay	Partner	Partner	Unclear	Single, widow	Cooking, cleaning, medication, personal care	Daily	6 months
Montréal 3	F	61	Heterosexual	Neighbor	Gay male friend	Confused, colitis, arthritis, glaucoma, insulin problems	Divorced	Functional support, instrument of tasks, companionship	3-4 times/week	8 years
Montréal 4	M	52	Gay	Partner	Partner	Disobedient in a wheelchair, multiple sclerosis	With partner	Cooking, cleaning	Daily	24 years
Montréal 5	F	62	Lesbian	Friend	Lesbian friend	Cancer	Single	Cooking, cleaning, personal care, medication	6 hours shifts around the clock	4 months
Vancouver 1	F	62	Lesbian	Partner	Partner	Unclear	With partner	Household tasks, cooking	Daily	N.A.
Vancouver 2	M	46	Heterosexual	Child	Gay father	Cancer, then died	Single	Personal care, shopping, cleaning	Progressively more intense to daily	6 years
Vancouver 3	F	47	Heterosexual	Child	Gay father	Cancer, then died	Divorced	Grocery shopping, instrument of tasks, physical needs	1 time/week	5 years
Vancouver 4	M	36	Gay	Friend	Gay friend	Unclear	With partner	Instrument of tasks, grocery shopping, physical needs	1-2 times/week	10 years
Vancouver 5	M	58	Gay	Friend	Gay friend	Unclear	With partner	Phone support, decisions, successional care	1-2 times/week	10 years
Vancouver 6	M	42	Gay	Friend	Gay friend	Unclear	With partner	Household tasks, phone support	2-3 times/week	12 years
Vancouver 7	F	61	Lesbian	Partner	Partner	Unclear	With partner	Household tasks, accompaniment to medical appointments	Daily	5 years
Vancouver 8	F	57	Heterosexual	Sister	Lesbian sister	Unclear	Divorced	Cleaning, cooking, phone support	Daily when visiting	5 weeks
Vancouver 9	F	57	Heterosexual	Child	Lesbian mother	Unclear	Married	Cleaning, groceries	4-5 times/week	3 years
Vancouver 10	F	68	Lesbian	Partner	Partner	In a wheelchair	Divorced, with partner	Accompaniment to medical appointments, personal care, organizing other CG's	Daily	4 years
Hull/fox 1	F	60	Lesbian	Partner	Partner	Brain hemorrhage, aphasia, then slow recovery	With partner	Accompaniment to medical appointments, instrument of tasks, emotional support	Daily	2 years
Hull/fox 2	F	72	Lesbian	Partner	Partner	Breast cancer	With partner	Decisions, accompaniment to medical appointments, emotional support	Daily	15 years

Note: CR = care recipient; CG = caregiver.

community-residing gay and lesbian seniors exists, recruitment of both seniors and their caregivers was far more successful. The concern of having to identify as a gay man or lesbian (in the case of spouses and partners) or as a child of a gay or lesbian senior (in the case of adult children) in order to participate in the study may have also contributed to difficulty in recruitment. Still, we must consider the possibility that gay and lesbian seniors in these locations have fewer avenues of informal support; or that there exists a lack of identification on the part of those who provide support to gay and lesbian seniors with the term *caregiver*. Our team theorized that those caregivers who form part of a friendship or fictive kin network with gay and lesbian seniors may not identify themselves as caregivers, particularly given the narrow definitions used in mainstream service agencies that focus primarily on advancing a caregiver agenda for heterosexual spouses or adult children. This may be a subject for future research initiatives.

Interviews lasted approximately 1.5 to 2 hr and were audiotaped and transcribed. We developed the interview protocol in a two-stage process in conjunction with the research advisory group. First we developed interview guides and tested them with a small number of caregiver participants. The interview protocol was semistructured, with open-ended questions in several theme areas that provided participants with the opportunity to discuss issues important to them. The interview was based upon four broad theme areas: (a) description of the caregiver role and relationship, (b) experiences of access to health care on the part of gay and lesbian seniors and the impact of these experiences on the caregiver role and relationship, (c) caregiver needs and issues, and (d) areas for future change. Included in the first theme discussion was a question designed to allow participants to explore their identity as a caregiver, whether they defined themselves as such, and their feelings regarding caregiving. Section 2 of the interview focused more specifically upon experiences of caring for a gay or lesbian senior in the context of access to and equity in health service delivery (i.e., caregivers' perceptions of the kind and quality of care the gay or lesbian senior received and what this meant for their caregiving role and responsibilities). Section 3 focused upon participants' own health care and service needs with respect to their caregiving role. Finally, Section 4 asked participants to talk about what services were needed, with respect to both the gay or lesbian senior as well as caregivers. Participants had the option of having a copy of the interview guide during the discussion. In addition, participants received a 1-page sheet on which the major themes were highlighted in order to provide them with an idea of where the interview was heading. All participants signed a consent form and were assured of confidentiality in conformity with ethical procedures of research. Interviews were

undertaken by the same interviewer in two of the three regions, allowing for interviewers to learn from their experience and transfer knowledge from one interview to the next over the entire period of the study. This supported integrity in the research process. The guide itself was meant to be open, allowing participants to focus on specific areas that they found meaningful while ensuring that they covered the major themes. Although some change in interviewers occurred in one region over the 3-year period, all interviewers were trained and were provided with support, feedback, and ongoing training to ensure consistency in the interview process across all regions.

We undertook analysis using the grounded theory method outlined by Glaser and Strauss (1967) and Strauss and Corbin (1998). Grounded theory is a popular research methodology developed as a model for theory-generating research. The goal of the analysis is to identify themes and the relationships between these themes (patterns). The researchers worked closely with the advisory group at this stage to ensure the credibility of the analysis and the applicability of the emerging concepts to practice (Lincoln & Guba, 1985). Various members of the investigative team simultaneously undertook content analysis of transcripts (Gilgun, 1994) using the constant comparative method (Strauss & Corbin, 1998). Members met regularly to compare and contrast their analytic themes. Blind review of coding occurred with a select sample of transcripts to ensure consistency in analysis and coding. We conducted qualitative analysis of data on an ongoing basis as the research proceeded, alongside data collection. In fact, analysis informed data collection in an iterative process. In the first pass, we analyzed the transcribed interviews in order to come up with working concepts and hypotheses that informed future phases of the work. At this stage, broad concepts such as what the caregivers said about their experiences, the experience of interventions by health and social service providers, and caregivers' needs and perspectives with respect to service intervention formed the basis of the analysis. Several interviews were completed and themes analyzed in order to determine the characteristics of further cohorts or themes we wanted to address in subsequent interviews. Therefore, interviews occurred throughout the 3 years in stages that sought to enhance the analytic depth of, and the comparison in and between, cases. The use of N6, a qualitative data software program, facilitated both data coding and analysis.

Finally, in order to ensure that the research process and the findings were authentic with respect to the voices and meanings of participants themselves (Lincoln & Guba, 1985), we employed techniques such as member checking (going back to participants and other key informants to check that our analysis made sense to them and reflected their original intent), referential adequacy (referring back

to the literature and to experts in the field to ensure the analysis was consistent with both interview transcripts and previous research), and prolonged engagement (staying in the field and continuing to interview for a prolonged period of time to ensure both adequate context and content for analytic purposes).

## Results

### *Description of Participants*

A total of 17 caregivers participated in the current study. These included 5 from Montreal, 2 from Halifax, and 10 from Vancouver. Participants in the study included 4 adult children (3 of whom identified as heterosexual and 1 as gay), 7 partners (5 lesbian, 2 gay), 4 friends (3 gay, 1 lesbian); and 1 sister and 1 neighbor (both heterosexual). The gender breakdown of the participants fit the expected finding of more women caregivers (10) than men (7). The age of the caregivers ranged from 33 years to 68 years, with an average age of 63 years for the partners and 41 years for the adult children.

The caregivers in the study reported a range of durations in the caregiving role. Some had only been caregiving for less than a year, whereas others had been caregiving for up to 20 years. Five of the caregivers had provided caregiving support for other family members and friends prior to the relationship in question. The frequency of contact varied from 24 hours a day to 2 points of contact (calls, visits) per week (see Table 1).

### *Self-Identification as a Caregiver*

Research in the general caregiving literature (reflecting the heterosexual caregiving relationship) suggests that those family members who provide unpaid instrumental, physical, financial, and emotional support to older family members do not often identify themselves as caregivers. This is particularly true of spouses who see caregiving as a natural extension of their spousal role, something done out of love or obligation or as a result of a reciprocal relationship with the care receiver. Caregivers in the current study identified with this reality, providing clear indications that caregivers of gay and lesbian seniors have the same sense of motivation and identity (self-identification as a caregiver) as caregivers of heterosexual seniors. The following quote exemplifies this:

I'm not really a caregiver, it's a relationship based upon love. I love my partner, I was always with him, we will always be together. ... It has been 30 years that we are together, so I take care of him. ... (Partner, gay)

One aspect of caring for a gay or lesbian senior may include the notion of community identity and

commitment as a motivating factor for providing care. This positive aspect of caregiving emerged in two of our interviews with caregivers in specific reference to lesbian communities where a value of solidarity stemming from previous involvement in feminist organizing may have contributed to other forms of caregiver identity for these participants. This pointed to a unique strength of the gay and lesbian community that could potentially influence the caregiving experience. One lesbian partner caregiver reflected on how her friends in the lesbian community might perceive themselves: "Not as ... caregivers, but there would be rallying within the community to say we need to put support around [her]."

This notion of community challenged the idea that older gay men and lesbians were, because of their sexual orientation, more isolated than their heterosexual counterparts. In fact, some research has suggested that older gay men and lesbians successfully engage in friendships and experience a wide sense of community throughout their lives that follows them into their senior years (Shippy et al., 2004; Thompson & Richardson, 2002).

What was made evident in the current study was that, for gay and lesbian seniors, the opposite was equally true. Although some seniors had large support systems, there were also those who lived in relative isolation, such as this care receiver before the lesbian caregiver network mobilized around her:

... we found out that she was very ill and had a terminal cancer. ... I was working at the book-store ... and she used to often visit. ... And then we realized we weren't seeing her anymore, and we asked around and we heard she was ill. ... Then someone I met by accident said to me, "Sue's always in her apartment. ... She's very ill and ... there's really no one looking after her." ... She wasn't eating, you know, she was too weak to eat ... and really take care of herself. (Friend, lesbian)

Mediating this reality was a sense of connection to a wider community exhibited prior to getting older that facilitated the coming out process, as well as limited experiences of discrimination faced over time that may have reduced the fear of connecting to others:

In her last round of cancer ... there were a number within the lesbian community who in different ways put support around her. ... There were lots of things that came to the door. ... The lesbian community, her friends, made ... lots of attempts to carry her through that time. ... She would name it as being held in a womb. ... The women's community, in that way, uh, was very supportive for her. (Partner, lesbian)

Finally, the existence of ageism in the gay and lesbian community may have diminished the sense



of community felt in younger years leading to potential areas of vulnerability as people aged:

I think that, the biggest worry was getting older ... because like he says, when you're young, you swing, you have friends ... but when you start to lose your hair, then you're less sexy and you are alone. (Female neighbor, heterosexual).

Overall, few caregivers identified outwardly with the term *caregiver*. Although the reasons vary, expanding definitions of *caregiver* to include experiences of those caring for gay and lesbian seniors have the potential to challenge more narrow definitions legitimated only through biological connection or heterosexual marriage currently held paramount in the field of gerontology.

### Discrimination

Previous research in Canada and the United States has identified the discrimination faced by gay and lesbian seniors in accessing health care and social services (Brotman et al., 2003; Kimmel, Rose, & David, 2006). The current cohort of gay and lesbian seniors articulated this discrimination in two distinct ways. First was the actual discrimination that these populations encountered in the health care system. Second was the anticipation of discrimination experienced by seniors prior to accessing health services that mediated their willingness to come out to health care providers or to access services altogether (Brotman et al., 2006). This anticipated discrimination was largely based upon previous negative encounters in the health care system as experienced by gay and lesbian seniors in their younger years, but also included such realities as hearing stories of discrimination from others or experiencing discrimination in other contexts (such as family, school, or workplace settings) that might have caused a person to develop a generalized expectation of discrimination.

Caregivers in the current study affirmed both of these realities. For a majority of caregivers interviewed, both experienced and anticipated discrimination played an important mediating role in the willingness to access resources.

Speaking of the general distrust of health and social services as a major factor in a care receiver's reluctance to use services, these caregivers explained

I am certain [that being gay or lesbian affects the quality of service one receives]. ... It's for sure that he won't have confidence in the health care provider. ... He is afraid of everything. (Female neighbor, heterosexual).

My dad's generation was more conservative, more guarded ... So they are [more] reluctant to accept help. ... My dad wouldn't want to be stigmatized as a gay. (Son, heterosexual).

Almost all of the respondents cited at least one discriminatory incident with a health or social ser-

vice professional. For example, when asked whether he thought the needs of gay and lesbian seniors were understood by health and social service providers, a gay son caregiver to his gay father remarked, "They told me that it would be better to hide this aspect ... the identity of my father."

Problems related to current experiences of discrimination (whether overt or covert) seemed particularly acute in relation to workers coming into care receivers' homes:

I do know people in home care services who, if they know a person is lesbian or gay, will refuse and say, "You must send someone else because I'm not comfortable with that situation." ... But they could also not treat you very well because they have to do the job ... especially when it was to do with personal care, so yeah ... I think it's a concern not just to [my partner] but to me and others, too. (Partner, lesbian).

Many caregivers expressed that discrimination was often covert or subtle, thereby making it difficult to identify, address, or respond to. This factor highlights the difficulty in distinguishing between subjective feelings or expectations of discrimination and actual acts of discrimination. For example, the following two quotes highlight the subjective feelings these caregivers had regarding health care providers' treatment in the form of "inferences" and "negative energy":

It's a bit of a grey area, it's hard unless somebody says something. ... [The care receiver] was aware of her inferences ... and he felt uncomfortable having her around. (Friend, gay).

Sighs. Yeah, we experienced homophobia, just in terms of energy around us. ... Sometimes we'd laugh about it and sometimes we would get irritated. I do think we had one experience of a nurse being more grumpy or sharp or impatient ... her responses were just more sharp. And I think it had something to do with her being homophobic. (Partner, lesbian).

These subjective feelings and anticipated forms of discrimination played an important role in the ways in which caregivers responded to and experienced their caregiver role. For example, more than half of the caregivers spoke of the worry they had in leaving the care receiver unattended during interactions with health care professionals for fear of rendering the care receiver more vulnerable. One lesbian partner caregiver stated, "She's going to have continued care from this person on the night shift. ... She is more vulnerable. ... I wouldn't want to leave her there on her own."

The fear of facing discrimination when accessing health services rendered the caregiving experience more complex. Of particular importance was the requirement of caregivers to mediate the coming out process, both with respect to care receivers, and in many cases, themselves. Partners discussed their concerns regarding respecting the care receivers'

desire to keep their sexual orientation private in the context of interactions with the health care system, thereby rendering the relationship between the care receiver and the caregiver invisible. Previous research has identified the common occurrence of older gay and lesbian couples identifying themselves as “friends” or “roommates” as a coping mechanism related to their generational experience of privacy and to mediate negative treatment by others (Brozman et al., 2003). This may make it increasingly difficult for caregiving partners to show affection, provide care when others were present, or gain recognition as the care receiver’s spouse. For example, one caregiving male partner described having to carry his ailing partner into the bathroom so as to give him a hug away from the eyes of others. Efforts to advocate on behalf of the care receiver were also more difficult as, by doing so, one risked outing the care receiver. Adult children addressed the difficulty in advocating for appropriate care for their parent in the context of attempting to keep the sexual identity of their parent private. As a result of discrimination experienced, adult child caregivers may have chosen not to discuss the sexual orientation of their parents with others:

I think that’s probably why my sister and I didn’t openly talk about it to certain people. Because I think they judged a lot more what’s going on in the bedroom, and I don’t think that was really important for my dad. When you talk to people, when you tell them he’s gay ... they want to know more details and that sort of thing ... what goes on. They wouldn’t ask the same sort of questions of a straight couple. And [my dad would get] frustrated with it. So I just don’t bring it up unless it’s close friends or something. ... We just have a dad who just happened to be gay, that’s all. (Son, heterosexual)

Needless to say, negative experiences of discrimination resulted in reduced trust in health and social service systems and the practitioners who work within them:

... being in the hospital, in terms of access for my partner, all those questions are there. ... How will the medical staff respond to us? Who’s going to withdraw good care, or shift care if they have homophobic attitudes or have a sense that they’re uncomfortable in the room? (Partner, lesbian)

Being vocal enabled both care receivers and caregivers to advocate for better service. Five caregivers gave testimony as to how the care receivers openly voiced their concerns and demanded professional, respectful care with both medical professionals and/or home care staff. When questioned whether he felt that sexual orientation affected the quality of health care and social services that the care

receiver would receive, one gay friend caregiver responded:

I think, you know, fortunately he’s able to voice his concerns and express ... what he wants ... whereas there are people that, I’m sure, aren’t able to, or are intimidated and they would just accept the status quo and ... not even necessarily as good as the status quo ... (Friend, gay)

In addition, caregivers also expressed that being out and having higher self-esteem made advocating for services easier:

I think the difference is that now ... we have more of an expectation that people will be more tolerant or more open than they were back then. ... And we are also in a different place because we’re more comfortable, and ... we can initiate something in terms of making change ... (Partner, lesbian)

I think that she [homemaker] was [religious] and she just says it’s wrong, and she didn’t want to acknowledge the relationship. ... And, I don’t think she was there very long, ‘cause I think he just contacted the agency and told them that she’s not welcomed back at the house anymore. (Friend, gay)

Finally, having the support of others who could help to navigate the system and identify supportive allies was an essential coping mechanism for mediating negative encounters among caregivers. For example, one caregiver to her lesbian partner found it helpful to have her son help them navigate the health system:

My son would know who was open to gays and lesbians in their [medical] practices, and who would not be ... or he might have more of a sense [of how] to navigate through. (Partner, lesbian)

Adult children providing care to gay and lesbian parents may have found themselves in a unique place with respect to the coming out process. Two children expressed that their parents being out may have led to assumptions about their own sexual orientation, thus exposing them to experiences of discrimination by association despite their own heterosexual orientation. One caregiver stated:

“What does it mean, if someone’s parent is gay?” ... They would probably ask that. And then they probably question, “What is your own sexuality?” ... which is a common question you hear. And it’s kind of frustrating after you tell it about 20 times and it goes on and on. ... It’s my dad, my dad’s partner, it’s [not me]. (Son, heterosexual)

This highlights the reality that caregivers who are put in a position of having to advocate for their loved one may find themselves exposed to discrimination.

## Support

Support can have an important mediating effect on the negative experiences of caregivers. Although approximately one fourth of the caregivers interviewed reported having satisfactory to significant family support, they also pointed to the importance of "chosen family" (friends and community members who are present to provide support and love in the absence of biological family).

Overall, interviews revealed that when people had come out to their families, under the condition that they were accepted once out, more potential existed for a wider breadth of support. Alternatively, when care receivers and caregivers were not well received by family and did not have other avenues of support, they may have had to rely on family members who may not have had the sensitivity, level of acceptance, or courage to advocate adequately for them. In this context, support from family members may have been more complex and/or stressful. One caregiver described how she and her partner dealt with their families:

... some of them are still learning what to do with her sister being in a lesbian relationship. And some of them did try to find ways to make connection, and for others it was just silence. I helped her to think through how she might want to talk to her family and identify what she needs from them and doesn't need from them. (Partner, lesbian)

Another caregiver expressed the difficulty gay and lesbian seniors faced when isolated from family. A lesbian friend caregiver discusses her friend's situation as follows: "The family rejection ... and not being able to have access to her child [was very difficult for her]."

When care receivers were connected to a gay or lesbian community, the support gap may have been filled by chosen family or community members. One lesbian friend caregiver explained, "... and she was very happy, you know, to see all these lesbians who were around, and I think that's very important ... because we were her family, you know."

This broadened sense of community as family is not always understood by mainstream health care providers who continue to view caregivers as biological family members. Anyone outside of this model is subject to misunderstanding, as one lesbian friend caregiver stated: "And it was funny ... the nurses asked her from what sect we were. They thought we were a religious sect, you know [laughs]. ..."

Needless to say, regardless of whether it is through social involvement or through community groups, the more connection a care receiver or caregiver has with his or her community or with gay or lesbian friends, the more potential exists for a wider network of support; consequently, the more potential exists for diffusion of caregiver responsibility and mobilization of caregiver support. Individuals who are isolated will be more vulnerable and

thus deserve the particular attention of service providers and systems.

The issue of finding supportive environments for caregiving children may have been more complex, however, as participants' friendship and family circles did not necessarily contain individuals who were gay friendly and, thus, these caregivers may have felt isolated in their role. Those who have managed to identify support for themselves did so through a pathway familiar to gay and lesbian people. Four caregivers interviewed expressed that they themselves received support from other members of their family network (including children, siblings, and nieces or nephews) as well as from within their friendship circle. This reality confirms that caregivers can also experience feelings of support from a broader network, just as gay and lesbian seniors do. Generally, they locate those members of their community, family, or friendship network who are supportive of gay and lesbian people and who have some knowledge of the community. In fact, 3 of the 4 caregivers of gay and lesbian seniors who themselves identified as heterosexual expressed the importance of selecting friends who were supportive of gay and lesbian people. An adult heterosexual son caregiver explained the source of most of his support: "Probably my friends, you know. I have a good, close network of friends, and they know that my dad is gay."

## Services

Given the important role that caregivers of gay and lesbian seniors play, it would seem essential for there to be some supportive services made available to them. Unfortunately, caregivers expressed a lack of awareness within mainstream service settings regarding their needs or realities. One caregiver stated:

I guess there's not many organizations that you can go to as a caregiver and say, you know, "Can you help me out? You know, I'm stressed out," and stuff like that. I would never do that. I would probably go to my friends. ... I don't know if there's any support group for ... sons and daughters looking after their gay parents. (Daughter, heterosexual)

Several caregivers also stated that, although they could identify a caregiver support group in their geographic area, they were reluctant to join because of fears of being ostracized, discriminated against, or isolated within the heterosexist environment. Indeed, previous research has indicated that many caregiver support groups are implicitly limited to a heterosexist framework (Moore, 2002). The following adult child caregiver reinforced this point:

... of course, it would be great to have ... a support group. You can go and talk about the caregiving needs of your dad or his partner and not be given the same sort of stigmaism. ... If I went

to a support group, it would probably be more of a straight group . . . and they would get into issues about you dad being gay and [ignore] his care needs. I find that frustrating. I probably wouldn't go back. (Son, heterosexual)

The following caregiver drew the connection between her partner needing a support group specifically for lesbians and the fact that she herself might also benefit from a similar group for caregivers:

. . . I know that [my partner] has attempted, even through the health care system, to find a support group where she could talk about what it's like to be a lesbian [with an illness]. And for her it carries some differences. . . . There isn't a place where she can talk about what it means, as a partner to a woman and in her own sense of herself as lesbian. . . . Perhaps that would have been helpful for me, too, because [lesbian] partners carry [the] journey differently. (Partner, lesbian)

## Discussion

In the current study, caregivers shared their experiences of caring for a gay or lesbian senior from a variety of perspectives and positions. Participants addressed discrimination in care, both from the perspective of what the care receiver experienced as well as in the context of caregiver support. For the most part, caregivers expressed that both actual discrimination and the fear of being discriminated against (what we have described as the anticipation of discrimination) have an impact upon how seniors use services and how caregivers interact with services in order to protect care receivers from potential harm. Anticipation of discrimination can be based upon many experiences (e.g., those of seniors and their caregivers in previous encounters or in their younger lives, or those they have heard from others). In addition, although experiences of hostility were more common in historical accounts, there continues to be discrimination, albeit often more subtle, in the form of negative attitudes, comments, or, as one caregiver put it, "energy" that surrounded their treatment. In the end, when care receivers are reluctant to access health and social services because of real or anticipated discrimination, the consequences for caregivers are numerous. First, if care receivers are alienated from services, then it is reasonable to assume that caregivers might also refrain from making the most of services available in an effort to protect and/or respect the wishes of their loved ones, or to avoid discrimination themselves. Second, the less care receivers make use of health and social services, the more is demanded of their caregivers. In essence, caregivers of gay and lesbian seniors may provide care for individuals who might otherwise receive care through the long-term-care or home care network. There

are several aspects to specialized services that could be considered. These include such issues as the development of mandatory training sessions on the needs, realities, and issues facing gay and lesbian seniors and their caregivers; the hiring of gay and lesbian health care workers; specialized support groups or telephone support lines for caregivers caring for gay and lesbian seniors; and community outreach programs designed to invite gay and lesbian community health professionals onto boards and committees within mainstream agencies.

In order for experts to address the important concerns revealed by this study, caregiver participants made several recommendations for current health and social service agencies and providers in the senior services sector. There was an expressed need for specialized senior services, including those found in the voluntary, home care, and residential sectors. Whether these are identified and created within existing publicly funded services or developed through the voluntary or private sector remains an important question for consideration, particularly with respect to access and equity. Several caregivers pointed to the debates within the gay and lesbian communities as to whether it is possible to advocate for the creation of specialized services through the public sector. As one caregiver stated in reflecting on retirement and nursing homes

With gay couples going into retirement more and more, I would hope someone would open up a gay seniors home one day. . . . And then the question of public versus private. . . . in the public system, which is funded by government dollars, you probably couldn't impose. . . . but private health care, because it's private, they might be able to open a gay home. . . . (Friend, gay)

The issue of financing is paramount in order to ensure the development and delivery of services and equitable access. It is essential that gay and lesbian community organizations, as advocates for the eradication of homophobia and heterosexism, be financially supported to develop expertise to address the needs of gay and lesbian seniors and their caregivers as the most appropriate place to begin change-making efforts. Findings also point to the need for the development of services, including support groups, targeted for caregivers. Five caregiver respondents either anticipated or had experienced support groups operating within heterosexist frameworks, and this served as enough deterrent for them not to access those support services that may have been available.

All of the caregivers highlighted education and training of health and social service professionals in hopes that these practitioners could learn acceptance, address heterosexist assumptions, and confront homophobia. Also, individuals who work with seniors in the health and social service sector would

benefit from learning to identify the more subtle clues behind individuals' reluctance to access services so that they may proactively address potential problems, concerns, or needs.

Caregivers who felt comfortable advocating for care receiver rights to full and equal access to services tended to have a sense of entitlement to and assurance of their own rights as well as a comfort with being out as gay or lesbian themselves, as was the case with partners and/or friends providing care. The implications of this finding for health and social service professionals entail working toward empowering seniors and their caregivers as well as developing explicitly gay- and lesbian-friendly services or safe spaces for those caregivers and care receivers who might still be "in the closet." This includes but is not limited to such issues as training employees at all levels so that they provide a warm and welcoming environment; using gender-neutral language in discussions about relationships, life history, and identity; providing opportunities to celebrate all forms of diversity; ensuring confidentiality in communication; supporting the wishes seniors have regarding care planning and making sure that they are understood and respected; and engaging in dialogue with gay and lesbian community organizations to enhance integration and knowledge transfer.

Findings indicate that, overall, support tends to mediate negative experiences, especially when it comes in the form of advocacy around potentially discriminatory behaviors or policies. The gay and lesbian caregivers in this study were mostly out to their families, and this seemed to be an important factor in garnering more support for the care receiver. When care receivers are less out in their gay or lesbian communities or are isolated from the potential of community, they may have to rely on inadequate family support or force more responsibility onto the relatively isolated sons/daughters of the caregiver. Here it is also important to address situations in which adult children (or other biological family members) are in conflict with a gay or lesbian partner in the care of an older adult. In some cases, the partner may be unlikely to have legal rights, and a biological family member who is not comfortable with a relative's sexual orientation might command power that alienates the partner. Although this reality has changed in Canada, where the legal recognition of same-sex partnerships has given legal rights to partners, these partners might not always be vocal, identify as a conjugal partner in the public realm, or be prepared to advocate for himself or herself in the context of a disagreement between the partner and the biological family. Family structures and relationships are complicated, and there may be some instances when heterosexual family members either get involved even though they are not entirely comfortable with the care receiver's sexual orientation or exclude a supportive partner or ally from decision-making capacity. The implication

for health and social service professionals again involves sensitivity to the needs of caregivers and care receivers as well as to the potential reasons for conflict in families regarding care and decision making. This puts the responsibility on health care providers to engage in family conflict resolution or to advocate for the same-sex partner in cases in which the older person cannot speak on his or her own behalf. It also points to the necessity of educating older gay and lesbian people about the need to create living wills and/or mandates to ensure that their care desires and needs are understood, to provide caregivers with adequate documentation as to their role, and to provide further assurances that these will be respected in emergency situations.

Finally, specific attention is warranted to the unique issues and realities facing heterosexual caregivers, particularly children, caring for gay and lesbian seniors. This population has not received much attention from researchers or practitioners to date. The current study points to shared concerns with other caregivers of gay and lesbian seniors, most notably regarding the role they play in mediating discrimination, advocating for appropriate services, and providing hands-on care. However, adult children who are heterosexual may also be exposed to homophobic and heterosexist discrimination as a result of their roles as caregivers; these are forms of discrimination that they may be ill equipped to face. For example, they likely have not experienced these forms of discrimination first hand. In addition, compared to gay and lesbian partner or friend caregivers, heterosexual caregivers may have fewer contacts with individuals or communities who can provide a supportive environment in dealing with this new and difficult experience. Only one of the heterosexual caregivers in the current study made mention of having supportive relationships within the gay community. Two other heterosexual caregivers spoke of having close friends who knew of the sexual orientation of the care receiver. Helping build connections to people who can help heterosexual caregivers deal with and respond to discrimination would surely reduce stress and provide opportunities to learn how to address both the experience, and anticipation, of discrimination. Although caregiver support services and voluntary caregiver organizations must be made more welcoming for caregivers of gay and lesbian seniors as a whole, it may be best to offer adult children a space to discuss their unique experiences and to connect with one another.

The results of this study clearly indicate that although experiences of caregivers to gay and lesbian seniors often echo those of caregivers to heterosexual older adults, differences do exist. These revolve primarily around the real and anticipated discrimination confronted from professionals, and programs and policies that not only do not take these populations into consideration but often deter them from making themselves visible. The legitimate fears

that seniors have of encountering homophobia and heterosexism in health and social services may mean that caregivers are called on to care more intensely and for a longer period of time than other caregivers. This points to a need for involving gay and lesbian health activists in organizations, services, and policy development to ensure that issues of overt and subtle discrimination are seen, highlighted, and addressed effectively.

The inclusion of gay and lesbian caregivers in already existing diversity agendas within mainstream senior services and caregiver organizations is a necessity in order to advance responsiveness and support to them. This could be facilitated by an expansion of the often narrow definitions of caregiving currently in place in both professional and popular discourse that prioritize recognition of those biologically related or married to the care receiver. Indeed, the sense of solidarity and community that lead some to the caregiving role in gay and lesbian communities can provide a new model of care beneficial to all seniors and their caregivers. Understanding under what conditions the development of such a sense of community solidarity can lead to a decision to care can help professionals enhance and support options that are truly community driven and responsive to all older people in society.

Finally, given the paucity of research on caregiving to gay and lesbian seniors, we suggest that much more research needs to be undertaken to explore these important and pressing issues. Our study was limited by several factors, including sampling processes that contributed to a lack of diversity in participants on the basis of race, ethnicity, and class. We also were unable to a large degree to identify caregivers in smaller regions. In addition, issues regarding identity as both a caregiver or as gay or lesbian contributed to difficulties in recruitment. In this study, several participants told us that they did not identify themselves as caregivers (as is consistent with all caregivers), but simply as family or loved ones. In light of this, future studies must adapt outreach and recruitment strategies to identify people through the widest lens possible in order to ensure inclusion of those who would otherwise not come forward because of lack of identification with the targeted population. Using terms that describe people's role in the context of care and not simply the *caregiver* label might help to increase the diversity of participants. Finally, the study was also limited by the use of gay and lesbian identity labeling for outreach and recruitment purposes. As with much research on gay and lesbian populations, those who were most comfortable identifying themselves as gay or lesbian were most likely to agree to participate. This resulted in a lack of representation of those who do not identify with these labels or who are not out to others. Most people we interviewed were comfortable either with being out or with their care receiver being out. As a result, the current study

missed the most invisible cohort of caregivers. Caregivers who were not part of this study because of even greater distress, greater disconnection, or greater distrust of the research establishment might have had even more serious limitations and problems. Certainly, the combined factors of not identifying as a caregiver and being private about the orientation of the care receiver as gay or lesbian posed some problems with respect to recruitment efforts. Future research areas include some proposed previously, such as a comparative analysis of gay and lesbian caregivers, heterosexual caregivers, and other minority caregivers (including ethnocultural minority populations); caregiving to pre- and post-liberation seniors; experiences in rural contexts and with respect to diverse social variables, such as race, ethnicity, and class; legal and financial concerns in the context of rights-based discussions across jurisdictions; caregiving to gay and lesbian seniors in institutional settings; and caregiving issues for bisexual and transgendered seniors.

There are many unexplored avenues of caregiving to gay and lesbian seniors. In Canada specifically, the possibilities for funding and institutional support for research and the interest in advocating for practice and policy changes to support gay and lesbian seniors and their families are slowly increasing. Researchers must be encouraged to undertake projects in a manner that prioritizes resource sharing and partnerships with community and health care organizations to ensure that results are communicated to health care professionals and community activists. In this way, research findings can contribute to the development of a commitment to change on the part of gay and lesbian communities and mainstream health care sectors in order to guarantee that gay and lesbian seniors and their families find support, comfort, and services designed to meet their needs as they age.

#### References


- Bowen, R., & Taylor, S. (1994). A positive approach to qualitative evaluation and policy research in social work. In F. Sherman & W. J. Ryle (Eds.), *Qualitative research in social work* (pp. 195-207). New York: Columbia University Press.
- Burrow, M. (1998). Identification, lesbianism or militational: The visibility problematics. *The articulation of lesbian identities in cultural areas: A problematic visibility*, 16(1), 11-26.
- Chapman, J. (1998). *Disability Encounters: Les lesbiennes face à la discrimination [Understanding rights—the confrontation against lesbian oppression]*. pp. 66-99. Montreal, Canada: Les Femmes de Kinross montage.
- Bromann, S., Ryan, B., & Guimier, R. (2004). The health and social service needs of gay and lesbian elders and their families in Canada. *The Gerontologist*, 43, 90-97.
- Bromann, S., Ryan, B., Jalkut, Y., & Rowe, B. (2007). The impact of coming out on health and health care access: The experiences of gay, lesbian, bisexual and two-spirit people. *Journal of Health and Social Policy*, 33(1), 1-29.
- Bromann, S., Ryan, B., & Meyer, F. (2006). *The health and social service needs of gay and lesbian elders: Final report*. Montreal, Quebec, Canada: McGill University School of Social Work.
- Bromann, B. (2001). *Social research methods*. Oxford, England: Oxford University Press.
- Caball, S., & South, S. (2007). Policy issues affecting lesbian, gay, bisexual, and transgendered people in retirement. *Generations*, 29(2), 49-54.

- Cantor, M., Brennan, M., & Shibley, A. (2004). Caregiving among older lesbian, gay, bisexual, and transgender New Yorkers. *National Gay and Lesbian Task Force*. New York: National Gay and Lesbian Task Force Policy Institute.
- Cantor, M., Shibley, A., & Brennan, M. (2007). Caregiving experiences of older gay men and lesbian women. *The Gerontologist*, 42(Special Issue), 378.
- Coon, D. (2001). Lesbian, gay, male, bisexual and transgender elders: Elder abuse and neglect issues. *Journal of Elder Abuse and Neglect*, 9(1), 35-49.
- Coon, J. (2004). *Lesbian, gay, bisexual, and transgender (GLBT) issues and family caregiving*. San Francisco: Family Caregiver Alliance, National Center on Caregiving.
- Dezin, S., & Lincoln, M. (1998). *Strategies of qualitative inquiry*. Thousand Oaks, CA: Sage.
- Elfrussen, C., Lantis, E., Saloner, B., & Allen, S. (1993). *Doing a narrative inquiry: A guide to methods*. Newbury Park, CA: Sage.
- Feistritzer, S. (1998). Family caregiving responsibilities among lesbians and gay men. *Social Work*, 43(2), 140-155.
- Gilmer, J. P. (1994). *From inside out: The grounded theory approach and social work practice research*. In F. Sherman & W. J. Rook (Eds.), *Qualitative research in social work* (pp. 118-125). New York: Columbia University Press.
- Glasser, B., & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research*. New York: Aldine De Gruyter.
- Grinnell, R. (1993). *Social work research and evaluation* (4th ed.). Boston, MA: Prentice-Hall.
- Jarvison, A. P. (1996). Primary care of lesbian and gay patients: Education on AIDS and our students. *Family Medicine*, 25(1), 10-15.
- Jarvison, A. P., & Silerakis, V. M. B. (1996). Gerontologists' care of lesbian and gay patients and families. *Primary Care*, 23(1), 31-46.
- Joshi, S. M. (2001). Preliminary study of caregiver and post-caregiving experiences of older gay men and lesbians. *Journal of Gay and Lesbian Social Services*, 13(4), 8-94.
- Joshi, S. M., & Carter, L. P. (2003). Empowering gay and lesbian caregivers and processing their unique experiences through the use of qualitative methods. *Journal of Gay and Lesbian Social Services*, 15(1), 14-63.
- Kaufman, S. (1998). *Muslim and other LGBT adults: Knowledge and affirmative practice for the social services*. Binghamton, NY: Haworth Press.
- Living, G., & Bee, R. (1996). Psychological distress among gay men who share a lover or partner with AIDS: A pilot study. *AIDS Care*, 7(6), 618.
- Johnson, M., Jackson, N., & Aronson, J. (1998). Gay and lesbian perceptions of discrimination in retirement. *Journal of Homosexuality*, 40(1), 83-101.
- Minich, J. C., Rose, P., & David, S. (1996). *Lesbian, gay, bisexual and transgender aging: Research and clinical perspectives*. New York: Columbia University Press.
- Kochman, A. (1997). Gay and lesbian elderly: Historical overview and implications for social work practice. *Journal of Gay and Lesbian Social Services*, 6(1), 1-10.
- Strauss, W., Habotnik, S., Jacobo, M., & Manos-Ruiz, M. P. (1996). *Advocacy in the lives of the elderly*. In R. Coleman (Ed.), *The psychology of advocacy* (pp. 68-75). Boston: University of Massachusetts Press.
- Lincoln, M., & Guba, E. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage.
- Moore, W. R. (2002). Lesbian and gay elders: Connecting care providers through a telephone support group. *Journal of Gay and Lesbian Social Services*, 14(3), 23-41.
- Murphy, W. L. (1991). *Social research methods*. Boston: Allyn & Bacon.
- Palce, R. (1994). Qualitative evaluation methods in the public sector: Understanding and working with constituency groups in the evaluation process. In F. Sherman & W. J. Rook (Eds.), *Qualitative research in social work* (pp. 83-104). New York: Columbia University Press.
- Rosenthal, D. (1999). Identity work among lesbian and gay elderly. *Journal of Aging Studies*, 13(2), 121-144.
- Sanders, J. M., Tuma, J. C. W., & MacFarlock, B. (1988). *A lesbian profile: A survey of 1,000 lesbians*. West Hollywood: Southern California Women for Understanding.
- Shibley, R., Brennan, M., & Cantor, M. (2003). Caregiving experiences among lesbian and gay elders. *The Gerontologist*, 43(Special Issue), 43.
- Shibley, R. A., Cantor, M., & Brennan, M. (2004). Social networks of aging gay men. *Journal of Aging Studies*, 18(1), 107-120.
- Strauss, A., & Corbin, J. (1998). *Basics of qualitative research*. Newbury Park, CA: Sage.
- Uhrmanson, J., & Richardson, V. (2002). Older men's relationships and social network. *The Gerontologist*, 42(Special Issue), 104.
- Wald, L. (1992). *Fast facts: New legal issues for LGBT caregivers*. San Francisco: Family Caregiver Alliance.
- Wright, R. G., Brishers-Cohen, C. S., & Lehman, A. J. (2003). Stress buffering effects of family support in AIDS caregiving. *AIDS Care*, 15(8), 899-913.

Received July 21, 2006  
 Accepted January 2, 2007  
 Discussion Editor: Linda S. Neuffer, PhD

## Appendix: T

### *Rainbow Health Ontario*



**Rainbow Health Ontario**  
Because LGBT health **matters**

**Information & Consultation**

**Education & Training**

**Research & Policy**

Rainbow Health Ontario is a province-wide program designed to improve access to services and to promote the health of Ontario's lesbian, gay, bisexual and trans (LGBT) communities.

[www.RainbowHealthOntario.ca](http://www.RainbowHealthOntario.ca)

**WHO WE ARE**

Rainbow Health Ontario (RHO) began operations in January 2008 and is based at Sherbourne Health Centre in Toronto.

The RHO team consists of 4.5 staff in Toronto and 14 part-time Community Outreach Team members, one in each of Ontario's Local Health Integration Networks (LHINs).

**WHAT WE DO**

Although much has changed, the needs of lesbian, gay, bisexual and trans people are often overlooked in our health and social service systems. Ontario's Ministry of Health and Long Term Care funds RHO to act as a catalyst in improving services, increasing knowledge, showcasing innovative practices and encouraging networking and collaboration. Our activities include:

**Information & Consultation**

- Maintaining a comprehensive website featuring searchable databases of LGBT health information, news and events
- Consulting with health and social service providers and community groups and conducting outreach in all LHIN areas


**Education & Training**

- Providing a database of trainers across Ontario and developing special training initiatives and curricula
- Hosting a provincial conference offering education, networking and partnership opportunities

**Research & Policy**

- Developing partnerships with researchers to gather LGBT health data and to encourage more LGBT health research in Ontario
- Promoting the uptake and integration of evidence into the development of public policy

To learn more, please visit:  
[www.rainbowhealthontario.ca](http://www.rainbowhealthontario.ca)





# *Tool Kit Evaluation*

*Diversity  
Our  
Strength*

## ***Tool Kit Evaluation***

*The LGBT Diversity Initiative Steering Committee would welcome your comments and suggestions regarding this Tool Kit. Please take a few moments to complete the following evaluation, and let us know what you liked about the Tool Kit and where we might be able to consider future improvements.*

1. Please indicate your overall satisfaction with the Tool Kit.

(Low)      1                      2                      3                      4                      5 (High)

2. Did you learn any new information as a result of reviewing the Tool Kit?

(Low-No)    1                      2                      3                      4                      5 (High-Yes)

3. Did you learn something new that you will consider using in your work in the home?

(Low-No)    1                      2                      3                      4                      5 (High-Yes)

4. What was most helpful/informative for you from the Tool Kit?

---

5. What would you suggest that the Steering Committee consider in improving the Tool Kit?

---

6. From your experience, and having read the Tool Kit, do you think that this Tool Kit has helped you understand the important role you play in assisting the home to become LGBT welcoming and inclusive? And how?

---

---

Thank you for taking the time to complete this evaluation.

Please forward your completed evaluation to:

Michael Saunders

Resident-Client Advocate

Toronto Long-Term Care Homes and Services

Metro Hall, 55 John Street

Stn. 1113, 11th Floor

Toronto, Ontario

M5V 3C6