

Identifying Barriers to Inclusive Long-Term Care:
Developing Affirmative Living Arrangements for Gay and Lesbian Seniors

by

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Abstract

This study was designed to identify the barriers to inclusive long-term care living arrangements for gay and lesbian seniors. Data were collected from three focus groups comprised of participants age 50 years and older who identified as lesbian or gay (N=20), and questionnaires distributed to professionals in Ottawa long-term care homes (N=5). Using grounded theory to analyze the data, the findings suggest that there is a substantial need to develop inclusive long-term care. While barriers to inclusive long-term care such as, deeply entrenched cultural beliefs and debates around identity recognition are not easily solved, enablers were identified by the participants. Building and strengthening community partnerships; increased public knowledge through education and training; and creating visibly inclusive long-term care homes substantiated by policy development, are some of the needed elements to move towards the goal affirmative long-term care housing for this population.

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Introduction

Gay and lesbian seniors often have been met with a lifetime of discrimination, hostility, and exclusion resulting from heterosexism. Today this group is faced with the double stigma associated with being gay and old. Despite a marked progression in the arena of gay and lesbian rights, heterosexist and ageist practices continue to create an environment of exclusion and discrimination. With the advent of the aging population, more people entering long-term care housing, and the increasing visibility of the gay and lesbian community in the discourse of gay and lesbian seniors' rights, this is an opportune time to increase the inclusivity of long-term care living for gay and lesbian seniors.

This study is a response to the findings and recommendations resulting from my initial research, *Moving Towards Inclusivity: A Study of Long-Term Care for Gay and Lesbian Seniors in Ottawa* (2007). Examining the current state of long-term care provision for aging gays and lesbians, the findings from the study identified both a need and a willingness from long-term care professionals to develop inclusive living environments in long-term care homes. Informal policy identified by long-term care administrators showed advancement towards inclusive long-term care, but further findings indicated an urgent need to formalize policy and develop affirmative living arrangements for gay and lesbian seniors.

The recommendations resulting from the *Moving Towards Inclusivity* study highlighted the importance of gathering the energy and time of members of the gay and lesbian community, allies, and professionals in the long-term care arena to plan for and implement formal policies that foster safe and non-discriminatory long-term care living arrangements. An examination of the barriers which impede the movement towards

inclusive long-term care housing is necessary to address the gaps in knowledge, which hinder the process towards affirmative policy development.

The purpose of this study is to answer the following research question: What are the barriers to inclusive long-term care for gay and lesbian¹ seniors? More specifically, the project will examine barriers to: a) gay and lesbian seniors accessing inclusive long-term care services, b) the planning and implementation of affirmative policy, and c) the involvement of the aging gay and lesbian population in the planning and policy development process. The goal of this study is intended not only to be an academic exercise, but it is action oriented; the study is directed towards making social change. Identifying barriers is a necessary step in the progression towards a participatory process of affirmative policy development and implementation and the identification of facilitators for development of inclusive long-term care living environments.

This thesis is divided into six chapters. The first chapter provides an overview of the literature related to gay and lesbian seniors, the organization of long-term care in Ontario, and the barriers to inclusive long-term care. Chapter two examines theoretical considerations that lay the foundation for the research and inform the research findings. Chapter three outlines the research methodology used to identify barriers to inclusive long-term care. Chapter four provides the research results and a discussion of the findings

¹ This study looks specifically at long-term care for gays and lesbians. Commonly in the literature gay, lesbian, bisexual, and transgender (GLBT) populations are combined. Bi-sexual and transgender identities were not included as the primary focus of this study. Although there are similarities in the hardships confronting these populations, the lived experiences are different. The decision to emphasize gay and lesbian identities was an effort to recognize these differences and an attempt to avoid undermining the lived experiences and realities confronting the bi-sexual and transgender communities. In addition, there is an inherent recognition in the research of the complexity of focusing on fixed identities (e.g. gay or lesbian) and the homosexual/heterosexual dichotomy. These complexities are recognized, but for the purposes of this study and policy making, the terms gay and lesbian are used to describe people who self identify as such.

resulting from the data are explored in chapter five. Final conclusions and recommendations resulting from the research are presented in chapter six.

Chapter I: Literature Review

This literature review focuses on Canada's aging population, gay and lesbian seniors, long-term care living environments, and the barriers to inclusive long-term care. Relevant literature has been gathered from Canada, the United States, and Europe, in an effort to obtain direction to achieve the primary goal of this study: identifying the barriers to inclusive long-term care.

Canada's Aging Population

Canada's population is getting older. According to Statistics Canada, in 2004, 13% of the general population was over the age of 65. This number is steadily growing as the baby boomers – those born post World War II and were children in the 1950s – enter older adulthood. After World War II a sharp increase in birthrates in Canada was followed by a decline in fertility rates; this combination was the essential piece to spark an aging population and has resulted in a preponderance of older adults in Canada (Chappell, Gee, McDonald, & Stones, 2003). The increase in the number of seniors is also the result of longer life expectancies brought on by advancements in medical technologies and scientific research combined with greater attention to living healthier lifestyles (Hunter, 2005; Statistics Canada, 2006). In addition, post-war prosperity and government attention to social well-being through the implementation of social programs such as medicare, pensions, and welfare has greatly impacted the longevity of Canadians. It is projected that by 2051, 25% of the general population will be seniors (Statistics Canada, 2006).

The term “senior” has many definitions, but the most commonly used entry point is 65 years of age. This age initially was chosen not because of characteristics of people, but more for the purposes of the labour market; 65 is the marker for private and government pensions, retirement and a range of other policies and programs (Chappell et al., 2003). It is important to note that the issues faced by persons over the age of 65 are diverse. Typically, there are large differences between persons who are 65 years and those who are 90. To highlight some of these distinctions, the category of seniors is further divided: the young-old (65-74), the middle-old (75-84), the old-old (85-89) and the frail-old (age 90 and over) (Chappell et al., 2003). In this study, the term senior will be used to describe individuals of 65 years and older, with the recognition that within this grouping there is a diversity of older adults.

Gay and Lesbian Aging: Confronting Ageism and Heterosexism

As the needs and concerns of an aging population are identified, there is an increasing recognition of the heterogeneous nature of older adults, but the lack of attention given to the sexuality and the sexual orientations of seniors is still problematic (Daatland & Biggs, 2004). Most gay and lesbian seniors experience hardships resulting from a multiple minority status based on their age and their sexual orientation. Further, categories such as gender, race², ethnicity, class, ability, and religious affiliation can greatly impact segments of this diverse population. Many of these categories have been evaluated negatively, resulting in hardship and discrimination (Kimmel, Rose, Orel, & Greene, 2006). The intersection of these categories adds an important element to understanding the social, political, and economic context in which this population has

² There is much debate around race as a category. Race is used here to exemplify racial discrimination; the negative stereotypes and stigmas confronting people of colour.

faced discrimination and exclusion. For the purposes of this study, primary consideration is given to the effects of ageism and heterosexism on the gay and lesbian senior population, while being mindful of these cross-cutting issues and the impact of other forms of discrimination.

It is also important to note that while this study combines an examination of long-term care for both gays and lesbians, the lived experiences of women and men are quite different. Studies have shown that personal beliefs and attitudes towards gay men and lesbians differ and that gay men generally face higher degrees of discrimination compared to lesbians (Herek, 2002; Schope & Eliason, 2004). Public beliefs about gay men are often more negative than those towards women, and gay men are more likely to be perceived as deviants (Herek, 2002). In contrast, lesbians face different hardships than gay men. Despite significant feats in the women's liberation movement, lesbians are confronted not only with the many challenges associated with sexism—women continue to be exploited in the labour market and in the home—they also contend with the negative stereotypes and discrimination associated with heterosexism and homophobia.

Moreover, gender relations are particularly important when discussing older adults. Since women live longer than men, they comprise the majority of the senior population. Women make up 73 percent of the population of those living in long-term care environments (Statistics Canada, 2006). In effect, more women are exposed to the challenges of long-term care living and generally encounter ageism for a longer part of their lives. The reality for aging lesbians is even more contentious because older lesbians experience a multiple minority status: old, female, and lesbian.

Ageism is the “organization of discrimination, devaluing, and exclusion of individuals and segments of the population due to their age” (Hunter, 2005, p. 117). Ageist stereotypes often rely on assumptions that seniors are unproductive, incompetent, asexual, and senile (Berger, 1996; Calasanti & Slevin 2001). Many myths concerning aging and sexuality exist that perpetuate the devaluing of sex and sexuality among seniors. Some of the more popular stereotypes include: that as one ages the desire for sex is absent; older people are physically unable or too frail to engage in sexual activity; and older people that engage in sex are perverse because it is unnatural or undesirable (Calasanti & Slevin, 2001). While factors such as illness, changes in hormones, and ability can contribute to diminished levels of sexual activity, beliefs that all older people are asexual prevail in society and can result in feelings of embarrassment and shame for seniors who are interested in sex (Sherman, 1998).

These ageist assumptions are particularly problematic for lesbian and gay seniors because this population faces both ageism and heterosexism. Heterosexism can be understood as an, “ideological system that dismisses and stigmatizes any form of behaviour, identity, relationship, or community that does not comply with heterosexist norms” (Hunter & Hickerson, 2003, p. 39). While gay and lesbian seniors of all ages contend with discrimination, the current cohort of seniors has experienced a lifetime of obstacles and overt forms of discrimination in both the private and public sphere (Brotman, Ryan & Cormier, 2003).

For many years same-sex practices were illegal in Canada. Homosexuals³ were seen a threat to the nuclear family, gender roles, and even national security—many civil servants were demoted or lost their jobs because homosexuality was constructed as a “moral turpitude” which signified a security risk during the cold war era (Girard, 1987). It has been only 40 years since same-sex practices were removed from the criminal code in 1969 and it was not until 1973 that *homosexuality* was removed from the American Psychiatric Association as a mental disorder (Brotman et al., 2003; O’Neill, 2006; Peterkin & Risdon, 2003). Further, gay and lesbian people were not allowed to immigrate to Canada until legislative changes were made in 1977 (O’Neill, 2006; Girard, 1987). These examples represent a small number of the overt heterosexist policies that the current cohort of gay and lesbian seniors has endured.

The discrimination and negative stereotypes associated with gay and lesbian sexualities, resulted in the loss of family, friends and jobs for many gays and lesbians. While some research indicates that gay and lesbian seniors may display more resilience and better coping mechanisms as a result of learning to deal with the negative effects of heterosexism (Balsam & D’Augelli, 2006; De Vries, 2006), there is an invisibility of gay and lesbian seniors because many people in this age group deny or hide their sexuality to avoid discrimination, hostility, and exclusion (Brotman, et al., 2003; Fish, 2006; Hunter, 2005).

This invisibility is predicted to change with the advent of the aging baby-boomers (Edwards, 2001). While discrimination and negative stereotypes have affected all age groups within the gay and lesbian community, many aging baby-boomers have had

³ Many gays and lesbians prefer not to use the term homosexual because it has been used to pathologize and criminalize this community (Hunter, 2005). The term homosexuality is used here to reference these historical realities and the use of the term at that time.

different opportunities than their predecessors as a result of the gay liberation movement. Political organizing among allies and members of the gay and lesbian community in the 1960s and 1970s resulted in a marked progress for this population, but the current cohort of seniors did not necessarily experience the feats of these movements (Hunter, 2005).

The experiences of contemporary middle age gay and lesbian adults during the gay rights movement had a profound effect on the lives of this population. Many baby boomers have lived their lives out and continue to challenge the underlying heterosexist ideologies inherent in society. It appears that among this segment of the aging population there are those who will be unwilling to hide their identity and relationships. As a result, it is predicted that gay and lesbian issues will make the shift from invisible to visible in long-term care environments (Cahill, 2007; Edwards, 2001). In other words, it is likely that gay and lesbian baby boomers who have lived the majority of their lives out will continue to do so as they age and enter long-term care facilities.

Long-Term Care in Ontario: A Brief Overview

As the population ages the role of long-term care as a living arrangement will increasingly become a reality for many individuals, their families, friends, and partners. With a large segment of the population entering their senior years, more than ever, this is a pivotal time to provide inclusive long-term care environments for the gay and lesbian senior population.

But, what is long-term care and how does it differ from other living arrangements for elders? To understand long-term care more fully, it is necessary to examine the terminology used to describe long-term care housing. The following section provides a

brief overview of the definition of long-term care, funding, types of long-term care facilities, and the admission process.

Defining long-term care

The concept of long-term care can be confusing and difficult to define as it is regularly used to describe a variety of medical services available to people in need of ongoing and supportive health care (Hollander, 2002). For the purposes of this study, the definition of long-term care will be used in accordance with the Ontario Ministry of Health and Long-Term Care (MOHLTC):

Long-term care homes are designed for people who require the availability of 24-hour nursing care and supervision within a secure setting. In general, long-term care homes offer higher levels of personal care and support than those typically offered by either retirement homes or supportive housing. (MOHLTC, 2002)

Long-term care homes provide a supportive space for individuals who are at risk living independently and unable to manage their own care (Havens, 2002). In Ottawa, this represents 28 facilities, which amounts to approximately 4,700 beds in the city (Ottawa Community Care Access Centre [OCCAC], 2006).

Long-term care environments are available to people of all ages, but the residents consist primarily of seniors (Alexander, 2002). Many people residing in long-term care homes have few informal supports or they have daily living needs which exceed the capabilities and resources of family members and partners (Havens, 2002). Moreover, people entering long-term care today are not only older, but they also have heavier health care needs (Havens, 2002).

Funding

Ontario long-term care homes receive funding from the Ministry of Health and Long-term Care which is transferred to Local Integrated Health Networks who disseminate the funds to long-term care homes within their catchments areas. Provincial funds are specifically directed towards nursing services, personal care, and activities provided by the facility. Residents are responsible for accommodation fees which are regulated by the Ministry and are standard across the province.

The type of accommodation an individual receives determines the cost. Depending on the style and construction of a home, long-term care facilities provide a variety of living accommodations. These accommodations include wards or basic accommodations, which are rooms shared with one or two other residents; semi-private rooms, which share an adjoining washroom; and private rooms. In addition to accommodation costs, other services such as hairdressing, cable television or special outings are at the cost of the resident (OCCAC, 2006).

People who are eligible for long-term care, but are unable to afford the cost of basic accommodations, can apply for financial assistance. Applicants must provide their Notice of Assessment from the Canada Revenue Agency to provide proof of their inability to cover the expenses associated with long-term care accommodation (OCCAC, 2006). Many publicly funded long-term care facilities require a co-payment plan in which residents give a portion of the Old Age Security Pension to pay for their accommodations (MacLean & Klein, 2002).

Types of long-term care facilities

In Ontario, The Ministry of Health and Long-Term Care (2002) has divided long-term care homes into three categories depending on their organizational structures: nursing homes, charitable homes, and homes for the aged (also referred to as municipal homes).

Unlike primary health care services in Canada, long-term care facilities consist of a public and private mix (Alexander, 2002). Nursing homes are privately owned and operated facilities and are governed by private corporations. Conversely, charitable homes are non-profit long-term care facilities, often which are owned and operated by groups with religious or ethnic affiliations (MOHLTC, 2002). Municipal homes are also non-profit. These facilities are owned and operated by the cities in which they are located. In addition to receiving funds from the Ministry, municipal homes also receive funds through city taxation. Each type of long-term care facility is subject to the standards and regulations laid out in three pieces of provincial legislation: *Homes for the Aged and Rest Homes Act*, the *Nursing Home Act*, and the *Charitable Institutions Act* (MOHLTC, 2002; OCCAC, 2006).⁴

Admission process

People entering long-term care either have a limited informal support network, or their care needs are beyond the means and capabilities of partners, family members, and friends (Havens, 2002). The decision for partners and family members to encourage a

⁴ New legislation, the *Long-term Care Homes Act* (Bill 140), which integrates the three pieces of long-term care legislation received royal assent in June 2007, but will not take effect until proclaimed by the Lieutenant Governor in Council. A date has not been established at this time (Government of Ontario Table of Proclamations, March, 09).

loved one to enter long-term care can be difficult. Often feelings of guilt and grief can accompany the decision and long-term care represents the end of life for many. People entering long-term care may feel abandoned and scared in recognition of a loss of independence.

In Canada, all provinces use a single system entry point into long-term care (Pitters, 2002). In Ontario, forty-three Community Care Access Centres (CCAC, 2006) are situated around the province and they act as the primary access points to a variety of continuing care programs (Alexander, 2002). People seeking long-term care living arrangements are assigned a case manager with their local CCAC to assist them in navigating through the process. Following the assignment, individuals then undergo a number of assessments to determine their eligibility for long-term care living. This process requires consent, but if the prospective resident is not deemed capable, a substitute decision maker or a person designated as the power of attorney must give consent on the individual's behalf (CCAC, 2006). In addition, applicants are required to have a health report completed by their doctors. Following the assessments, the CCAC case manager determines the eligibility of an individual and if long-term care is deemed necessary, the applicant is placed on a waiting list for entrance into one of the facilities of their choice. Applicants may choose three facilities (CCAC, 2006).

Loneliness, Isolation and Long-term Care: The Importance of Relationships

It is important to note that the relationships among both people who identify as gay or lesbian and heterosexuals include more than sexual contact. Healthy relationships typically include support and trust, mutual respect, companionship, love, sex and caring. Studies have shown repeatedly that intimacy, human touch, and affection are important

aspects of well-being for people throughout their lives (Miles & Parker, 1999). Seniors are particularly susceptible to isolation and loneliness. Loneliness and isolation often accompany death of family and friends, the acquisition of an illness, and institutionalization (Miles & Parker, 1999; Agich, G., 2003). Whether a person identifies as lesbian, gay, or heterosexual, personal intimate relationships serve to foster the necessary elements that help defeat loneliness and isolation.

Concerns about isolation and loneliness are particularly significant for seniors without partners. The absence of additional informal supports, due to factors such as relationship strain with family members and no children, further compounds this problem. This raises the question of the availability of support systems for older gay men and lesbians in a society that still depends heavily on family to support its aging members (De Vries, 1999; Calhoun, 1999). While gay and lesbian seniors have been reported to be less likely to have children and family supports, it is important to note that some gay and lesbian seniors receive significant support from partners, relatives, friends and networks within the gay and lesbian community (Daatland & Biggs, 2004; Calasanti and Slevin, 2001).

For gay and lesbian seniors without informal supports, many will need to rely more heavily on the services of formal institutions for their emotional and psychological well-being. People need to build friendships and relationships and only inclusive long-term care facilities can foster an environment for the gay and lesbian population to do so.

Inclusive Long-Term Care

It is apparent that there is more acceptance of relationships, sex and intimacy among married couples in long-term care homes (Sherman, 1998). Lesbian and gay

seniors often hide their identity, in some cases referring to their partners as “friends”, in order to avoid mal-treatment, negative stereotypes, and heterosexist attitudes (Brotman et al., 2006). While knowledge and acceptance around gay and lesbian seniors’ issues are increasing, a great deal of progress is required to adequately accommodate the needs of this population.

The concept of inclusive long-term care environments for gay and lesbian seniors is central to this study. They have confronted the exclusion and discrimination associated with heterosexism and ageism in all facets of their lives (Hunter, 2005). Inclusive long-term care reevaluates heterosexist health care provision and living environments. It challenges dominant ideologies through the implementation of policies and health care delivery that rely on gay and lesbian affirmative principles and acceptance (Edwards, 2001; Hunter et al. 1998; Peterson, 1996). Inclusivity recognizes the needs of the gay and lesbian community and implements the means to address those needs. This includes, but it is not limited to, involvement of the gay and lesbian community in planning and policy development; the development of knowledge and awareness programs for long-term care workers; and addressing the individual assumptions and attitudes of health care employees regarding gay and lesbian seniors. Further, inclusive long-term care focuses on heterosexist language and environments and the implementation of affirmative policies such as mission statements which include the elimination of discrimination based on sexual orientation (Edwards, 2001; Hunter et al., 1998; Peterson, 1996).

The Current Movement Towards Inclusive Long-term Care

Initiatives to provide long-term care and related services for gay and lesbian seniors are slowly beginning to take place in North America and Europe. Primarily

housing services for gay and lesbians seniors are happening in the retirement sector. While, condominium and retirement communities exclusively designed for the GLBT population are underway in areas such as San Francisco and Montreal, only a small number of long-term care facilities are meeting the needs of the lesbian and gay community.

Toronto Long-Term Care Homes and Services, the governing body of 10 municipal homes in Toronto, has put forth the first initiative to provide inclusive long-term care in Canada. Capitalizing on community involvement through the 519 Church Street Community Centre and the Sherbourne Health Centre, the task force providing inclusive long-term care is tackling issues such as affirmative activity programming, positive lesbian and gay living spaces, and educational tools for practitioners in the realm of long-term care. Currently four homes have taken on this task and Toronto Long-Term Care Homes and Service hopes to expand its focus to the remaining homes. To assist in this task, the organization has developed a comprehensive tool kit as a template to help the remaining homes provide competent care to the LGBT population (Toronto Long-term Care Homes and Services, 2008).

Barriers to Inclusive Long-term Care

There is a paucity of research and literature concerning barriers to health and social services for gay and lesbian seniors. More specifically, little published information is available about barriers to inclusive long-term care living arrangements. Drawing on research by Betty Bergin (1988), who looked at access and barriers to social services for ethnic minorities, barriers to inclusive long-term care are defined in this study in three ways: a) barriers in relation to gay and lesbian seniors accessing inclusive long-term care

services, b) barriers to planning and implementation of affirmative policy, and c) barriers to the involvement of aging gays in the planning and policy development process.

This conceptual framework of barriers to inclusive long-term care provides a structure for developing a greater understanding of how barriers intersect and affect the lives of gays and lesbians as recipients of long-term care and as active members involved in the planning and policy development process. In addition, it provides policy makers and long-term care professionals with opportunities to identify barriers that inhibit the planning and implementation of policies necessary for affirmative health care and living environments.

The following discussion examines some of the barriers confronting gay and lesbian seniors in relation to health care delivery and long-term care identified in the literature. Because very few studies look specifically at long-term care, literature related to gay and lesbian health care provision and overall barriers confronting this population are looked at to inform the research.

Heterosexuality as an ideal and the dominance of heterosexual practices

Heterosexist ideology aligns heterosexuality with normalcy and assigns privileged positions to individuals and groups who identify as heterosexuals, while devaluing and stigmatizing any other form of sexual desire or behaviour (Fish, 2006; O'Neill, 2006). This ideology underlies the approach to health care provision and policy development in Canada (Peterkin & Risdon, 2003). Heterosexism exists at both cultural and individual levels and is manifested in overt and subtle forms of discrimination towards gays and lesbians (Hunter et al., 1998).

Although there has been a reduction of overt forms of discrimination with the removal of heterosexist laws and an increased recognition of gay and lesbian rights, discrimination is still prevalent; particularly in more subtle forms (Brotman et al., 2007; O'Neill, 2006). For example, a common presumption is that everyone is heterosexual unless identified otherwise (Fish, 2006). This is evident in long-term care admission procedures, which often fail to recognize other forms of family units beyond the nuclear family. Questions on intake questionnaires, admission interviews, and assessments often revolve around husbands and wives, children, and biological families. Commonly, the spectrum of sexualities and relationships are not taken into account. Moreover, long-term care environments frequently reinforce heterosexist values with pictures of solely heterosexual couples and families; activities that reinforce heterosexist norms, such clubs and dinners for husbands and wives ; and the language used in long-term care facilities is commonly representative of the dominant ideology (Edwards, 2001).

These manifestations of heterosexism in long-term care living environments act as barriers to inclusivity for gay and lesbian seniors resulting in identity suppression and the invisibility of this population. Heterosexist provision of care compounded with the ageist assumptions that depict seniors as asexual, result in the reluctance to disclose one's sexual orientation for fear of discrimination and hostility from health care workers and other residents (Fish, 2006). Fish (2006) documents instances in which health care workers have provided inadequate care or verbal, emotional, and physical abuse to residents who identify as lesbian or gay. These accounts substantiate the fears of gays and lesbians and reinforce the invisibility of this population in long-term care.

Invisibility

There appears to be an invisibility of lesbian and gay seniors. Because many of them have encountered hardship, hostility, and heterosexism, due to their sexuality they have learned to conceal their identities and relationships as a way to protect themselves (Brotman, et al., 2006; De Vries, 1999). This invisibility makes it particularly difficult to develop social policies concerning the gay and lesbian senior population (Fish, 2006). Moreover, this invisibility is perpetuated by heterosexism, which in turn results in the absence of knowledge and awareness of the unique issues pertaining to this population. In effect, the resulting invisibility could be understood as a mechanism for upholding dominant heterosexist ideology that prevents gay and lesbian affirmative policy development and service provision for seniors. Put more simply, the invisibility of gay and lesbian seniors in long-term care makes it is easier for policy makers and health care professionals to conclude that gay and lesbian seniors are not using long-term care services or that there are not many seniors who identify as gay or lesbian (Brotman et al., 2003).

Identity

According to Hunter (2005) sexual orientation “incorporates the virtues of two other definitions: (1) behavior and (2) self-identification” (p. 24). The former includes behaviour, desires, and fantasy in which desires and behaviour may be the same or different. Self-identification means that a person adopts an identity such as gay, lesbian or bisexual (Hunter, 2005). Sexual identity may or may not be congruent with sexual behaviour. For example, a woman may adopt a lesbian identity for political reasons, but

may not engage in sex with women (Bernstein, 2002; Hunter, 2005). It is important to recognize that sexual identities can be difficult to define and identities rarely fit neatly or concisely into predefined social categories. As a result, there is much debate around the discourse of identity.

Inherent in the concept of identity is a paradox; identity can bring community, self-definition, comfort, assuredness and resistance, but it also can include restrictions and control through naming (Weeks, 1991). It can be argued that through the affirmation of difference that the marginalization of individuals and groups is perpetuated. Further, identity, in terms of gay, lesbian, and heterosexual social categories, may be construed as essentialist and rejects the notion of fluidity within sexualities (Richardson, 2006).

Debates within the identity politics arena may create barriers to planning and policy development for gay and lesbian seniors. A study by the author found that some long-term care professionals believe that policy specifically geared towards gay and lesbian seniors directs attention to difference and, therefore, reinforces discrimination associated with sexual orientation; instead of focusing on difference, the goal of long-term care is to provide environments that incorporate the principles equality and fairness for all (Richards, 2007).

Conversely, critics argue that equality can be perceived as “sameness” (Fish, 2006). Although gay and lesbian seniors confront many of the same processes and issues associated with aging as anyone else—issues such as isolation, retirement, health complications, change of financial status, and ageism are all potential prospects associated with growing old—“sameness” fails to recognize the unique issues and needs confronting gay and lesbian seniors (Fish, 2006; Peterson, 1996).

The identity debate creates tension and confusion among members of the gay and lesbian community, allies, academics, and within the social service and social policy arena. This topic is further explored in the theoretical component of this study. Both critics and proponents of identity politics provide valuable considerations in relation to barriers associated with the provision of inclusive long-term care for gay and lesbian seniors.

Chapter II: Theoretical Considerations

In Canada, there are growing divisions between groups of people based on a multitude of characteristics, which are constructed into a wide range of identities (Rice & Prince, 1999). As a result, a number of tensions exist concerning the construction of identities and how the adoption of an identity can help or hinder the plights of marginalized populations. To understand how these debates affect the gay and lesbian senior community and the provision of inclusive long-term care, it is necessary to examine the role of identity politics as a mechanism for social change and the critiques of this approach.

Identity Politics

Arthur (2004) defines identity politics as “activism, politics, theorizing, and other similar activities based on the shared experiences of members of a specific social group.” (p.1). Social groups are categorized into a variety of identities based on characteristics such as gender, sexuality, ability, race, ethnicity, religion, and nationality (Arthur, 2004). The fundamental principle of identity politics is that groups of people should not have their cultural differences overlooked, but instead those differences should be recognized and celebrated (Arthur, 2004). Taylor (1994) notes that recognition is an essential component to understanding and defining ourselves and he asserts that the consequences of non-recognition are significant: “Nonrecognition or misrecognition can inflict harm, can be a form of oppression, imprisoning someone in a false, distorted mode of being.” (p. 25).

Identity politics emerged in Canada, Europe and the United States in the 1960s and the development of identities came to the fore with national and ethnic identity movements (e.g. the Black Power movement, the Quebec Separatist movement etc.). Identity movements crossed the public and private divide, particularly the women's movement and the gay movement, which brought historically private issues such as family and sexuality into the public sphere (Zaretsky, 1995).

Identity politics assumes that within minority groups there are boundaries and a "natural" element to the formation of identities. In order to engage in activism, minority groups must exist with fixed and stable identities (Bernstein, 2002; Arthur, 2004). For example, gay and lesbian identities are seen as fixed notions, which result from either natural or biological sources such as genetics or from socialization and environment entrenched in early childhood (Arthur, 2006; Epstein, 2007).

Identity: The Problematization of Social Categories

Ostensibly, identity politics is a viable approach to mobilizing marginalized groups to actively engage in social change, but the adoption of identity categories has been problematized in a variety of ways. For the purposes of this study two primary critiques are explored: a) social categories are not static and b) identity politics tends to displace issues of class⁵.

⁵ Arguably, identity politics may displace issues of other groups when beliefs and values of various identity groups come into conflict with one another. For example, 70% of Black voters and 53% of Latino voters in California voted yes to Proposition 8 which overruled the Supreme Court's decision to legalize gay marriage in the state of California (Vick & Surdin, 2008).

The restrictive nature of identity

The construction of gay and lesbian identities are particularly challenging because an identity does not necessarily match the assumed practices associated with the identity (Epstein, 2007; Hunter 2005). Individual desires, practices, and fantasies may all be the same or different. It is also possible that throughout a person's life trajectory identification with a particular sexuality or gender changes (Epstein, 2007). Further, some individuals may feel that it is not necessary to identify with a particular category (Weeks, 1991).

The understanding that gender and sexuality are fluid and do not fit neatly into socially constructed categories is a central component of queer theory (Eliason & Schope, 2007; Richardson, 2006). Queer theory aims to deconstruct gender and sexual categories in recognition of the fluidity and transient nature of identities, while offering a critique of heterosexuality as normative (Richardson, 2006; Hennessy, 2006). The primary focus of queer theorists (and many post-modern feminists) is around the discourse of gender and sexuality. Queer theory rejects the essentialist notion which assumes that sexuality is a "natural" state regardless of the social or historical context (Calhoun, 2002).

Although many feminists have argued that queer theory fails to recognize the importance of identity categories as mechanisms for mobilizing groups of people for political action, many queer theorists understand identity categories as restrictive. In effect these categories perpetuate marginalization (Richardson, 2006; Weeks, 1991). It is argued that identity categories are constructed by the dominant social order to maintain its own interests (e.g. through patriarchy, heterosexism etc.) (Kitzinger, 1989). Put more simply, identity categories are a means of subjugating groups of people through

discriminatory discourse and the construction of negative stereotypes and myths (i.e. labeling gays and lesbians as sexual deviants and sinners). Further oppressed through this process of subjugation, these groups of people are confined to the essentialist notion of their identity which perpetuates their social location by reinforcing and stabilizing the positions of those in power. Moreover, identity groups are often placed in opposition to other identity groups to compete for resources, funding, and recognition (Rice & Prince, 2000).

Gay and lesbian and feminist movements may engender the false illusion of fixed and united identities based on gender and sexuality (Richardson, 2006). People are comprised of multiple, and often competing, identities based on race, ability, sexual orientation, class position, and gender. The formation of one overriding identity may minimize the needs of competing identities and interests (Heaphy, 2007). Moreover, the issues confronting some members of the groups may be vastly different from other members. For example, much of the identity formation literature on sexuality exemplifies the experiences of the gay white male, thereby ignoring the experiences of gay men of colour, lesbians, lesbians of colour and so on. (Eliason & Schope, 2007).

Conversely, queer theory and post-modern thinking has been criticized for the removal of identity, which is viewed by many groups, including many feminist thinkers, as the primary grounds for political action. Queer theory is further impugned for its lack of recognition of class issues faced by marginalized groups, particularly in the current context of globalization which accentuates growing material disparity (McLaughlin, 2006).

Bringing Back Class

Giving priority to identities often fails to incorporate an analysis of material inequality (Heaphy, 2007). Michaels (2006) argues that the problem with social categories and the recognition of diversity is that it does not solve the problem of poverty. In fact, Michaels (2006) furthers his argument claiming that society's focus and energy on diversity masks the problem of economic inequality. The focus then becomes one of trying to change the individual behaviours of people who are, for example racist or homophobic, rather than recognizing the divisions in society based on access to material need (Michaels, 2006).

Fraser (2003) suggests recognizing social status rather than giving priority to specified groups. Her analysis rejects assigning priority to the needs of group specific identities in favour of attributing recognition to the status of individuals within groups as "full partners in social interaction" (Fraser, 2000, p. 113). This approach recognizes the interactions of "institutionalized patterns of cultural value" (i.e. heterosexism) and the economic structures which subordinate people (i.e. class), with the recognition and affirmation of difference. In contrast to identity politics, which is critiqued for its displacement of struggles for economic justice (Michaels, 2006), Fraser's (2000) status model is viewed as an alternative to identity politics, by addressing institutionalized subordination and economic redistribution without reifying identity groups.

Intersections: What Does This Mean for Gay and Lesbian Seniors?

Using these theoretical constructs as lenses through which to view the issues facing gay and lesbian seniors highlights their struggles in terms of the broader organization of society. It serves to locate their issues as part of the inequalities that

persist. Extending this lens to the realities of long-term care for gays and lesbians, offers an increased understanding of the challenges in long-term care homes for this population and the tensions related to inclusive policy development. For those who identify as lesbian and gay, access to long-term care that offers affirmative environments and quality health care which incorporates equal rights and abolishes discrimination on the basis of sexual orientation is fundamental to healthy aging and quality of life. Identity politics within the gay and lesbian movement recognizes the need for self determination among gays and lesbians to be actively involved in all facets of social life including decision making and policy development (Arthur, 2006). Community engagement in the form of a collaborative effort between allies in the long-term care community and members of the gay and lesbian community is necessary to ensure that long-term care meets these requirements and addresses the unique needs of gays and lesbians (Fish, 2006; Peterson, 1996).

While the premise of identity politics encourages gay and lesbian seniors to be heard as a cohesive group based on shared characteristics, there needs to be further recognition of the heterogeneous nature of this population. Although, people may be united on some fronts, others may put other identities and issues at the fore. Rice and Prince (1999) highlight this point:

In contemporary identity politics, struggles for citizenship may not mean gaining equal rights and participating in common culture, but rather attaining a bundle of equivalent individual rights and group rights. Citizenship, then, is about crafting connections and differences. (p. 255).

Further, caution should be exercised when analyzing the sexual identity of older adults.

Recognition of a gay or lesbian identity may fail to incorporate other issues, such the

economic status of the individual, and may construe the experiences of gay and lesbian seniors because the analysis is based solely on their sexuality (Heaphy, 2007).

Identity politics provides an arena for groups to come together and engage in social change (Richardson, 2006), but it is important to be mindful that identity does not have to take on an essentialist notion. Although, gay and lesbian populations may mobilize around their sexual identity, it is important to recognize that this could be one part of a larger identity or number of identities. In fact, others may choose not to identify with a group (Weeks, 1992). What is important to note here, is that whether or not people unite within a social category, a voice needs to materialize to engage in social change. Mobilizing around an identity provides a shared vision, support from others, and a means to bring about social change.

This study is not informed strictly by one of the above theoretical approaches. Instead, tenets from the various theoretical orientations are utilized to understand the heterogeneous nature of the gay and lesbian senior population, and the impact of what it means to identify or not identify as gay and lesbian to understand the barriers to inclusive long-term care. While gay, lesbian, and senior identities are regularly used throughout this study, there is recognition of how these identities can help or hinder the plights of gay and lesbian seniors. In addition, a fundamental principle of this study is to be mindful of the other social categories, including class, that intersect and interact with these identities. Finally, there is also an inherent recognition of the potentially fluid and transient nature of sexuality and gender. The social constructs of gay and lesbian and male and female, may carry different meaning for different individuals and may change and alter throughout a person's life trajectory.

Chapter III: Methodology

Design of the Research

This study employs a qualitative research design and uses two methods of data collection: three focus groups with members of the aging gay and lesbian community and written questionnaires distributed to professionals in the long-term care community.

Qualitative research is information-rich and provides depth regarding participant experiences, knowledge, and the social processes associated with the phenomena under study (Marlow, 2005; Dowsett, 2007). While qualitative research can be limited in that the size of the sample can restrict the generalizability of the findings to the larger population, it is nonetheless useful in providing valuable information that can be used as a baseline to be tested through further study. The findings from the focus groups and written questionnaires in this study provided important insights into the study's exploratory question: What are the barriers to inclusive long-term care?

The Focus Group

Actively including the community under study is essential to obtain a detailed understanding of the experiences, needs, and expertise of community members (Marlow, 2005). For the purpose of identifying the barriers to inclusive long-term care living arrangements for gay and lesbian seniors, it was essential to incorporate input and participation from members of this community.

Focus groups maximize community expertise and participation (Marlow, 2005). To obtain rich information, three focus groups were employed with members of the gay and lesbian aging population. With the assistance of networks at Centretown Community

Health Centre in Ottawa, Ontario, both purposive and snowball sampling techniques were employed to recruit participants (N=20) who identified as lesbian or gay and were older than 50 years. The Centretown Community Health Centre provided the venue for the focus groups and recruitment posters were sent out to GLBT networks via email (Appendix 1).

The Ottawa recruitment poster sparked a significant interest from networks in Peterborough, Ontario. Two interested individuals agreed to find a venue in Peterborough for an additional focus group and recruitment posters were distributed to GLBT networks in Peterborough (Appendix 2).

Two focus groups were held in Ottawa: a) a women's focus group, consisting of three women who identified as lesbian and one woman who identified as transsexual (n=4), and b) a focus group consisting of gay men (n=7). An additional focus group was held in Peterborough, Ontario. Participants in the Peterborough focus group included six women who identified as lesbian, one woman who identified as transgender, one man who identified as gay, and one woman who had a significant interest in the focus group as a family member of a gay man living in a long-term care facility (n=9).

The focus groups each lasted for approximately 1.5 to 2 hours and consisted of a series of semi-structured open-ended interview questions to obtain information regarding the barriers to inclusive long-term care (Appendix 5). The responses were audio-recorded and additional observational notes were recorded by the researcher.

Participants received a consent form prior the focus group (Appendix 3). The consent form provided a brief description of the research project and the contact information for the researcher, the research advisor, and the chair of the Carleton

University Research Ethics Committee. Participants were notified that anonymity was not possible in the focus group environment, but anonymity and confidentiality were upheld outside of the focus group by the researcher and the participants were informed of their responsibility to uphold confidentiality and anonymity, as well. To prevent any form of coercion, the voluntary nature of participation in this study was emphasized to the participants and they were informed that they could withdraw their participation at any time without consequences.

Limitations of the Focus Group

Although this study examines the barriers to inclusive long-term care for seniors, age 65 years or more, the invisibility of seniors accessing and residing in long-term care facilities who identify as lesbian or gay imposes difficulty in achieving a reasonable sample within the confines of this research project. The objective of the focus group was to gain information concerning the experiences and perceptions of members of the gay and lesbian middle aged and older adult community concerning the barriers to inclusive long-term care housing. As people age they consider their futures, which for some may include the reality of long-term care living for themselves, their family members or their friends. Using a sample of participants who identified as lesbian and gay and who were age 50 years or more, provided valuable information regarding the perceived barriers to inclusive long-term care living based on their future considerations or experiences with members of their social network.

Written Questionnaires

Written questionnaires were distributed to long-term care professionals (e.g. administrators, social workers, and executive directors). Although questionnaires are commonly used in quantitative studies, this method of data collection was chosen to reach a larger number of Ottawa professionals in the realm of long-term care with the aim of obtaining the descriptive data that is inherent in posing open-ended qualitative questions. Due to the time constraints of this study and the busy nature of long-term care employment duties, surveys were chosen as an alternative to lengthy interviews, and it was anticipated that a larger sample would be achieved through electronic questionnaires.

The written questionnaires consisted of a number of open-ended questions which were intended to obtain rich and detailed information regarding the barriers to inclusive long-term care living arrangements for the gay and lesbian senior population (Appendix 6). Using purposive sampling procedures, the questionnaires were distributed via email to long-term care professionals who met the sampling criteria.

The criteria for the sample population included professionals currently working in one of the city of Ottawa's 28 long-term care facilities in positions such as long-term care director/ administrator or social workers. Administrators and social workers were chosen for the questionnaires because they have direct involvement with residents and their social support networks. In addition, administrators are accountable to the board of directors surrounding issues such as the budget, employee training, hiring, and policy development.

The questionnaires were disseminated to the long-term care professionals via email. Each email contained a letter of information describing the intention of the

research project, the role of participants, the information regarding confidentiality, anonymity, and consent (Appendix 4). Email addresses were acquired through the online directories, networking with long-term care professionals, and telephone calls to long-term care facilities.

Limitations to the written survey

The primary limitation to the use of questionnaires in research is the potential for a low response rate. For example, some individuals do not like to answer questionnaires, others may feel that the questionnaire is too time consuming, and some participants may simply forget about the questionnaire, particularly when questionnaires are distributed through email (Brun, 2005). For the purpose of this study it was impossible to control some of the factors inhibiting the response rate, but in an effort to achieve a reasonable response rate follow-up calls were made to the long-term care professionals to encourage their participation. In addition the survey consisted of a minimal number of questions that required a short completion time in order to respect the respondents' busy schedules (Appendix 4). Further, the use of email surveys versus mail out surveys was an effort to reduce the amount of time that participants had to engage in this research project and to overcome the difficulties presented by hand written responses.

Despite the controls used by the researcher to mitigate the problems associated with low participation, response rate was a significant problem. Emails were sent to 28 long-term care facilities in Ottawa, but two responses were received. Follow-up phone calls produced three additional responses resulting in a total of five completed questionnaires (N=5). Reasons for the low response rate varied from the researcher's

inability to get a response from the long-term care professional, one professional was not permitted by her superior to complete the questionnaire, and time constraints were a significant issue for professionals. Many long-term care employees are very busy and were regrettably unable to participate in the research. Moreover, the low response rate raises questions about the impact of email distribution on the level of response.

An additional limitation in the use of surveys is the formulation of the questions. The interpretation of questions is a common problem associated with surveys (Brun, 2005). Questions that are convoluted and unclear will not only reduce the response rate, but participants are less likely to understand the question and they may respond differently than intended by the researcher. To mitigate this potential problem, the questionnaire consisted of five questions that were formulated in a clear and concise manner. Although the surveys were only distributed in English, clear and simplified language was used to assist individuals who do not speak English as their first language, and to reduce the confusion that is sometimes associated with the interpretation of survey questions. In addition, the researcher's contact information was supplied to the potential respondents to answer questions and provide clarification.

Organizing the Data

The primary sources of data were the audio-recordings and observational notes from the focus groups and the responses from the written questionnaires. The audio-recordings were transcribed by the researcher and the resulting data from both the focus groups and the surveys were organized into categories with the assistance of the qualitative research software, Nvivo. Nvivo is software program that helps access, manage, shape and analyze detailed textual information. Nvivo is designed for organizing

and tracking large portions of qualitative data and it offers tools for classifying, sorting, and arranging the data.

Analysis

A Grounded Theory approach was used to analyze the data from the focus groups and the questionnaires. Grounded Theory was developed by Glaser and Strauss (1967) to establish guidelines for analyzing qualitative data. This methodological approach is inductive and aims to develop theory directly from the data. Corbin and Strauss (1998) explain that “theory derived from data is more likely to resemble “reality” than theory derived from putting together a series of concepts based on experience or solely through speculation” (p. 12).

The recordings of the focus groups were transcribed by the researcher. Each focus group transcript and questionnaire was carefully analyzed. Words and phrases expressed by the participants were conceptualized and labeled accordingly. The purpose of conceptualizing is to identify words and phrases containing shared characteristics and meaning (Corbin & Strauss, 1998). Upon finishing the process of conceptualization, the researcher tallied the frequency of the labels, which were organized by participant, group, and total. The frequencies were carefully analyzed and then grouped together and abstracted to create nodes⁶ in Nvivo.

References in the transcripts and questionnaires were attached to the corresponding node. As this process continued, free nodes⁷ and tree nodes, which include

⁶ Node is an Nvivo term used to describe concepts and categories emerging from the data (QSR International, 2008).

⁷ A free node is a discrete category that fails to have a direct relationship with the other categories or cannot be organized in a hierarchical fashion (QSR International, 2008).

both parent and child nodes,⁸ were created and altered in Nvivo until the data were appropriately represented. Nvivo compiles frequency of mention (i.e. number of references) and the sources (i.e. focus group 1, 2 or 3) in which the data was extracted from.

For the purposes of this study, the primary categories resulting from the research are represented as both free nodes and the tree nodes that catalogued at the top of the hierarchy (parent nodes) in Nvivo. The term child node is frequently used to describe sub-categories.

⁸ A tree node is organized in a hierarchal format and includes both parent nodes and child nodes. Parent nodes are abstracted or general categories and child nodes are the relating sub-categories (QSR International, 2008).

Chapter IV: Results

The results are derived from carefully analyzed data emerging from the three focus groups: the Ottawa men's focus group (n=7); the Ottawa women's focus group (n=4); and the Peterborough focus group (n=9) and the written questionnaires completed by long-term care professionals (N=5). This chapter is divided into two primary sections: the focus group results and the results from the written questionnaires. The categories and sub-categories⁹ are displayed in this chapter and the number of sources¹⁰ and references are depicted for each category. Graphs are included for categories consisting of three or more child nodes to provide a clear outline of the results. Chapter five provides a discussion of the findings from the focus groups and the questionnaires presented in this section.

Results 1: The Focus Groups

The responses from the focus group participants (N=20) were organized into 12 categories emerging from the data. The categories were arranged into three sections and the numbers of references for each category were tallied in Nvivo:

- a) *Barriers*
 - 1. Heterosexism and Homophobia
 - 2. Cross-Cutting Issues
 - 3. Generational Differences
 - 4. Identity Politics
- b) *The Path Forward*
 - 5. The Ideal of Inclusive Long-term Care
 - 6. Partner Recognition
 - 7. Raising Awareness and Education
 - 8. Community Mobilization

⁹ In correspondence with Nvivo, the term child node is used to indicate a sub-category.

¹⁰ Sources indicate the origin of the data. The source represents a focus group or a questionnaire.

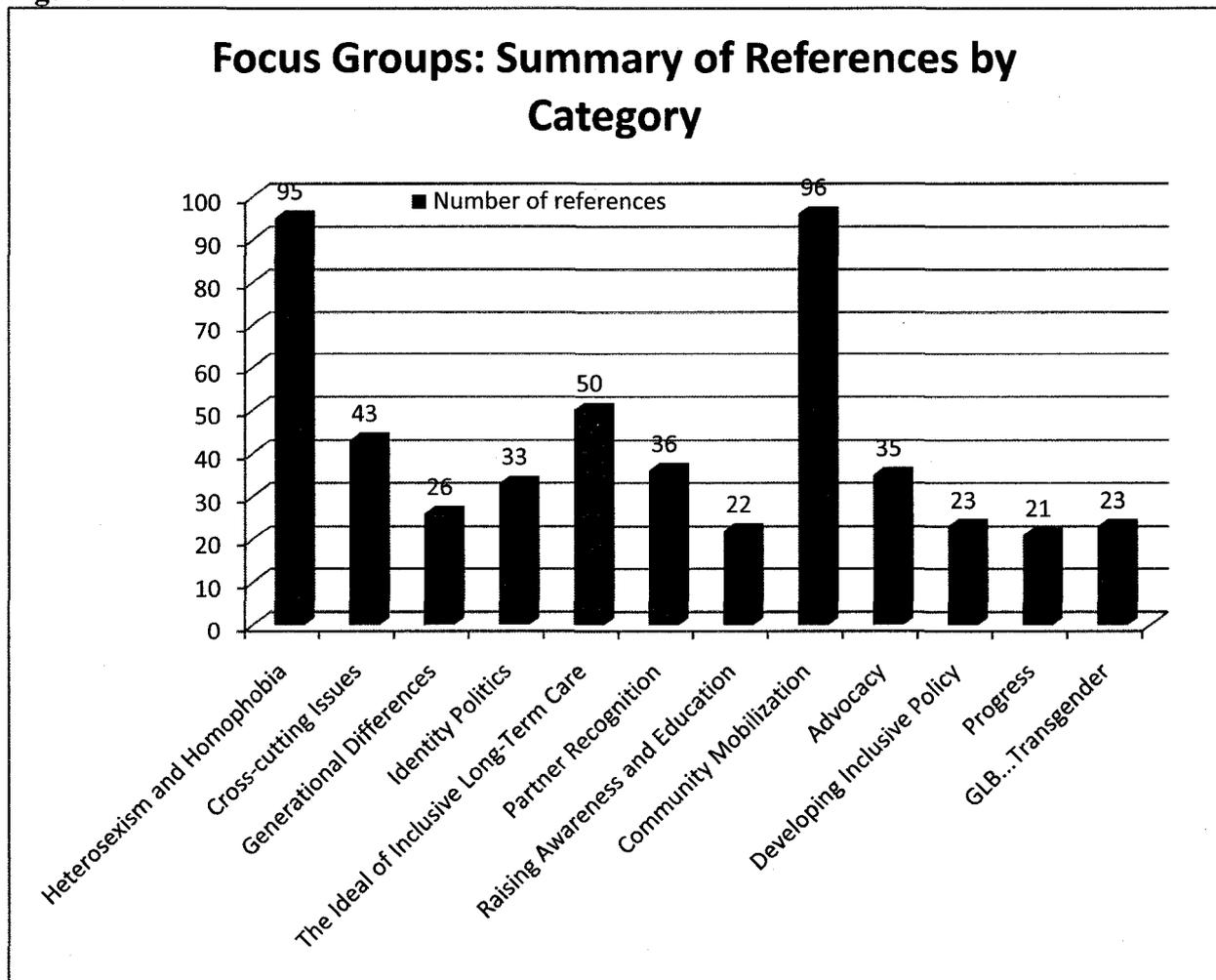
- 9. Advocacy
- 10. Developing Inclusive Policy

c) Additional Findings

- 11. Progress
- 12. GLB...Transgender

Figure 1 provides a summary of all the focus group categories derived from the data and highlights the number of references by category.

Figure 1.



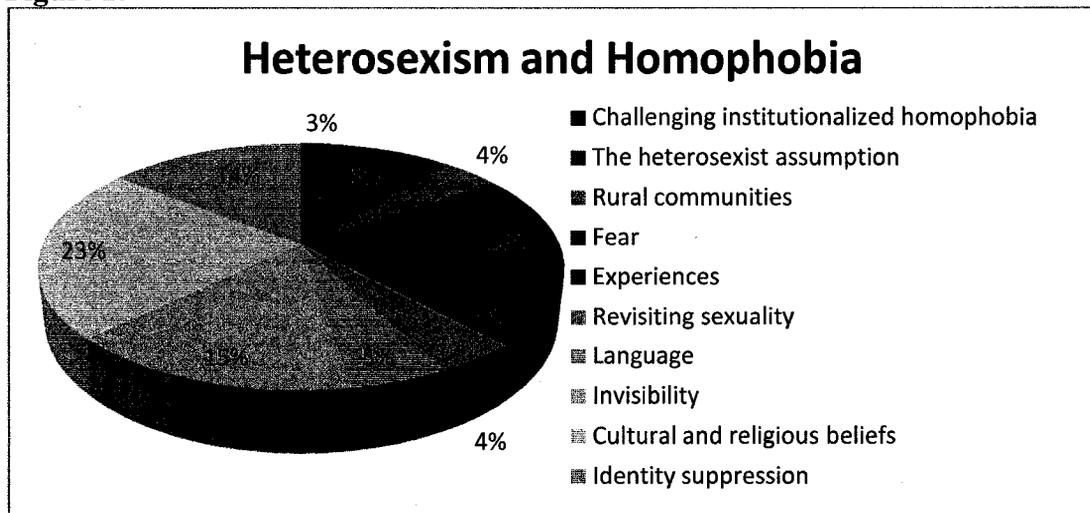
It is important to note that the sections on barriers and the path forward are not confined to these parameters. While it is evident that there are clear barriers and enablers

to inclusive long-term care, participants identified an overlap between the two and some of the categories presented in these two sections contain both barriers and solution-focused suggestions.

Barriers to Inclusive Long-term Care

Category 1: Heterosexism and Homophobia

Figure 2.

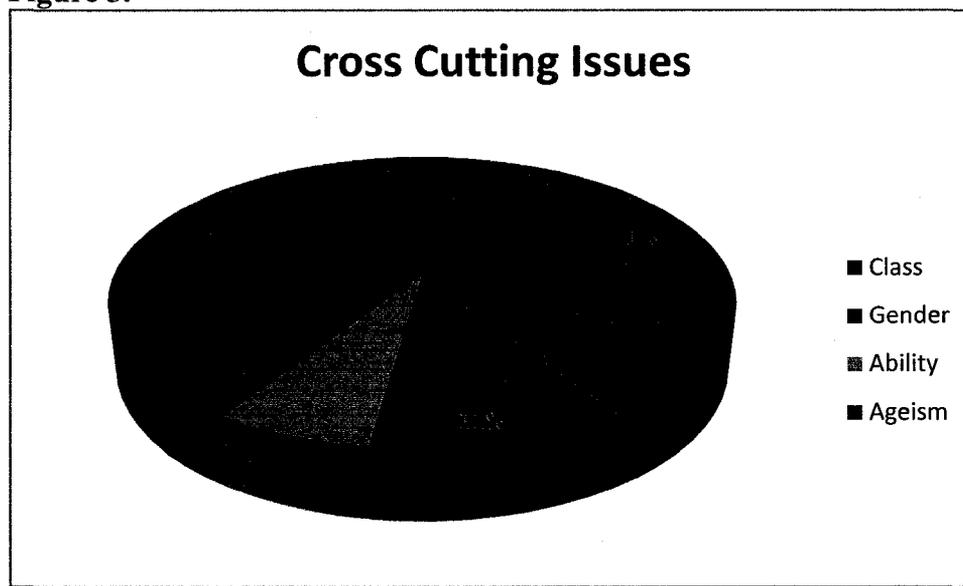


Both heterosexism and homophobia were seen as significant barriers to the development of inclusive long-term care (3 sources, 97 references). Ten child nodes were developed under the category “Heterosexism and Homophobia” to highlight the challenges resulting from heterosexist ideology and homophobia: the heterosexist assumption (3 sources, 8 references); rural communities (1 source, 4 references); revisiting sexuality (1 source, 4 references); language (2 sources, 5 references); invisibility (2 sources, 15 references); identity suppression (3 sources, 14 references); fear (3 sources, 17 references); experiences (2 sources, 5 references); cultural and religious

beliefs (3 sources, 22 references); and challenging institutionalized homophobia (3 sources, 3 references) (see Figure 2).

Category 2: Cross-Cutting Issues

Figure 3.



The participants noted that they are greatly impacted by the effects of homophobia and heterosexism, but they were also cognizant of the intersection of sexual orientation with other social categories. Using the term “cross-cutting issues” to describe the intersection of other categories (i.e. class, age, gender, etc.) the focus group participants described multiple stigmas as a barrier to inclusive long-term care (3 sources, 42 references). The category “Cross-Cutting Issues” was further divided into four child nodes: gender (3 sources, 5 references); class (3 sources, 18 references); ability (2 sources, 3 references); and ageism (3 sources, 18 references) (see Figure 3). The child node “ageism” was further broken down into 3 nodes: the asexual assumption (2 sources,

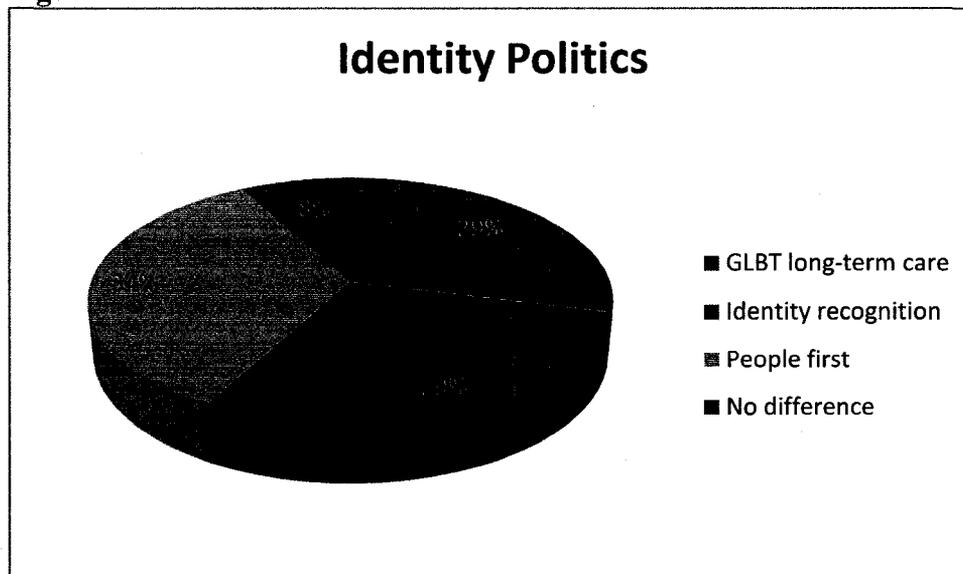
8 references); fear of aging (2 sources, 7 references); and ageism in the gay community (1 source, 3 references).

Category 3: Generational Differences

While some participants discussed the marked progression transcending from older generations to younger generations, there were a number of concerns raised about generational divides. Generational differences were discussed in all three focus groups (3 sources, 26 references).

Category 4: Identity Politics

Figure 4.



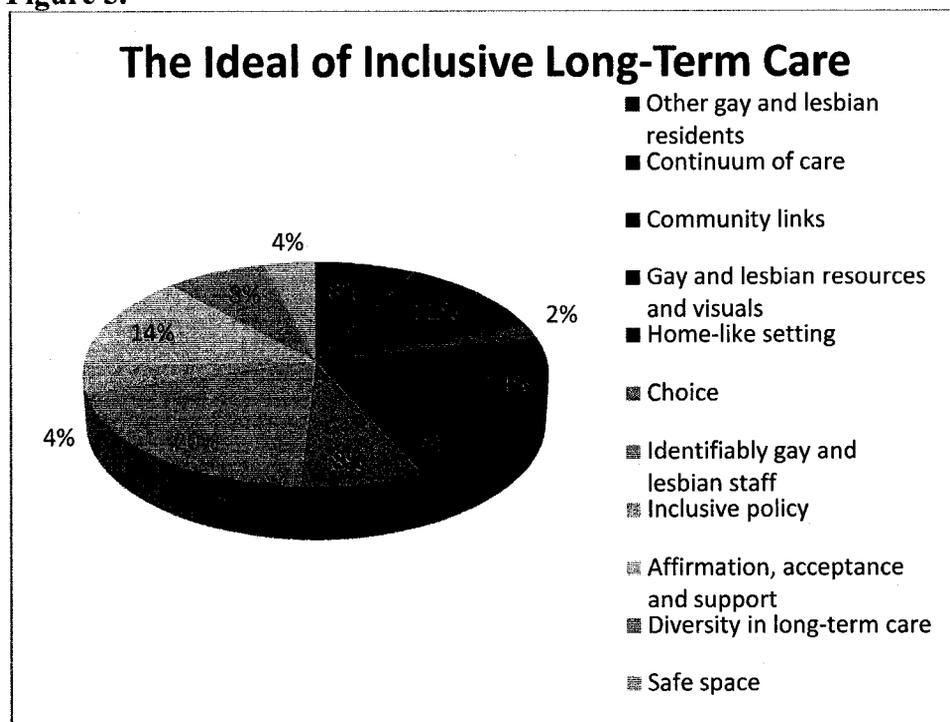
There are numerous debates around the politics of identity. Questions are commonly raised around the concept of identity in policy making, activism, and institutions such as long-term care facilities. Concerns about identity were raised frequently throughout the focus groups (3 sources, 33 references). More specifically, the

discussions centered on four themes which were developed into child nodes: people first (3 sources, 13 references); identity recognition (3 sources, 11 references); no difference (1 source, 3 references); and GLBT long-term care (3 sources, 11 references) (see Figure 4).

The Path Forward

Category 5: The Ideal of Inclusive Long-Term Care

Figure 5.

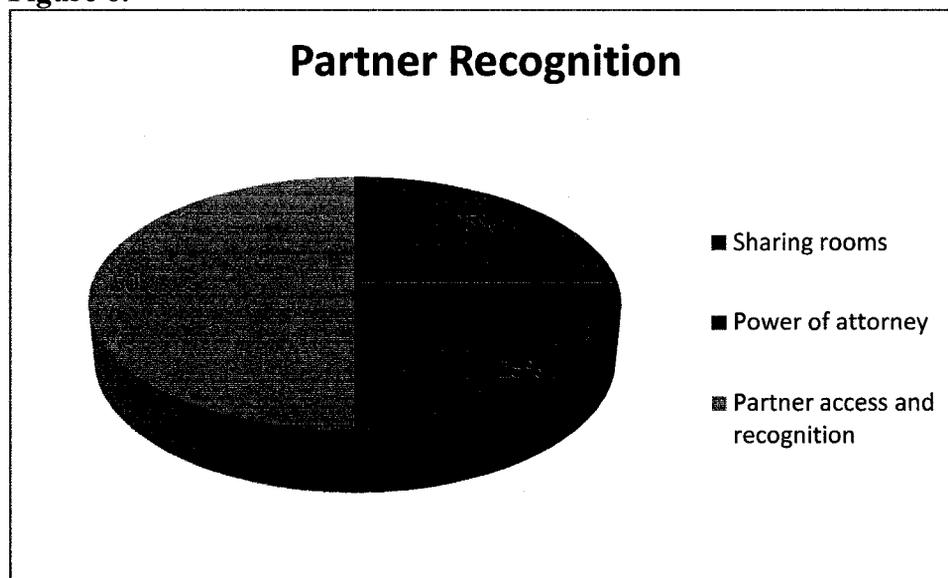


The focus group participants were asked to describe their ideals for inclusive long-term care (3 sources, 51 references). The question was intended to identify components that would comprise inclusive long-term care. Although this question sparked debates about exclusively GLBT long-term care living—which is addressed under the category “Identity Politics”—the responses were compiled into 11 child nodes: safe space (1 source, 2 references); other gay and lesbian residents (2 sources, 4

references); identifiably gay and lesbian staff (3 sources, 10 references); inclusive policy (1 source, 2 references); home-like setting (2 sources, 4 references); gay and lesbian resources and visuals (3 sources, 7 references); diversity in long-term care (3 sources, 4 references); continuum of care (3 sources, 6 references); and choice (3 sources, 4 references); affirmation, acceptance, and support (2 sources, 7 references) (see Figure 5).

Category 6: Partner Recognition

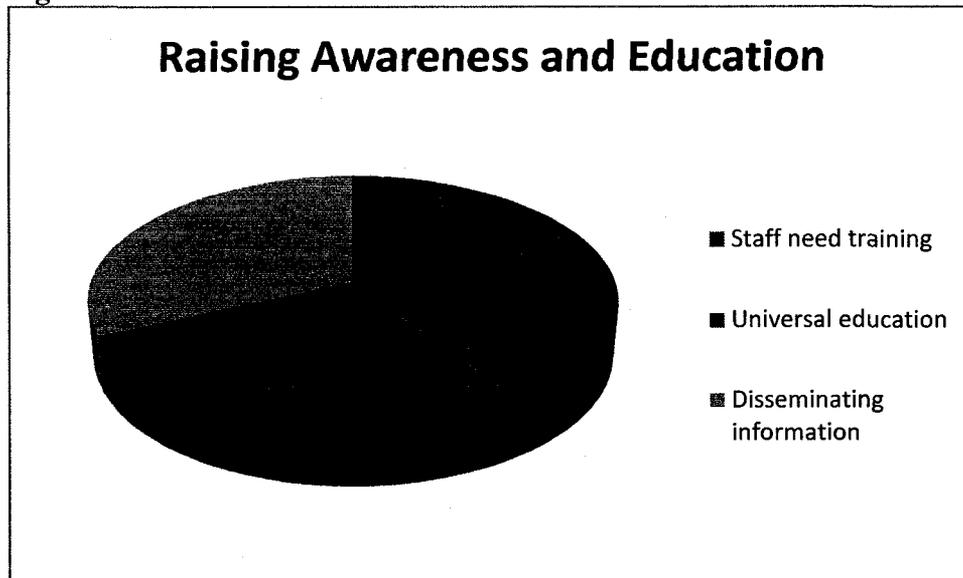
Figure 6.



Participants discussed the importance of partner recognition (3 sources, 36 references). The category “Partner Recognition” was further divided into three child nodes: sharing rooms (2 sources, 9 references); power of attorney (2 sources, 9 references); partner access and recognition (3 sources, 18 references) (see Figure 6).

Category 7: Raising Awareness and Education

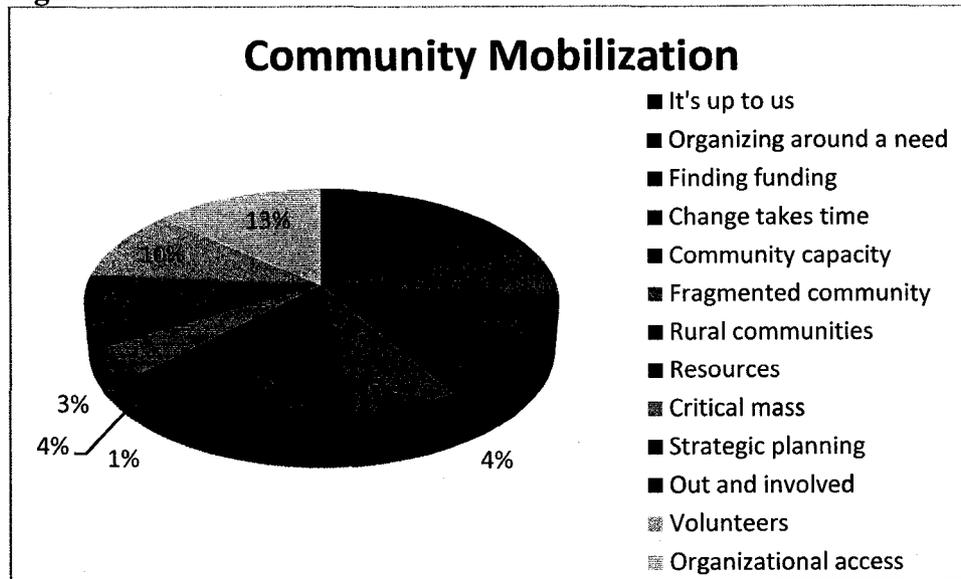
Figure 7.



Participants identified an urgent need to raise awareness and provide education about the need for affirming long-term care for gay and lesbian seniors (3 sources, 22 references). Three child nodes were developed to highlight this discussion: universal education (2 sources, 6 references); staff need training (3 sources, 9 references); and dissemination of information (1 source, 7 references) (Figure 7).

Category 8: Community Mobilization

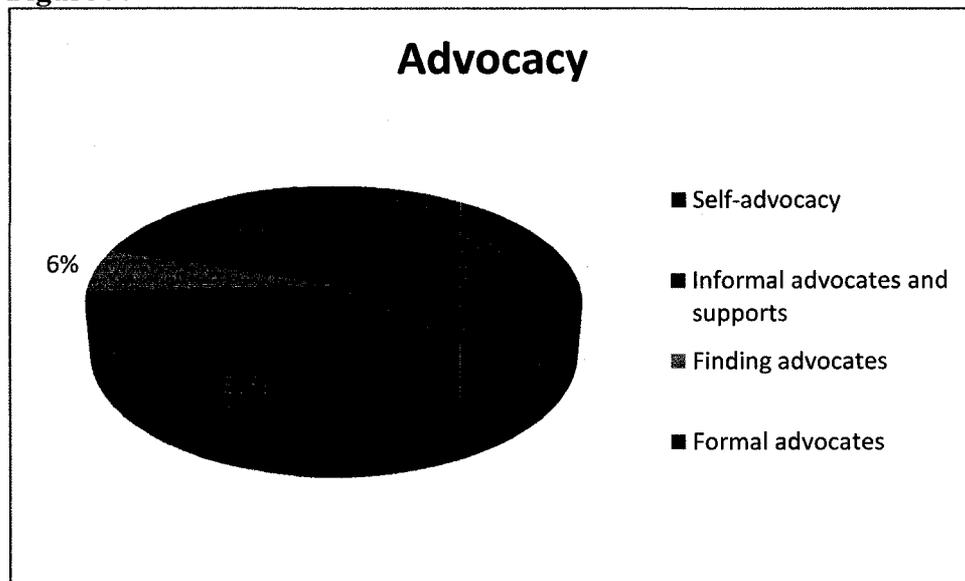
Figure 8.



Drawing from past experiences and knowledge as activists, community organizers, and members of a marginalized population, the focus group participants addressed challenges related to community mobilization and provided insightful ideas as to how to mobilize the community to develop inclusive long-term care. The category “Community Mobilization” received the most references (3 sources, 98 references). Child nodes were developed to emphasize the primary topics discussed by participants: volunteers (1 source, 10 references); strategic planning (2 sources, 3 references); rural communities (2 sources, 13 references); out and involved (2 sources, 7 references); organizing around a need (3 sources, 11 references); organizational access (2 sources, 13 references); it’s up to us (2 sources, 8 references); fragmented communities (2 sources, 6 references); finding funding (2 sources, 7 references); critical mass (2 sources, 4 references); community capacity (1 source, 4 references); resources (1 source, 1 reference); and change takes time (2 sources, 11 references) (see Figure 8).

Category 9: Advocacy

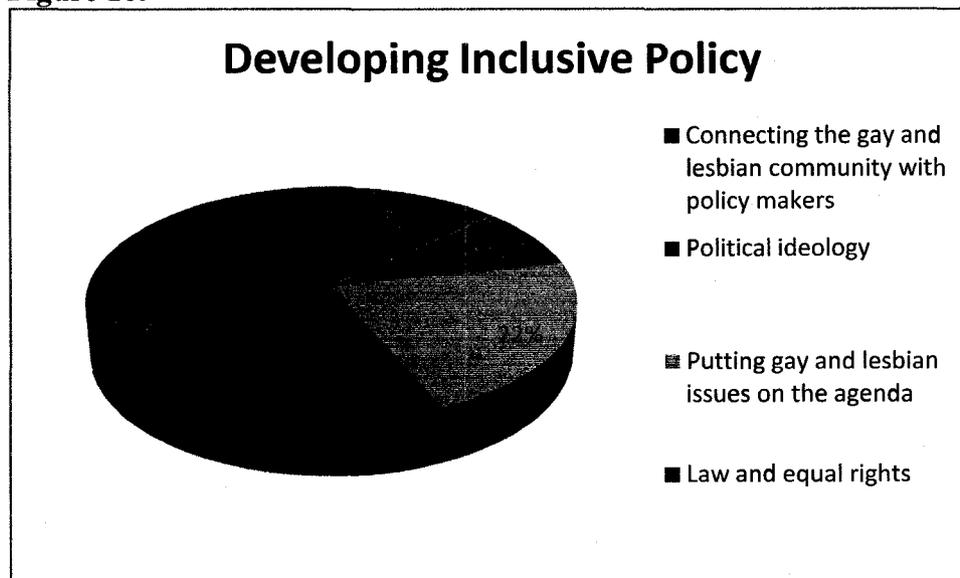
Figure 9.



The issue of advocacy was addressed in all three focus groups (3 sources, 35 references). Under the category “Advocacy” four child nodes were developed: self-advocacy (3 sources, 13 references); finding advocates (1 source, 2 references); formal advocacy (2 sources, 7 references); and informal advocates and supports (3 sources, 13 references) (see Figure 9).

Category 10: Developing Inclusive Policy

Figure 10.



Participants discussed the challenges and the facilitators to developing inclusive policy (3 sources, 22 references). The category “Developing Inclusive Policy” contains four child nodes: putting gay and lesbian issues on the agenda (2 sources, 5 references); law and equal rights (3 sources, 13 references); political ideology (2 sources, 2 references); and connecting the gay and lesbian community and policy makers (3 sources, 3 references) (see Figure 10).

Additional Findings

Category 11: Progress

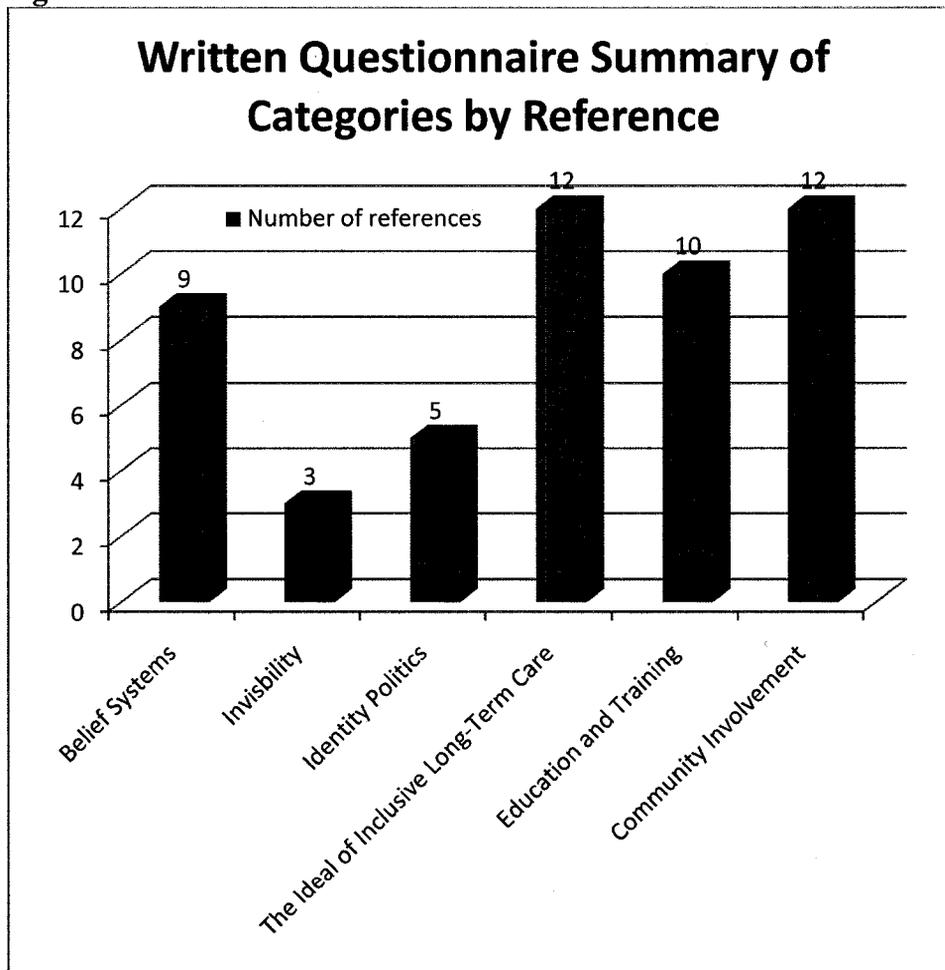
Throughout the focus group sessions participants described marked progression in the arena of gay and lesbian rights. The category “Progress” had references in all three focus groups (3 sources, 21 references).

Category 12: GLB...Transgender

The focus group in Peterborough included the active participation of a transgender woman and one participant identified as a transsexual woman in the focus group in Ottawa. Both of these participants and the other participants in the two groups identified a need for the recognition of transgendered individuals in long-term care settings (2 sources, 23 references).

Results 2: Questionnaires from Long-term Care Professionals

Figure 12.



Completed questionnaires were received from five long-term care professionals working in five separate long-term care homes in the Ottawa region. All of the

professionals were in administrator or director positions and the responses originated from two municipal homes, two non-profit homes, and one private facility. The five homes represent approximately 848 beds in the City of Ottawa.

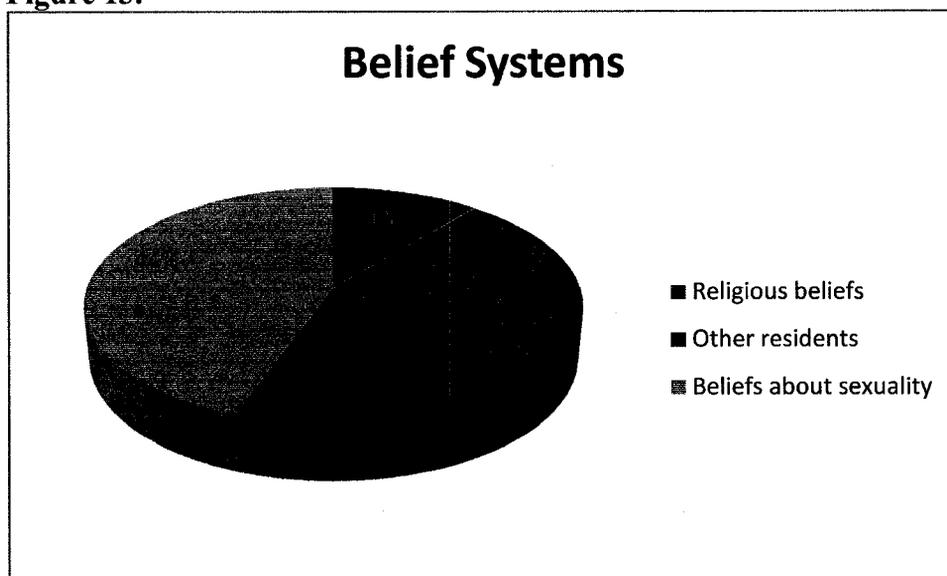
Participants thoughtfully answered five open-ended questions. Their responses were organized and analyzed in Nvivo resulting in six categories:

1. Belief Systems
2. Invisibility
3. Identity Politics
4. The Ideal of Inclusive Long-term Care
5. Education and Training
6. Community Involvement

Each category represents the barriers and enablers to inclusive long-term care. This section looks at the sources and frequency of mention for each category¹¹ (see Figure 12 for a summary of references by category).

Category 1: Belief Systems

Figure 13.



¹¹ The low response rate resulted in lower frequencies and affects the transferability of the data.

Respondents discussed the impact of various belief systems as a barrier to inclusive long-term care (4 sources, 9 references). Child nodes were developed to represent the beliefs impacting long-term care living environments for gay and lesbian seniors: beliefs about sexuality (2 sources, 4 references); other residents (3 sources, 4 references); religious beliefs (1 source, 1 reference) (see Figure 13).

Category 2: Invisibility

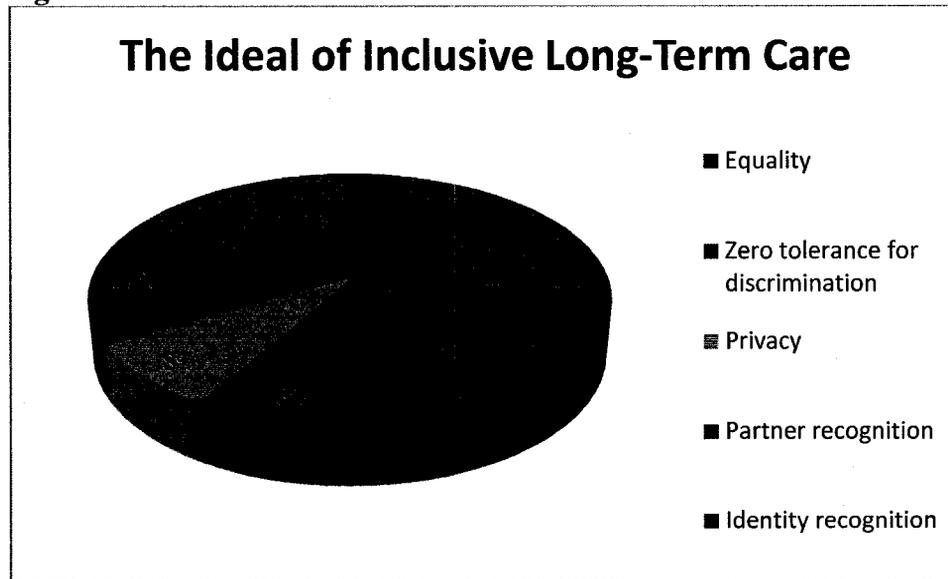
The invisibility of residents who identify as lesbian or gay and reside in long-term care living environments was described by 3 respondents as a barrier to inclusive long-term care (3 sources, 3 references). No child nodes were developed for this category because invisibility is a discrete category and while the issue of invisibility is a result of other factors such as negative beliefs about gays and lesbians, it does not exist in a hierarchy.

Category 3: Identity Politics

The category “Identity Politics” was created to address the respondents’ discussions about exclusively GLBT long-term care and the challenges associated with recognizing different identities (3 sources, 5 references). Two child nodes were developed to represent the discussions: GLBT long-term care (2 sources, 2 references) and attention to difference (1 source, 3 references).

Category 4: The Ideal of Inclusive Long-Term Care

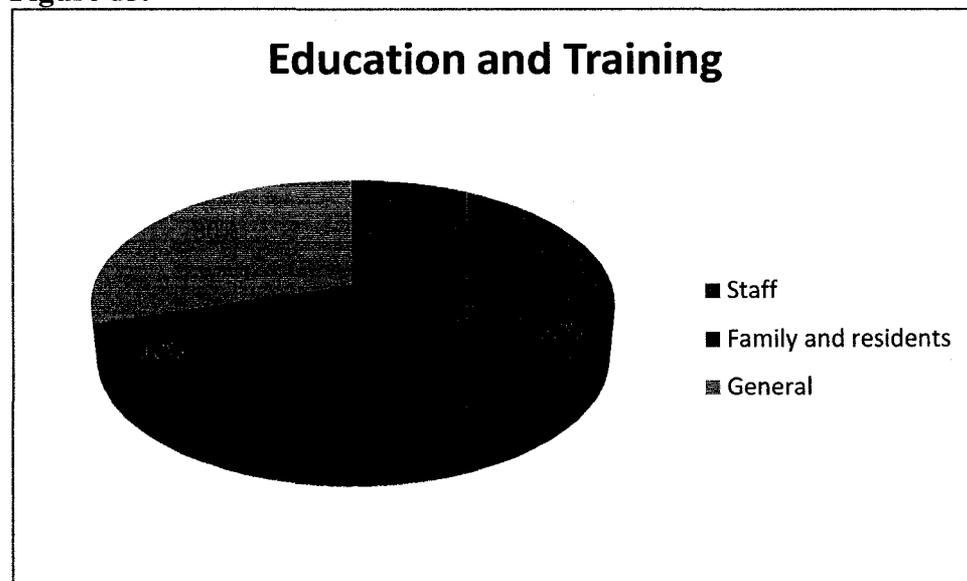
Figure 14.



Questionnaire respondents described their vision of inclusive long-term care (4 sources, 12 references). The following child nodes were developed to depict their responses: equality (3 sources, 6 references); identity recognition (1 source, 2 references); partner recognition (2 sources, 2 references); zero tolerance for discrimination (1 source, 1 reference) (see Figure 14).

Category 5: Education and Training

Figure 15.



All of the long-term care professionals identified a need for education or training about gay and lesbian issues in some capacity (5 sources, 10 references). Their responses were organized into three child nodes: staff (4 sources, 6 references); family and residents (1 source, 1 reference); and general (2 sources, 2 responses) (see Figure 15).

Category 6: Community Involvement

Community involvement was discussed as a primary method of breaking down some of the barriers to inclusive long-term care (4 sources, 12 references). Two child nodes were developed: community groups and partners (4 sources, 7 references); and advocacy (3 sources, 5 references).

Chapter V: Findings and Discussion

The three focus group discussions and the questionnaires completed by long-term care professionals resulted in responses that provided rich insight into the identification of the barriers to inclusive long-term care for gay and lesbian seniors. Naturally, the discussions about barriers developed solution-focused results highlighting a path towards inclusivity.

This chapter describes the results displayed in chapter four and expands on the findings to include supplementary quotes from the participants and a discussion of the themes emerging from the data. The chapter is organized into two sections: a) Discussing Emergent Themes from the Focus Groups and, b) Discussing and Comparing the Long-term Care Questionnaires.

Discussing Emergent Themes from the Focus Groups

Twelve themes emerged from the three focus groups held in Ottawa and Peterborough. The themes are organized into three sections: Barriers to Inclusive Long-term Care, The Path Forward, and Additional Findings. It is worth noting that many of the themes overlap as do the discussions on barriers and enablers. In addition, comparisons between the focus groups are interspersed throughout this section.

Barriers to Inclusive Long-term Care

This study focuses on barriers in an effort to highlight the obstacles facing older gays and lesbians entering care homes. As identified in chapter four, focus group responses about barriers were organized into four categories to bring forth an

understanding of the barriers to inclusive long-term care as described by the focus group participants: heterosexism and homophobia; cross-cutting issues; generational differences; and identity politics. These barriers are discussed here as both separate entities with distinct features and as concepts that interact both with each other and external forces to create barriers to inclusivity.

The Persistence of Heterosexism and Homophobia

Historically, gays and lesbians have confronted barriers perpetuated by heterosexist ideologies and homophobia. Members of this group have lost support networks, been excluded from groups and communities, experienced employment loss, and confronted challenges within health care, social services, and educational systems (Brotman et. al, 2006; de Vries, 2006; Kinsman, 1996). Despite marked progress, this community still confronts challenges resulting from heterosexism and homophobia.

Heterosexism is understood as the privileging of heterosexuals in society. Practices that are perceived to be outside of the confines of male/female relationships are discriminated against and stigmatized through discourse, policy, and a variety of cultural practices (Hunter & Hickerson, 2003; Herek, 1995). Homophobia¹² refers to the fear and hatred of gays and lesbians at the individual level, which can lead to discrimination and acts of hostility towards this group (Brotman, et al., 2007; Herek, 2004).

¹² The term homophobia is not used in some literature because it fails to recognize the broader social context as a means to privilege heterosexuals and marginalize gay, lesbian, and bisexual persons (Herek, 1995). Further, the term homophobia means fear of the “same” and is linguistically problematic in its application. Also, the notion that homophobia is in fact fear based is arguable. Other emotional responses, such as anger are likely to precipitate hostility towards gays and lesbians (Herek, 2004). Homophobia is used in this study to represent participant responses, which often included the word homophobia, and to signify discrimination at an individual level with an understanding that heterosexist ideology informs individual subjectivities which perpetuate discriminatory practices and policies.

Heterosexism and homophobia elicited the second highest number of references from the focus group participants (n=97) evidencing the challenges resulting from an ideology construct that privileges heterosexuals and discriminating practices that are harmful to this community. Heterosexism and homophobia generate a multitude of hardships for all people who identify as gay, lesbian, bi-sexual and transgender, and for aging gays and lesbians transitioning into long-term care, the privileging of heterosexuals results in numerous challenges.

There are significant concerns that in long-term care heterosexism and homophobia negatively impact the quality of care received by gay and lesbian residents. While there is an overall concern about the level of care in the Ontario long-term care system due to the bed crisis, budget woes, and poor staffing, focus group participants expressed fear that disclosure of their sexuality may put them on the bottom of an already struggling system.

There is not enough care by hour provided to residents. There is subtle rationing that can occur if you're not one of the people they prefer to deal with... In Ontario the statistics are damning—[many] residents in long-term care do not get visitors and those are the people who can be easily targeted if they make too many demands or if they express a desire to do something that is not consistent with the philosophy of the home and it is very subtle.

Homophobic attitudes of staff, other residents, and visiting friends and family produce an environment of hostility, uncertainty, and contribute to the invisibility of gay and lesbian residents residing in long-term care homes. Fear of maltreatment, social exclusion, and concerns about safety, whether substantiated by experiences in the home or resulting from previous confrontations with homophobic attitudes or heterosexist policies, leads to fear of disclosure. In addition, these concerns further perpetuate the

vulnerability of a population already primarily reliant on the care of others. From application to admission, lack of inclusive language on intake forms and during initial assessments assumes heterosexuality and leaves little room for identity expression.

To me a huge barrier is systemic and it has to do about lack of inclusive language and the way it's conceptualized. If you come in and start asking someone for their chart: "So where is your wife? How do we get a hold of your wife?" And there is that assumption immediately—the heterosexist assumption. And here is someone in a crisis or an extremely vulnerable situation who is having to educate their caregiver. That simply shouldn't happen. There should be inclusive language right from the get go on the intake forms. Clearly there is an anticipation that the person is heterosexual, until proven otherwise and you're the one who has to begin the conversation when you're in an extremely vulnerable situation or when sometimes you find that this is a particularly private part; particularly for previous generations. This is a private part of your life that you don't necessarily want to get out there.

In addition to the lack of inclusive language, the failure to include gay positive visuals and symbols such as rainbows or pictures representing the diversity of family and partnership, fosters uncertainty and fear.

The inclusive language...Change all your frickin' forms. They can say spouse, partner, whatever and those kinds of things. Some of those simple little things again like that little [rainbow] sign in the corner gives us a signal.

Fear of heterosexist policies and homophobic attitudes is an increased issue in rural communities. This discussion was particularly prevalent among the Peterborough focus group participants. Peterborough is a smaller city, located an hour north-east of Canada's largest centre, Toronto. The county and city of Peterborough has a population of approximately 135,000 (City of Peterborough, 2007). Large urban centres, such as Ottawa and Toronto, contain the critical mass of people willing to mobilize and put the issues on the agenda. The needs of aging gays and lesbians are gaining recognition, but there is significant concern that increased levels of heterosexism and homophobia in rural communities are contributing to higher numbers of isolated gay and lesbian seniors.

Well, in rural Ontario we don't exist in many ways. We live in essence in a retirement community and that's already a real stretch for people. So to think beyond that, trying to be accepted and out at all without being closeted is a huge barrier in the really rural areas... you're almost non-existent.

This also raises the question: are gay and lesbians seniors residing in rural areas, less visible? Fear coupled with a higher likelihood of limited informal supports, may significantly impact a person's willingness to seek out services or disclose their sexual identity.

Further, issues such as cultural and religious beliefs about gays and lesbians raises concerns about discrimination in long-term care. Some cultural and religious sects construct homosexuality as sinful, perverse and/or abnormal. Concerns that personal religious or cultural beliefs and norms could negatively impact the care and treatment received in long-term care were widely expressed by participants.

Oh yeah, I sure wouldn't want to go there. The rooms are very nice but it is the belief systems of the caregivers, the other people in the home, and the volunteers.

A lot of gay people have to go back in when they go into the home. They have to go back into the closet. You can't say you're gay.

Consequently, prejudicial cultural and religious beliefs compounded with heterosexist assumptions and discriminatory practices perpetuate fear in the gay and lesbian community and results in identity suppression in long-term care homes.

Cross Cutting Issues: The Complexities of the Intersection of Age, Class, Gender, and Ability

Heterosexism and homophobia are further compounded by other forms of discrimination based on categories such as age, gender, race, ethnicity, class, and ability. Focus group participants described age, class, disability, and gender in conjunction with heterosexism and homophobia as barriers to inclusive long-term care living.

Seniors are regularly confronted with negative stereotypes and assumptions associated with ageism. The assumption that seniors stop engaging in forms of sexual expression is a primary issue. While illness and level of ability can impact the frequency of sexual activity, the level of desire and the form of sex that a person engages in, the asexual assumption can deprive people of a basic human act. The assumption that seniors do not engage in sex was perceived as a barrier by focus group participants.¹³

I mean one of the problems with the homes that I've seen—and this works for straights and gays—is that they are utterly asexual, anti-intimacy.

While seniors continue to be perceived as asexual, many long-term care homes are recognizing the invalidity of this assumption and are instituting policies about privacy and sexuality to ensure that residents feel comfortable expressing themselves sexually (Sherman, 1998). This is a step in right direction for all seniors and particularly those who identify as gay or lesbian because when sex among older adults receives limited recognition the presupposition is that gay and lesbian senior sex will receive even less acceptance.

An additional issue raised by focus group participants is the fear of aging. Aging often has negative associations. Older people are described as incompetent, senile, and unattractive (Berger, 1996; Calsanti & Slevin, 2001). These negative assumptions instill fear into younger generations about getting old and the fear of aging is exacerbated by the possibility of living (dying) in long-term care. The fear of aging engenders a denial of getting old creating a divide between younger and older generations and veiling the issues associated with aging resulting in the displacement of seniors.

¹³ It is important to note that two participants significantly questioned the expression of senior sexuality happening in long-term care. This discussion developed into a debate among participants.

Of course, of course, but people don't want to face that it is coming at them. They're like, "Ewww, it's creepy man." Personally though, I would rather stay in the community for as long as possible, no interest in being assessed before I am ready, but we do have to face reality that there will come a time when we can't take care of ourselves. It's creepy but true....

Participants in the men's focus group described the denial of aging and ageism in the gay community as significant challenges. Ageism in the gay community can impact the willingness and motivation of gay men to act as advocates for aging gays, potentially leading to increased levels of isolation of older gay men.

To me the biggest barrier in the gay male community is a profoundly developed sense of denial. You get two responses when you talk about aging in an institution: one is, "I will kill myself first." Which is very common and the other one is, "It is never going to happen to me."

Issues of class further aggravate the challenges faced by gay and lesbian seniors. Accommodation fees for long-term care homes are regulated by the Ontario Ministry of Health and Long-term Care and placement into a preferred home is dependant on bed availability. These regulations ostensibly provide equal access for all citizens regardless of class, but financial stability provides people with greater flexibility when accessing long-term care.

For example, private rooms are more costly than shared rooms or wards. People applying for government subsidies to pay for long-term care living or those who do not have the financial means to afford more than the basic accommodation are required to reside in a room with other residents. Further, the waiting times to access private rooms are often shorter than those for basic accommodations and it is far easier to access preferred long-term care homes because of the increased availability of private rooms due to cost. While all people with limited financial means have reduced access to long-term

care, gay and lesbian seniors who do not have the financial means to access costlier long-term care may face more challenges due to less privacy, and a more limited choice selection (i.e. choosing homes that have a reputation of inclusivity).

If you have a low income, you really don't have a choice on where you can go...
If you have an average income, you have a better chance of going to your choice of place – rather than what is chosen for you.

An additional class issue raised by participants is the perceived affluence the gay community. Gay men often have been stereotyped as wealthy (Barrett & Pollack, 2005). While there are wealthy gays, there are many gay men who are poor. Many older gay men continue working to support themselves and the gay male constructed as wealthy fails to acknowledge the lived experiences of gay men in financial disparity. Further, lesbians face even graver financial outcomes—women in general receive lower incomes than men.

Stats show that gay men, we have this marketing niche, *gay man*, that has been a contrived... image of us. But I think what the studies show is that gay men actually get paid less than others with similar educational experience and lesbians, of course, are way down.

While gender differences are evident in the division of income levels between men and women (Rice & Prince, 1999) and, therefore, gays and lesbians, participants in all three groups discussed other gender related barriers to inclusive long-term care. One participant reflected on her experiences with her partner in the hospital and identified gender as a bigger barrier to health care communication than her sexual identity:

The one issue we had was with a doctor and it wasn't a gay issue. It was a uhh male/female issue. It was like "We can't tell them nothing. We've got to talk to the man." You know, he had to talk to her sons instead of talking to me because I'm just a partner. But it definitely was a male/female thing, not a gay issue...

Also, the differences between gay men and lesbians were discussed in terms of acceptance. Participants noted higher levels of acceptance of lesbians than gay men.

The thing that I probably thought about was that in the GLBT community, L and B are probably easier to fit in than the G and definitely the T. You know. It's just like, "Oh they're friends" and people just don't even go there in their head...

Commonly, women are seen as more caring and emotional than men. As a result, the notion of two women being intimate is not necessarily a far stretch from those caring characteristics; whereas, men face greater challenges with acceptance particularly from heterosexual men (Herek, 1995; Schope & Eliason, 2004). Gay men may be perceived as a threat to the masculine identity and women whose gender displays are outside established gender norms receive less acceptance. Both are seen as threats to the traditional gender binary (Schope & Eliason, 2004). Using a feminist lens, this threat is particularly problematic because it not only threatens the privileging of heterosexuals, but it also challenges patriarchal structures and societal dominance by men.

The intersection of ability received little attention from focus group participants.

One participant noted that her age coupled with a disability challenged the social construction of what a lesbian looks like:

I worked for the school board for years and you know I've got rainbows all over my vehicle. Because I'm handicapped I have a handicapped permit I got to park at the front door [at] every school that I worked in. And as a counselor, not a teacher, I went to a lot of schools. You know, kids would say, "Is that your van out there?" And I would say, "Yup." You know, you would see them kind of compute: old lady, cane, rainbow. You know, they test it out and stuff and it was great...because I didn't fit the stereotype or anything and I was able to break some barriers down.

As with age, the assumption of asexuality is strongly linked with disability (Shakespeare, 2003). Although the type of sexual practices may vary dependant on the

level of disability, the assumption that people with disabilities do not engage in sexual interactions is a fallacy. This creates further problems for gays and lesbians with disabilities, particularly aging gays and lesbians because the likelihood of disability increases with age. The discourse about gay and lesbian identities is commonly centred on sexual desires and the engagement of sex between persons of the same sex. While for many gays and lesbians sex is an important component of their identity formation, it is not necessarily the sole focus. Relationships, partnership, support, and political ideologies are just some of the additional factors influencing the development of the gay and lesbian identity (Hunter, 2005). The failure to acknowledge other components of gay and lesbian identities is particularly problematic for people with disabilities. Consequently, this leads to increased invisibility of gays and lesbians with disabilities.

Surprisingly, race and ethnicity were not discussed by participants. The failure to address people of colour who identify as lesbian and gay may be representative of the demographics of the focus groups. This is a limitation to the study because the lived experiences of people of colour are not represented in the sample. The exclusion of race and ethnicity in the data coupled with a very small amount of research on the aging gays and lesbians and ethnicity and race, emphasizes much needed research in this area.

Generational Differences: Fighting the Views of the Past

I think if you talk to young people in their 20s and 30s, especially if they have been to college and university, they're like "ho hum" or "what's the big deal?" Unless they have been brainwashed to think that it's a problem... I mean it's more our peers and slightly younger that have the issue because [of what] they were taught.

Generational differences were discussed as a barrier to inclusive long-term care. One participant identified three primary generations: the younger generation, the baby boomers, and the generation residing in long-term care, which consists of people primarily 80 years and older. The social, political, economic context of peoples' lived experiences, shape their beliefs and behaviours. How people interact with their families, peers, and institutions is strongly defined by the politic of the day.

While communities, policy makers, and social activists have advanced and continue to advance the gay and lesbian movement, the baby boom generation—the upcoming cohort moving into long-term care homes and group responsible for the dramatic increase in the percentage of the aged population—is often perceived as the age group that significantly advanced the rights and recognition of gays and lesbians. Active involvement in the gay liberation movement and an increase in gay and lesbian visibility have lead to a greater quality of life for gays and lesbians in North America. Conversely, the generations previous to the baby boomers, were regularly confronted with overt homophobia and heterosexist policies and did not necessarily experience the accomplishments associated with the gay liberation movement (Brotmans et al., 2006). Many people within the population of older seniors still carry negative beliefs and attitudes about gays and lesbians; beliefs and attitudes that were overtly encouraged and supported throughout much of their adult life. Given the older age of residents in long-term care, this can create challenges for gays and lesbians residing in the home.

In a long-term care facility, you usually don't have a lot of problems with any staff, it's more problems with the rest of the...cell mates [laughter]...if you want to call them, which they basically are. Staff don't want you to come out because it will upset their little programs that they're running for everybody and we want everything to run really smoothly [sarcasm] because we don't like anything that upsets the children. So, uh, they prefer you not to come out, and of course after

being out for many many years, you aren't about to go into the closet. Once was enough. So it's definitely going to cause problems if you're in a straight facility with no other lesbians or gays.

It is important to note that while the context in which people grow and age impacts beliefs, not all older seniors carry the negative stereotypes and beliefs that were prevalent in the years bygone. There are numerous seniors who are accepting and supportive of gays and lesbians.

The Struggle for Identity Recognition

Identity discourse precipitates strong debates, particularly in the realm of policy development. Long-term care housing for gay and lesbian seniors is familiar with the identity polemic. Debates about exclusively gay long-term care, primacy of identities, and attention to difference were repeatedly addressed by participants in the focus groups and no easy answers are evident; making this a significant barrier to planning inclusive long-term care.

Participants in all three groups discussed exclusively GLBT long-term care. The responses ranged. Some participants exhibited a desire to live in exclusively GLBT care facilities.

Get the government to give us a building. Even a floor on a building would be good...that's the ideal thing.

Other participants stated their desire to live in a home available to everyone regardless of sexual orientation.

I don't want to be segregated. I just want to go into any nursing home or long-term care facility and live with everybody.

There are many non-profit long-term care homes that are developed around identities, such as faith-based homes. A long-term care home specifically for the GLBT population appears to be a viable option, but the idea of exclusively GLBT housing for seniors has brought on much debate. There are questions as to how the housing should be arranged: Should it be divided by gender? Should heterosexuals be allowed? While the purpose of an exclusively GLBT home is to foster an accepting environment that is without discrimination, there are concerns about segregating individual groups (Quam, 1997).

It is important to note that while being gay or lesbian may play a significant part of one's identity, it is not the only identity or necessarily the primary identity (Heaphy, 2007). Some participants expressed that they have other identities that deserve equal or more recognition and long-term care homes need to reflect the multitude of identities.

For those who want to be in gay specific nursing homes—perfect. I might choose to be a gay old person in a Buddhist home because I'm a Buddhist, or with a bunch of swimmers or whatever. But it is with whomever you choose to be with, whatever community, but it has to be respectful of everybody. Some people would only want to be segregated with gay people and that's fine, but that is not in my interest.

The notion that people have multiple identities was evident in the focus group discussions. The ability to self-identify was described by some focus group participants as an important component of inclusivity. One participant explained that her primary identity was not lesbian.

I don't need to be with gay people, I need to be with people who have my interests. I don't identify with being gay, I identify as being an artist. I have many interests. I would want to be with people with similar interests, I wouldn't want to be in a group just based on who I am. So I judge on what kind of people they are, not their sexual orientation – unless I was looking for a partner.

Further, more participants noted that first and foremost they are human and, as humans all people should be treated with dignity and respect regardless of identity.

I'm gay, but first and foremost I'm a human being. And everybody that's going into long term care, beginning care, are human beings. I respect people who have fought for things, but even in today's society, people get disgusted with certain individuals behaving in a certain way. All around here, I see men as human beings; behaving as human beings. Not, "Hey I'm gay and I need long-term care." If people don't [stop] and realize that the first and foremost thing is a human being, then all is lost. You mentioned about walking in and [questioning] how sensitive is the security guard, but the same thing can happen to a person who has been a minister all their life but has an atheist looking after them.

The translation of this concept into long-term care was a running theme throughout the groups. Participants were cognizant that regardless of affiliations or characteristics, all residents deserved to live comfortably in long-term care and receive respect and be treated with dignity based on their inherent human worth.

Within the context of identity politics, recognition of gays and lesbians for the purposes of inclusivity, mobilization and ultimately action, was described by the majority of participants as a means to develop and sustain inclusive long-term care. Conversely, the discussions about equality bring attention to the debate that attention to difference may result in segregation and fail to address the underlying issue that all people should be treated equal regardless of sexual orientation. Focusing on fixed identities may result in the displacement of people who do not fit into pre-constructed categories and redirects attention from potential foundational features such as class, which arguably is a primary producer of other forms of marginalization (Michaels, 2006). But caution should be exercised, because the failure to recognize gay and lesbian identities in favour of focusing on general equality is problematic. Barriers such as heterosexism, homophobia, religious

beliefs, and generational differences are challenges specific to gays and lesbians. The promotion of general equality does not recognize these realities.

I think the comment often is, “we treat everyone equally” and that is, you know, the most cruel thing to do is to assume... We are not the same, by a long shot.

Marginalized populations need some leverage before a promotion of general equality can be discussed. Further, lack of recognition of the distinct challenges confronting this population can contribute to heterosexual dominance by reinforcing the invisibility of gay and lesbian seniors’ issues.

The Path Forward

The focus group discussions concentrated on strategic plans to provide inclusive long-term care. Six themes representing the path forward were discussed by participants: the ideal of inclusive long-term care; partner recognition; raising awareness and education; community mobilization; advocacy; and developing inclusive policy.

Although six themes were developed to highlight the enablers, they were discussed in the context of barriers to inclusive long-term care. Consequently, the barriers and enablers are intrinsically linked. The move from the section identifying barriers to inclusive long-term care to the path forward does not mark an end to the discussion about barriers, but rather, it highlights a bridge between the presenting challenges stifling the development of inclusive long-term care and the means necessary to meet the objective of inclusivity.

The Ideal: What Does Inclusive Long-Term Care Look Like?

What does inclusive long-term care for aging gays and lesbians look like? This is a question that should not be developed in isolation by policy makers or academics. The participatory process of community defined inclusive long-term care truly represents the nature of inclusivity. While narrowing a definition of inclusive long-term care to fit the needs and wants of all members of a community is impossible, overarching themes raised by community members can provide a template for the development of inclusive living.

Participants noted that affirmation, acceptance, and support were qualities conducive to inclusivity. Although the notions of affirmation and acceptance are linked, each quality contains important differences. Some participants identified acceptance as an important feature. Acceptance had a range of definitions which includes the concepts of favourable reception and approval. It encapsulates the idea of being welcoming.

Other participants explained that in conjunction with acceptance, affirmation is necessary to provide and promote inclusive living environments. To affirm one's identity is to celebrate and validate that identity. Affirmation substantiates the identity through support and in some cases official measures such as policy development and legislative changes.

It goes beyond acceptance even. It goes more to affirming. When everything else in the whole system is ripping your identity apart, in a care facility you would like to hang on to some of who you truly are, rather than to let that go as well.

Therefore, inclusive long-term care that accepts and affirms gay and lesbian identities consists of four key components noted by the focus group participants: identifiably gay and lesbian staff and residents; gay and lesbian resources and gay positive visuals; and choice.

Long-term care homes with identifiably gay and lesbian residents were perceived by participants as an important component of inclusivity and support. There is an invisibility of gays and lesbians within the current cohort of seniors residing in long-term care (Brotman et al., 2006). This invisibility exists for a number of reasons (i.e. generational difference, historical realities, heterosexism and homophobia) and is particularly problematic because support is lacking in these environments. Often, people identify with groups based on similar characteristics to normalize experiences, gain support, decrease vulnerability that is commonly linked to isolation, and achieve a sense of comradery. Despite the different lived experiences within this heterogeneous community, it is important to note that people often achieve a greater sense of belonging and are less likely to feel judgment and discrimination from others who have similar experiences or characteristics.

I go along with both of you to a degree, but I would not want to be the only one there because, you know, you still want to be able to share some humour or stories or whatever and so being isolated within a place where it was all [heterosexuals]...

This is also true of identifiably gay and lesbian staff. Although, there was acknowledgment among participants that long-term care homes have gay or lesbian employees, there were concerns that these employees are not identifiably gay or lesbian. First, if staff members do not feeling comfortable openly identifying as gay or lesbian in a long-term care home this sends messaging to residents that there are reasons for concern. Employees who are out make a strong statement to employers, other residents, and family members. Further, staff members are sometimes perceived as advocates and support networks for residents. Gay or lesbian people living in long-term care may feel

that they are receiving greater amount of understanding and perceive the staff member as an ally, in effect creating a safer and more supportive living environment.

And I ideally would like part of the staff to be gay... identifiably gay. Not hidden away, so that if they are out there are other staff that if they come across something and say, "I don't really know what to do." There is sort of somebody that maybe will have a better understanding too... I want some of the staff to be gay on every shift so that I can feel that there is someone that I can relate to.

Long-term care homes are criticized in the literature for their promotion of heterosexual norms and values through pictures, activity programs, language, and resources such as books and movies (Edwards, 2001). The failure to include gay positive visuals and resources sends negative messages to the gay and lesbian community. Simple actions such as placing a rainbow decal in the entrance window or adding gay and lesbian literature to the library provides a welcoming message for gays and lesbians and represents a significant step towards inclusivity. While rainbows and inclusive language do not guarantee substantial acceptance and affirmation—in fact many gays and lesbians still proceed with a level of caution—this gay positive messaging relieves some of the questioning that occurs when entering a care home: Is it okay to be gay here? Am I safe to disclose? Will I be accepted?

I mean there are other institutions where people are encouraged to display a rainbow symbol on the desk, in a corner of window or whatever. To be able to say to us that if we did approach there, with that small emblem means that somewhere in their literature or whatever, means that they have done some sensitivity training within their environment with their staff and that they are willing to ensure that it would also happen among the population if need be. We have to respect all the rights of residents as well and the diversity of everyone, but some simple little steps...

Debates about exclusively GLBT long-term care have been discussed in the context of identity politics, and although there is much indecisiveness about the issue, one

notable finding is the need for choice. Within the discussion of the ideal of inclusive long-term care, participants across the three focus groups indicated choice as an important component of inclusivity.

[M]aybe straight people don't want to hang around a bunch of old dykes and whatever, gay guys. And maybe some old dykes don't want to be with old straight people. So the ideal to me would be that I have the choice. That there might be a retirement or long-term care for gay guys, and lesbians and straight people and some people are completely mixed up and that the choice is there; whereas now there is practically no choice. So, I'm saying if you like everybody, go to it. I know my mentality...I would just want to be surrounded by lesbians, period.

There is very little choice during admission to long-term care. Often, people are admitted to a home based solely on availability and are put on lengthy waiting lists to access their choice of home. While the choice of long-term care homes is limited for the population at large, the very concept of choice for gays and lesbians is narrowed further, if not, non-existent all together. Efforts to establish inclusive long-term care in all homes gives all gays and lesbians access to supportive, safe and affirming care and furthers the advancements for those who would prefer the option of exclusively GLBT long-term care.

Recognizing Partners in Long-Term Care

Participants expressed significant concerns about being able to visit their partner, access their partner's medical information, make decisions on their behalf, and sharing rooms. Further, partner acknowledgment and recognition were paramount to the affirmation of gay and lesbian relationships. Studies have shown that people in positive social relationships and secure partnerships are healthier, have higher levels of emotional wellness, receive regular support, and have longer life expectancies (Statistics Canada, 2006; Brown et al., 2001). Given the difficult nature of transition into long-term care,

recognition and involvement of a partner in the long-term care living environment can ease some of the challenges associated with the transition.

Participants noted a significant amount of progress with partner recognition—encouraging life experiences about partner recognition in long-term care homes and other health care institutions were freely shared among group members.

What is surprising here, when I was enquiring about long-term care and so on we had no problem in getting what was called matrimonial set up for my friend and I...Several places, I inquired and no problem at all. And they call it matrimonial. I am talking about the last two years that I have inquired.

While participant responses noted progress concerning partner recognition, other participants had recent experiences in health care institutions that raised concerns about partner recognition.

I rushed my spouse four years ago to the [hospital] and I was told “sorry” and the doctors treated me like I was a pervert. “Excuse me. I am not leaving right now. I am the spouse. I will stay here and I want to know everything.” And the two interns just ignored me.

Coupled with partner recognition, were numerous discussions about the need to identify a power of attorney. This unanticipated finding speaks to the important role of legislation as a protective device. Participants expressed significant concern that without legal designation, medical professionals may likely contact family members who have little involvement in their lives or may not make decisions on behalf of their best interests.

You raise an interesting point with power of attorney for those who, for whatever reason, had become incapacitated quickly who hadn't put those ducks in order. Then who makes those decisions? Is it the next of kin from Saskatchewan that you don't know? It doesn't matter if you're gay or straight, but I think it's more compounded in a gay world.

This discussion sparked notable interest by participants. Many questions were raised about the process of designation and the role of power of attorney. While some focus group members appeared to be well informed, other participants, including people who previously had partners in long-term care or other medical facilities, seemed uncertain about the role and process of obtaining a power of attorney, denoting the important role of social workers, lawyers, and related professionals in providing education and resources about power of attorney.

Putting Gay and Lesbian Seniors' Issues on the Agenda and Providing Education.

There is a paucity of research and literature about gay and lesbian seniors.

Although there is more awareness about this segment of the population in recent years with the advent of community groups and groundbreaking studies (e.g. Brotman et al. 2003), much more work is required. Many service providers fail to acknowledge the needs of gay and lesbian seniors. In fact, when the topic is addressed, it is not uncommon to see raised eyebrows and questioning looks: Are there gay and lesbian seniors?

Raising awareness and providing education about gay and lesbian seniors were identified by participants as two of the first steps to providing inclusivity in long-term care homes, other health care facilities, and social service agencies.

And I think that is part of it, getting back to education, that some of the people that are sitting on it aren't aware of all the issues either. They can't bring it to the table because they don't know the issues. The bigger picture of gay, lesbian, transgender, they can't bring it; they don't know...

Many service providers and policy makers are not aware of the issues and the invisibility of gays and lesbians within the current cohort of seniors living in long-term

care paired with the ageist belief that seniors are asexual exacerbates the problem. Developing awareness about the needs of gay and lesbian seniors and providing gay positive education and diversity training is needed in all health care sectors. While participants identified that diversity training including positive gay and lesbian messaging and education is a necessity for staff in long-term care, it is a practice that is often overlooked and, when it is provided, commonly other residents and service providers interacting with the care home resident do not have access to similar training. Providing education about gay and lesbian seniors cannot happen unilaterally. Education and training needs to happen on all fronts.

I think education in a number of sectors, not only for ourselves as a community. What is available, what are your rights, ensure that you have a power of attorney, all of that piece. That's one. Education of family and friends, significant others who need that information as well. Education of politicians or government or the legal system.

Finally, focus group participants discussed methods for disseminating information. Participants made recommendations to utilize community resources, such as tapping into academic institutions to do further research and capitalizing on the skills of journalist students to report on the issues. Further, gay positive media networks were seen as methods to disseminate information about aging gays and lesbians within the community. Moreover, accessing nursing homes by sitting on committees, acting as board members for policy making bodies, and joining internal groups were described as viable methods to provide information targeted to long-term care.

Fostering Community Involvement and Building Partnerships

All of the focus group discussions centred on community mobilization as the primary means to achieve inclusivity in long-term care. Drawing on the knowledge, capacities, resources, and determination of members of the gay and lesbian community, the results from the focus group indicate that community mobilization is a means to eliminate barriers to inclusive long-term care.

What I'm talking about for the gay community is that we've got to get into these homes. We've got to participate in these homes. Not only in watching and having dialogue with the directors on what are the issues, we have to be able to advocate for the people who are there and make it happen. We can make it happen at every one of these places and then it rolls up. We have a region, we have seven regions. Roll the seven regions and you've got the province covered.

Mobilizing communities to take action and precipitate social change is not an easy feat; there are many challenges to community mobilizing, but when communities encourage participation from its citizens and stabilize a cohesive critical mass of active members, they gain power. As community power mounts, the number of victories increase, which generates momentum for further action (Lee, 1999).

Mobilizing the gay and lesbian community to organize around the needs of gay and lesbian seniors was discussed in terms of enablers and barriers. The Peterborough focus group suggested capitalizing on community capacity and skill.

You start with a contractor. You put the different skill sets together. Someone who's got the nuts and bolts, someone who's got the legislature, someone who's got the fundraising, someone who knows how to write grants, someone who has connections in the community...

All of the groups discussed methods to access long-term care homes and, as with disseminating information, sitting on councils, boards, and connecting with policy makers to raise awareness about the issues was perceived as a great way to get involved. Finding

ways to gain organizational access was identified as a key element to bringing about change and establishing policy for inclusive long-term care.

I am an advocate of family councils and this is a system whereby family and friends of residents form a group within the home but totally independent of the home... And it is under legislation and basically it provides you the right to advocate for groups and individuals in the home. It's also access to books and all sorts of things in the home... So the future for our community is really to get involved with that, so that we are in the homes and providing support to our people that are in the homes... If we can get gays and lesbians on all those family councils we would be watching those homes like hawks and making sure that they comply with the law.

And then there is strategic planning... I didn't know anything about those family councils or whatever to really come up with some sort of plan. Who here sits on the council for aging? But we should have a lot of people on that. Should it be ten percent? The social planning council, we should be looking at that... Do we have directors on hospital boards and now there is the local, what do we call it, LHINs. Who do we know who is on there even? But I think we have to find ways to get into the system.

Participants noted that being out and active was a necessity to community mobilization. The men's focus group, in particular, carried on a debate about what it means to be out and involved. It was decided that many gays and lesbians are already actively involved in the long-term care community. They sit on long-term care related boards and councils, are members of associations, are staff members, long-term care directors, and policy makers, but being out was perceived to be the missing piece.

Participant 1: We have members on that, but they are not public.

Participant 2: Well excuse me [but] that is not very helpful!

There appeared to be a considerable amount of ownership from focus group participants to bring about changes in long-term care. The concept "it's up to us" exhibited the feelings of ownership and sense of responsibility carried by focus group members to mobilize and bring about change in long-term care.

I think it's up to us really...In little Italy they developed this community just for old Italians and the community did it themselves. So, if the GLTBQ wanted to get involved, we would have to get off our collective asses.

The responsibility expressed by focus group participants to achieve inclusivity in long-term care exhibits the validity of the concern about long-term care living for gay and lesbian seniors. Moreover, this expression of concern and willingness to strategize and act speaks to the determination of the gay and lesbian community.

Although the notion of "it's up to us" establishes a need, an important motivating factor necessary to encourage community mobilization, this notion is also problematic because it places the onus on the gay and lesbian community to rectify social injustices used to marginalize them and privilege heterosexuals. Should the right to safe living environments, equitable care, acceptance and affirmation for gay and lesbian seniors be solely the responsibility of gays and lesbians? In fact, this stance perpetuates the marginalization and oppression of this population by making gays and lesbians work for these rights while, for example, many heterosexuals can access long-term care without fear of inadequate care because of their sexual identity or concern that their partner will not receive recognition.

In this context, community mobilization must happen within and outside of the gay and lesbian community. Accessing allies at the policy making level, recruiting service providers, long-term care residents, and family members alike is an important piece towards gaining a collaborative effort and relieving some of the responsibility of "if we don't do it, who will?" from the gay and lesbian community.

Fighting for Inclusivity through the Promotion of Advocacy

Advocacy was raised as a significant facilitator to developing inclusive long-term care. Challenges relating to advocacy were discussed by participants, particularly pertaining to self-advocacy and finding advocates. While some participants shared examples of their experiences engaging in self-advocacy in health care settings, other participants felt that advocacy in long-term care may be too difficult. The population in long-term care is commonly confronted with medical conditions and cognitive deficits that place them in vulnerable positions. Many residents may not have the strength to self-advocate.

I think at the point where we're going into long-term care, Ministry defined long-term care, not retirement home where I am making a choice to leave my home, we're talking about assisted living, we're probably less able, even those of us who are normally quite vocal and willing to say take me as I am . At that point in time we probably have a lot less strength to be able to advocate for ourselves.

While self-advocacy is an empowering notion (Lee, 1999), finding motivation, displaying strength, and even having the capability to question the functions of the care facility may not be feasible. Moreover, residents in long-term care homes are often completely reliant on care staff for their activities of daily living. This dependency places the caregiver in a position of power. Residents may be fearful to advocate on their own behalf because the consequences could impact the quality of care. Therefore, finding advocates to provide support to residents who are able and wanting to self-advocate, while promoting inclusive long-term care on behalf of those who cannot, is necessary to challenge heterosexist norms and foster safe and affirming long-term housing.

Informal supports such as family and friends often take on the role of advocacy.

While many gay and lesbian seniors have sizable support networks such as partners,

children, supportive families, chosen families, and friends (Calasanti & Slevin, 2001), others are isolated. Finding advocates for people with limited informal support systems poses a significant problem.

I don't think you can expect people when they require those sorts of services to be running around advocating vehemently for their own rights. I think that somehow the advocacy had to be done by others and one of the problems is that I am not sure I am seeing anyone doing this.

For gay and lesbian seniors without informal supports, many will need to rely more heavily on the services of formal institutions for their emotional and psychological well-being. Formal advocates, service providers, volunteers, GLBT organizations, and policy makers have a responsibility to promote inclusivity particularly for the most isolated individuals.

Developing a Inclusive Policy: Providing Protection

Developing policy is a means to substantiate the needs of gay and lesbian seniors while enforcing affirming living environments for this population. It provides residents, family members, staff, and management with the support to take recourse and rectify maltreatment based on homophobia and heterosexism. Further, inclusive policy can act as a measure to prevent homophobic behaviour through mandating GLBT positive diversity training and education in long-term care homes and among related service providers. Long-term care living environments that truly represent inclusivity require policy stipulations that provide inclusive language, living environments, adequate care, and statements exhibiting zero tolerance for discrimination based on sexuality and gender identity.

In an effort to further the development of inclusive long-term care, putting gay and lesbian issues on the agenda of policy makers at both the provincial and federal levels was viewed by participants as the first step. Making links between raising awareness and education with the development of inclusive policy is imperative. An absence of knowledge about the challenges confronting gay and lesbian seniors in long-term care can manifest in a failure to take the measures necessary to rectify the issue. Further, conservative ideology, which is often linked to heteronormative ideals, perpetuates heterosexism and homophobia and can create barriers to establishing changes that challenge the privileging of heterosexuals.

And you know, policy makers are sort of bound by their governments. Certainly Harper is not exactly Mr. Social Conscious on this issue or any other...

To implement inclusive policy, the needs of gay and lesbian seniors must be visible. Gathering the energy of the gay and lesbian community, allies; finding advocates in all facets of care; and encouraging a collaborative approach is a necessary step towards this development. A dialogue between the gay and lesbian community and policy makers both increases visibility and raises awareness of the needs as defined by the community.

Moreover, legal means and using human rights legislation to implement inclusive long-term care living arrangements was viewed by participants as an additional method to stress the urgency of this issue, particularly with the aging population. Historically, the Canadian legal system has been used to demonize and criminalize gays and lesbians (O'Neil, 2006), but with the legislative changes such as the addition of sexual orientation to the Canadian Charter of Rights and Freedoms, and legalization gay marriage, legal protection is increasingly becoming seen as a protective measure and in some cases a buttress for gay and lesbian activism.

I think another piece that's in our favour at this time in our history is that the laws have changed. In fact if you had the time and the energy you could go and in fact demand your place...for example as spouse and spouse. Legally, they would have to serve you in that way. Again, that's an improvement that you can demand certain things based on the laws, but you have to have the energy to do it.

Conversely, legal protection does not necessarily guarantee substantive protection from discrimination in the long-term care home.

The reality is the difference between legal equality and social equality and that is very noticeable in long-term care. You can walk in as a gay man, as a lesbian or a transsexual, walk in or be wheeled in, more likely, and they'll say welcome and give you the package and everything else. When you try to live your life there you find that there are barriers in the home and some of them are very strong psychological issues. A lot of gay people have to go back in when they go into the home. They have to go back into the closet

Making the transition from protective regulations to substantial protection is still a challenge. While covert forms of heterosexism and homophobia are becoming less and less prominent, the prevalence of covert forms of discrimination is still frequent. Despite this challenge, legal protection and inclusive policies are steps in the right direction by challenging the heterosexist ideology and increasing the discourse around gay and lesbian rights.

Additional Findings

Recognizing and Celebrating Progress

Well, I never thought I would see a day where gays and lesbians could actually get married. I didn't think I'd live long enough to see that day.

Focus group participants acknowledged the significant feats made in the gay and lesbian rights arena. In some cases progress was perceived as unexpected and the participants were surprised at the changes taking place over the last few decades.

Emphasizing progress and the success of the last 20 years was identified as a motivator to move forward. One participant described being positive and bringing attention to the victories as encouraging.

I think that's a really important point because I think people of our age, with our history, it is so easy to be absolutely completely negative period. And in actual there actually is a fair amount of progress. This group would not have taken place 20 years ago... There would not have been an interest in a university to do a study. And that's pretty significant progress. Not to indicate that there isn't a long way to go, but I think we need some positive thoughts.

The acknowledgment of progress did not redirect focus away from the challenges confronting many gays and lesbians and as one participant noted, "Although it's changing, it's still not a safe world for all gays."

GLB...Transgender: Bringing Trans Issues to the Fore

One transgender woman and one transsexual woman participated in the focus groups. Both participants were aware that the purposes of the focus groups were to elicit information about barriers to inclusive long-term care for gay and lesbian seniors, but each participant had a strong interest in the study and believed that a voice from the trans community was necessary to bring an additional issue to the fore.

Transgender¹⁴ is often used as an umbrella term to describe individuals who challenge the sex-gender binary, such as pre-operative, post-operative, and non-operative transsexuals, intersexed individuals, cross-dressers, people who identify as androgynous, and in some cases gay, lesbians, and bisexuals are put into this category because they are

¹⁴ It is important to note that there is debate around the application term transgender because it is broadly used and associated with many identity types that challenge the gender binary. As a result, the term transgender is sometimes viewed as misrepresenting the realities of transsexuals. One participant explicitly noted that she uses the term transsexual to self-identity.

sometimes seen as challenging the traditional sex-gender norms (Hunter, 2005). The term transgender became popular during the nineties in an effort to move away from the terms that pathologized (i.e. transsexual, gender dysphoria etc.) people who did not fit neatly into the perceived sex-gender norms of man or woman (Hunter, 2005).

While there is a paucity of research pertaining long-term care for gay and lesbian seniors, the pool of studies available about transgender aging and long-term care is even smaller. The intimacy of long-term care can create great discomfort for the trans resident. Non-operative, pre-operative transsexuals and people who have had partial operations such as the removal of breasts or breast implants, may “pass” for daily activities, but during intimate levels of care such as bathing or changing, there is significant fear that caregivers may respond negatively when anatomical body parts do not match gender displays (Toronto Long-term Care Homes and Services, 2008).

Well I feel as a trans person if I had my surgery I can go in with my sexual orientation that is nobodies business – but then there is a huge problem if you don't have your surgery...

Further, the trans community has very little protection. Discrimination on the grounds of gender identity is not explicitly protected in the Ontario Human Rights code despite studies identifying the transgender population as one of the most marginalized communities (Ontario Human Rights Commission, 2000).

It's interesting in the year 2000 review of the Human Rights legislation, a very thick book, said that transgender is the most...what term did they use...discriminated against group in Canada and they firmly recommended that it be included. That was in the year 2000. I wrote the politicians in 2002 about transgender and I got a reply back which very proudly sent me another copy of this legislation [review] saying what the review board said. I wrote back and said that I was quite aware of that but the question I'm asking is when is the government going to act upon the recommendation. That was the end of the dialogue.

Moreover, the transgender community has not reached the levels of progress gained by the gay and lesbian community. While the transgender community is often blended with the gay, lesbian, and bisexual community, the transgender piece does not receive the same level of recognition.

Egale, which is a great organization, it took quite a while for them to add the T to the GBL. Finally, the T got attached to it and it stuck there in the letter head. It's never in the body of the letter.

Although many of the challenges faced by the transgender community are similar to those of gays and lesbians, there are distinct differences; in part because there is much more knowledge available around gay and lesbian needs and also because transgender is still very much perceived to be a pathological condition. Further, transgender may be perceived as a significant threat to the status quo. Therefore, trans people have faced substantial discrimination on all fronts.

The overall findings from the focus groups about transgender aging exhibit a need for further research. Raising awareness about transgender issues will help bring transgender aging to the forefront. The lack of protection provided to this population coupled with high levels of discrimination, abuse, and overall maltreatment, substantiates a need for further research and inclusive policy changes.

The Questionnaires from Long-Term Care Professionals: Findings and Discussion

Five long-term care professionals completed the questionnaires to inform the research with additional perspectives about the barriers to inclusive long-term care living

for gays and lesbians. While the response rate was low¹⁵ the responses provided were thoughtful. The responses from the five long-term care professionals are discussed in two sections: Barriers and Enablers.

Barriers

The questionnaire responses about barriers centred on belief systems. The participants described underlying religious beliefs, beliefs about sexuality in general, and the beliefs and values of other residents as primary challenges to inclusive long-term care. Similar to findings from the focus groups, the invisibility of gays and lesbians in long-term care was attributed to the underlying negative beliefs stemming from generational factors and religious morals and values.

[I]n a strongly [religious] facility, attitude/acceptance of same sex relationships may be impacted. I believe that changes in legislation re: same sex marriage will facilitate acceptance over time but the Catholic Church or other faith based exclusionary groups is an entirely different matter.

As previously discussed, sexuality in long-term care is increasingly receiving attention, but many people, including staff and other residents are still struggling with sexuality among seniors. Two of the participants noted beliefs about sexuality as a barrier to inclusive long-term care and a challenge to residents regardless of their sexual orientation.

¹⁵ Of the 28 long-term care homes in the Ottawa region, five long-term care professionals completed the written questionnaires. While possible factors contributing to the low response rate include time constraints placed on long-term care professionals and the challenges associated with the email distribution of the questionnaires, the topic of the study should not be disregarded as a possible explanation for the low response. Given the enthusiasm of the long-term care professionals who agreed to participate while noting that one potential participant did not participate because she was unable to gain approval from her superior raises questions about the perceived validity of the issue: Does the absence of some long-term care professionals' participation in the study reveal a failure to recognize the importance of inclusive long-term care for gay and lesbian seniors? This question denotes an area to pursue for future research.

The staff in long-term care have some level of discomfort with the expression of sexuality (both heterosexual and gay and lesbian) and would find it difficult to firstly understand the need for sexuality and secondly make judgments about the expression of sexuality.

In addition to underlying religious beliefs and ageist beliefs about sexuality, long-term care professionals described other residents as a possible challenge for gays and lesbians in long-term care.

The main barrier is intolerance. The majority of individuals in long-term care today are seniors. The average age in the long-term care facility where I work is 86 at present. I think it would be fair to say that the society in which these individuals grew up in was less tolerant of homosexuality than today.

This finding indicates that negative attitudes and beliefs about gays and lesbians on the part of other residents corroborates the concerns of the focus group participants. The generation currently residing in long-term care lived much of their adult life when the social context was quite different. Displays of heterosexism and homophobia were overt and both accepted and supported en masse. While it is important to note that a number of older seniors are accepting and even celebrate gay and lesbian identities, there are still many who hold deep-seated prejudices.

Further, society is more secular than it once was and a significant proportion of religious congregations are comprised of older adults. Although some religious sects affirm gay and lesbian identities and have strong GLBT communities—many have reevaluated their positions in recent years—there are many religious organizations that still struggle with the issue. The spectrum ranges from the construction of homosexuality as sinful to tolerance. But tolerance is still not acceptance or affirmation and many religious sects that preach tolerance still construct same-sex behaviour as sinful. In effect, some religious beliefs can play a role in perpetuating homophobia and heterosexism. For

the older long-term care residents who were raised in a time that placed more emphasis on religion and carried strong conservative values, this may bring about conflict and create barriers to inclusivity. Consequently, this raises specific challenges for policy makers and long-term care operators. How do you affirm one group when that affirmation may be offensive to another?

Challenges within the identity politics arena were raised by both focus group participants and long-term care professionals. When asked to describe their vision of inclusive long-term care, some participants expressed the importance of equal access for all residents regardless of sexual orientation.

That all citizens of Canada have equal access to comfortable and safe long-term care services and programs.

The focus on equality, exhibits the commitment of long-term care professionals to ensure that the long-term care environment are safe and comfortable for everyone. Achieving this raises a different challenge because different groups have unique needs. One participant wondered if the inclusion of gays and lesbians on intake forms would be helpful.

LTC asks many questions as part of social history development, perhaps we need to add a question about sexual orientation. This would allow individuals to maintain control over their decision to disclose or not to disclose and would demonstrate a level of openness on the part of the LTC home.

Consequently, the debate around bringing attention to difference as problematic continued with long-term care professionals.

Again, like left handedness or right handedness, just assume that we've evolved sufficiently as a society that specific language/ interests are considered. If we had every "interest group" lobbying for inclusion we would never get anywhere. Just assume homosexuals are part of the main stream and they will be. Let's stop identifying people based on colour, sexual orientation, sex, etc. Just assume we're

all included in the language... Let's spend less time/ energy/ money/ brain-power on identifying areas where we differ—we draw attention and controversy when we do. Just assume it is inclusive and it will be. It's quite simple, really.

This debate around identity recognition manifests into significant challenges for policy makers. Grappling with providing equality, safety, and comfort for all residents in care facilities is not easy, particularly when many groups are marginalized on the basis of sexual orientation, race, ethnicity, sex, ability and other characteristics. Competing interests of varying groups can create barriers. Making decisions about what constitutes inclusivity for all, makes this task especially difficult and raises the question: How do you promote people's interests while minimizing the consequences of that recognition?

Enablers

Long-term care professionals indicated community involvement and education and training as the primary means to develop inclusivity in long-term care. These findings support the suggestions made by focus group participants.

All of the participants described education as a necessary means to provide safe and comfortable living environments for gays and lesbians. This discussion also extended to education about senior sexuality in general. The focus on education and training was primarily directed towards long-term care staff, but some participants noted the importance of educating family members, residents, and general diversity programs.

In dealing with multi-culturally diverse workplaces, our education and awareness programs have included residents and families, not just staff and management.

Recommendations provided by long-term care professionals mirrored the focus group discussions. Participants suggested that the gay and lesbian community should

work in collaboration with long-term care associations and organizations (i.e. The Ontario Long-term Care Association; Local Health Integrated Networks) and key stakeholders, as a means to raise awareness and shape long-term care education and policy. Furthering the development of community partnerships by creating or accessing pre-existing organizations, such as the Ottawa Senior Pride Network, were described as effective channels to organize, educate, and incite discourse about long-term care for gays and lesbians. In addition, advocacy was described as an important element. As discussed in the men's focus group, one long-term care professional recommended family councils as a method to access the home and advocate on behalf of residents.

I believe that the LGBT community could become involved in planning through provincial initiatives, but also through local family councils. As individuals from the LGBT community they may participate on a long term care family council because they have a family member in the home, but they could also build awareness and help influence the local home's policies.

Finally, two participants raised exclusively gay and lesbian long-term care as a viable option.

There is provision for specific community groups to operate long-term [care]. In Ottawa at present there are private for profit long-term care facilities as well not-for-profit facilities run by both the municipality, as well as various charitable organizations (i.e. various faith-based groups, etc.). There would be nothing to stop the gay and lesbian community from forming a charity and approaching government with a request to open a facility specifically to cater to the needs of gay and lesbian seniors.

The responses by the two long-term care professionals regarding exclusively GLBT long-term care, denotes a recognition of choice and some of the unique needs facing this population.

Chapter VI: Conclusion and Recommendations

Older gays and lesbians have contended with a long history of heterosexism, stigma, negative stereo-types and violence. The gay and lesbian seniors of today were the criminals, the mentally ill, and the deviants of the past. Many lost their jobs, their families, their friends, and their livelihood (Brotman et al., 2006; Hunter, 2006; Kinsman, 1996). These factors have greatly impacted the older lesbian and gay community and as a result, invisibility of lesbian and gay seniors prevail, but this invisibility is anticipated to change as the baby boomers age (Brotman et al. 2006; Edwards, 2001; Hunter, 2006). As more people age and enter long-term care, aging gay and lesbian issues are being brought forward, making this an opportune time to work towards living environments that provide safe and affirming care for a population that has contended with so much hardship.

The goal of this research project was to answer the question: What are the barriers to inclusive long-term care? Three focus groups with aging gays and lesbians (N=20) were employed in combination with questionnaires distributed to long-term care professionals in Ottawa (N=5) to examine barriers in regards to a) gay and lesbian seniors accessing inclusive long-term care services, b) the planning and implementation of affirmative policy, and c) the involvement of the aging gay and lesbian community in the planning and policy development process.

A prominent finding from the research indicates that there are substantial challenges confronting gays and lesbians accessing and residing in long-term care. Using a larger sample size, this finding corroborates the research findings from my previous study, *Moving Towards Inclusivity: A Study of Long-term Care for Gay and Lesbian Seniors in Ottawa* (2007). While the last few decades have produced numerous

advancements in the gay and lesbian rights arena, heterosexist ideology and homophobic attitudes continue to marginalize this community. Aging gays and lesbians, some of whom are in the most vulnerable situations due to health decline, ageist beliefs, and higher likelihoods of income disparities are particularly affected. Vulnerability coupled with a lack of knowledge about aging gays and lesbians makes them liable to discrimination and maltreatment.

These factors reinforce the fears of this population, contributing to an additional finding: a perception of challenges for gays and lesbians in long-term care. This perception of challenges is not validated by negative experiences specifically in long-term care. The perception is supported by negative experiences with other healthcare institutions and relies on a history of discrimination faced by the gay and lesbian community in all avenues of life (i.e. discrimination in the work place, loss of personal support networks, heterosexist policies etc.). The word perception is not used to signify imagined challenges, but rather to exhibit the fear and cautionary approach exhibited by many gays and lesbians due to past experience and the context of heterosexual dominance.

The material challenges confronting aging gays and lesbians in long-term care, substantiates the need for safe and affirmative living environments. Whereas the perception of challenges signifies a need to ensure that long-term care homes plan for and develop *visibly* inclusive long-term care.

Conversely, the process of planning for and developing inclusive long-term care faces many challenges. The findings from the focus groups and the long-term care written questionnaires highlight the complexity of this issue. Developing long-term care living

that meets the needs of all individuals and groups, is a difficult task. Creating policy that affirms an identity group must be cognizant of the needs of other groups, while promoting general equality. Further, it is important to recognize that identities exist on a continuum or hierarchy and that they can be fixed or fluid and, while a person may identify with a particular group, this does not indicate that the individual views that identity as the overriding self-association (Richardson, 2006; Heaphy 2007). For these reasons, placing people into categories or groups should be exercised by the individual.

The data indicates the importance of recognizing both gay and lesbian identities and diversity in long-term care. Seniors deserve access to long-term care homes that are safe and welcoming for all people. While the values and norms of individuals and groups may conflict (i.e. negative religious beliefs about gays and lesbians), changing prejudicial beliefs that are deeply rooted in religious, cultural, and political ideologies is not within the periphery of long-term care operators and policy developers. Therefore, the responsibility of long-term care homes is to foster safe environments that model respect and aim to affirm a diverse set of identities.

Expanding on this understanding, the unique needs and challenges of aging gays and lesbians continue to require recognition. Gays and lesbians continue to face hardships and discrimination because of prevailing heterosexist ideologies and this population is further marginalized because of cross-cutting issues such as age, race, class, and gender. To achieve long-term care that encapsulates the affirming equality of care deserved by all, additional efforts must be made to compensate for the presenting barriers that subjugate this group.

Recommendations

The following four recommendations resulting from the findings are put forth to assist long-term care facilities in making the efforts to work towards inclusive long-term care for gays and lesbians.

Recommendation 1: Building and Strengthening Community Partnerships

The findings indicate that making long-term care homes inclusive for gays and lesbians relies on a collaborative approach. Policy makers, long-term care service providers need to work with the gay and lesbian community to establish strong partnerships that enable raising awareness, education, and policy development that is informed by the gay and lesbian community. The responsibility to develop partnerships rests on both parties to seek out ways to connect through joint initiatives such as community developed groups or task forces (i.e. Senior Pride Networks).

Recommendation 2: Access to and Active Participation in Organizations

Gaining access to and actively participating in organizations in the community is an extension of community partnerships. Strong voices from the gay and lesbian community at all organizational levels informs long-term care planning and provides support to aging gays and lesbians who are not in positions to self-advocate. Drawing on findings from the research, gays and lesbians can, with the support of long-term care partnerships, gain organizational access to long-term care and actively participate as: a) members of long-term care organizations responsible for education and advocacy (e.g. the Ontario Association for Non-Profit Homes and Service; Ontario Long-term Care Homes Association); b) board members, consultants, and employees involved with the

bodies responsible for long-term care planning and policy development (e.g. Local Health Integrated Networks; Ministry of Health and Long-term Care) and; c) advocates, family members and friends working in the homes as volunteers and/or members of internal groups that shape the home's policies (e.g. Family Councils).

Recommendation 3: Raising Public Awareness through Increased Education and Training

Diversity training that includes education about the unique issues of gays and lesbians is required for long-term care staff to provide affirming care to this population. Furthermore, education and training must move beyond front-line workers. Family members, other residents, volunteers and outside service providers all contribute to the overall atmosphere of the home. While raising awareness and providing education may not change deeply entrenched negative beliefs about gays and lesbians, an increased understanding of the challenges confronting this population, while focusing on respect for other people can establish an increased level of safety and comfort for all residents, particularly gays and lesbians.

Extending education to people and organizations outside the long-term care home to groups such as the gay and lesbian community; health care service providers, those responsible for health care planning and development is necessary. Education increases the visibility of aging gays and lesbians and contributes to placing the needs of this population on the agenda of policy makers and raises awareness that this is an urgent issue needing advocacy and support from gays and lesbians and allies in the community.

Recommendation 4: Visibly Inclusive Long-term Care Substantiated by Inclusive Policy

The findings from the research indicate that long-term care homes need to show their intention to provide inclusive living environments for gays and lesbians by using gay positive visuals, emphasizing inclusive language, and providing resources such as information pamphlets that explicitly note the homes' gay positive stance. Increasing visibility of inclusivity informs concerned aging gays and lesbians that the home is taking steps to provide affirmative living. Visibly gay positive spaces foster environments for staff, partners, family members, volunteers, friends and residents to work, visit, and live in the home as identifiable members of the gay and lesbian community; in effect creating a more inclusive environment that offers a greater sense of belonging and support.

In addition, the visibility of inclusivity requires substantiation through policies that ensure long-term care homes are implementing the steps required to offer care that recognizes the challenges confronting this group (i.e. regulating the language on long-term care assessment forms, mandating diversity training, partner recognition etc.). Further, policies and statements developed by the long-term care home that explicitly state "zero-tolerance" for discrimination based on sexual orientation can serve as recognition of the hardships facing gays and lesbians. These statements display a clear message that discrimination is not tolerated.

Moreover, the development of inclusive standards at the level of the state can serve to provide some uniformity and consistency in the provision of long-term care services in the same way that other pro-active social policy measures have been used. One approach to policy development and analysis that with some alterations may serve as a model for social policy development in this arena is the gender-based initiatives many

governments, NGO's and, private institutions have been adopting. The federal government, for example, adopted a gender-based analysis in many of its departments as a way of attempting to include the differential impact of policy on women and men (Status of Women Canada, 1998). Currently there are several other lenses being developed with a similar approach which consider disability, ethnicity, and so on. It is within this extension to other marginalized groups that makes an approach based on sexual orientation and gender identity conceivable. The tenets of gender-based analysis (i.e. promoting participation of the group affected by the policy and awareness of how policies impact groups based on shared characteristics) applied to a gay and lesbian lens, may make this useful approach for identifying issues and working towards inclusive long-term care.

Areas for Future Research

The enthusiasm of focus group participants and the completion questionnaires by long-term care professionals in this study combined with increasing contributions to the literature and large scale Canadian studies such as McGill University research project, *The Health and Social Service Needs of Gay and Lesbian Seniors* (Brotman et al, 2006), exhibits an increasing interest and growing need to address health care and long-term care living for gays and lesbians. More research needs to be employed on a larger scale to corroborate the findings of this study and gain much needed knowledge about this issue.

Moreover, the lived experiences of gays and lesbians residing in long-term care would be a valuable contribution to the literature by evidencing the experiences of this population in long-term care homes, while substantiating future directions for inclusive care. Although, obtaining a sample of people residing in long-term care poses challenges

because of increased ethical concerns around gaining consent from participants and difficulties locating gay and lesbian residents due to invisibility, creativity on the part of researchers is necessary to overcome these obstacles to gain invaluable insight from this population.

Interest in participating in this study by the Peterborough focus group members represents the concerns of people in smaller cities and rural communities. Larger urban centres such as Toronto are already engaging in initiatives to ensure safety and comfort for gays and lesbians in long-term care facilities. The findings from this study indicate that rural communities face more challenges, which impact their progress. More research about the realities of aging gays and lesbians in rural communities is necessary to provide future directions for community mobilizing and the development of inclusive long-term care.

The focus of this study was to identify the barriers to inclusive long-term care for gay and lesbian seniors. The small amount of literature pertaining to gender identity and the valuable input from two women in the focus groups who identify as trans highlighted the importance for research about the aging transgender community. Moreover, the bisexual community was not included in this study. Further exploration is necessary to understand the challenges, needs, and wants of this community in regards to long-term care.

Finally, the absence of people of colour in this study represents a limitation the research. The realities confronting aging gays and lesbians of colour are underrepresented in the literature. Greater attention to this community is needed to bring insight to their

lived experiences and the barriers confronting safe and affirmative long-term care living for this population.

There are a variety of extensions to this study and clearly more research needs to be employed to understand and work towards inclusive long-term care environments for gay and lesbian seniors, subsets of this population, and other groups, such as the transgender and transsexual communities, that became apparent during this project.

Role of the Study in the Literature

The identification of barriers to inclusive long-term care indicates the challenges confronting gays and lesbians in long-term care homes and elicits a discourse around the enablers that facilitate an alleviation of the presenting challenges, while calling attention to possible modes of action for the path forward. This study contributes to a growing body of literature about aging gays and lesbians. The specific focus on long-term care was chosen to address a gap in the literature and contribute to the movements occurring in major urban centres in Canada.

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Appendix 1: Focus Group Participant Recruitment Poster Ottawa

SEEKING RESEARCH PARTICIPANTS

Identifying Barriers to Inclusive Long-Term Care:

Developing Affirmative Living Arrangements
for Gay and Lesbian Seniors

Do you identify as gay or lesbian?

Are you 50 years of age or older?

Are you concerned about long-term care living arrangements for gay and lesbian seniors?

If you answered yes to all three questions, you may be the perfect candidate for this research project!

I am seeking volunteers to participate in a focus group. Previous experience with long-term care is not necessary to participate. This is an opportunity to brainstorm and to share ideas and experiences in the quest for inclusive long-term care living environments.

Women's Focus Group

Date: April 3, 2008

Time: 6:30pm

Place: Centretown Community Health Centre

Men's Focus Group

Date: April 1, 2008

Time: 6:30pm

Place: Centretown Community Health Centre

If you are interested in participating in this project or if you require more information please contact:

Erin Richards BSW, MSW (Candidate, Carleton University)

Phone: 613-863-8256

Email: erichard@connect.carleton.ca

This research project has been approved by the Carleton University Research Ethics Committee.

Appendix 2: Focus Group Participant Recruitment Poster**Peterborough****SEEKING RESEARCH PARTICIPANTS**

**Identifying Barriers to Inclusive Long-Term Care:
Developing Affirmative Living Arrangements
for Gay and Lesbian Seniors**

Do you identify as gay or lesbian?

Are you 50 years of age or older?

**Are you concerned about long-term care living arrangements for gay
and lesbian seniors?**

If you answered yes to all three questions, you may be the perfect candidate
for this research project!

I am seeking volunteers to participate in a focus group. Previous experience with long-term care is not necessary to participate. This is an opportunity to brainstorm and to share ideas and experiences in the quest for inclusive long-term care living environments.

Date: April 17, 2008

Time: 7:00pm

Place: The Spirituality Centre

If you are interested in participating in this project or if you require more information please contact:

This research project has been approved by the Carleton University Research Ethics Committee

Appendix 5: Focus Group Questions

What, if any, are the barriers to accessing long-term care living for the gay and lesbian senior population?

How can access to long-term care living be improved?

What, if any, are the barriers to involvement of the gay and lesbian community as active participants in the policy development process?

What, if any, are the barriers to affirmative long-term care policy development for gay and lesbian seniors?

What methods can be used to implement policy development that ensures inclusive long-term care?

Describe your vision of an ideal long-term care facility that is inclusive for lesbian and gay older adults?

Describe the barriers that impede that vision?

Appendix 6: Written Questionnaires

It would be greatly appreciated if you could answer the following questions. Point form or short hand answers are acceptable. Please do not hesitate to contact me if you have any questions.

What is your vision of inclusive long-term care for gay and lesbian seniors?

What, if any, are the barriers to achieving that vision?

Describe some barriers to policy development for inclusive long-term care?

In what ways can the gay and lesbian community be engaged in the development and planning process to achieve long-term care living arrangements that are inclusive?

What recommendations, if any, do you have to provide affirmative living arrangements long-term care?

Additional comments

Thank you. Your participation is greatly appreciated.