"We don't have any of those people here"

Retirement Accommodation and Aged Care Issues for Non-Heterosexual Populations

GRAI (GLBTI Retirement Association Inc)

Curtin Health Innovation Research Institute
WA Centre for Health Promotion Research
Centre for Research on Ageing
Curtin University, Bentley Western Australia

May 2010

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- Paul Coates — Carers WA
- Stephen Kenny — Retirement Villages Association (WA)
- Stephen Kobelke — Aged and Community Services WA
- Ken Marston — Council on the Ageing WA

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EXECUTIVE SUMMARY

Approximately 8% of the population identify as gay, lesbian, bisexual, trans and intersex (GLBTI). By 2051 it is estimated that 1/2 million GLBTI people aged 65 years and over will be living in Australia. Despite the size of this minority group, older GLBTI people have been almost invisible within ageing policy.

This report presents the findings of a 12 month research project supported by a Lotterywest Social Research Grant. The project evolved from formative research conducted by GRAI (GLBTI Retirement Association Inc) in 2006/07. This project confirmed that older and ageing GLBTI individuals accessing retirement and residential aged care services in Western Australia (WA) experienced unmet needs and fears of discrimination. This was in line with other national and international research indicating that older GLBTI people are likely to be disadvantaged in the aged care sector due to their minority sexuality.

This research explored Western Australian retirement and residential aged care service providers' practices and attitudes towards older GLBTI clients. This was used to help inform the development of best practice guidelines for the industry with the aim of providing more GLBTI-inclusive services.

Issues

In addition to the usual issues facing older adults, such as loneliness, isolation, loss of autonomy and increasing dependence, older GLBTI individuals may experience further stressors (Meyer and Northridge 2007). These are usually associated with sexual orientation, disclosure of sexual orientation and/or gender identity to health care providers, discrimination, lack of legal recognition and little if any protection of lifetime partnerships, and limited opportunities to meet other older GLBTI people (Equality South West 2006; Meyer and Northridge 2007).

Furthermore, the heteronormativity (presumption and preferences of heterosexuality) of retirement and residential aged care facilities is a concern to many older GLBTI people. Heterosexual assumptions coupled with the notion of older people being asexual, can make GLBTI people feel that their same-sex relationships are not valued or understood and that partners will be excluded in care planning and decision making (Irwin 2007). Additionally Addis (2009) reports some older GLBTI people fear a lack of recognition and support of their 'families of choice' from service providers.

A mono culture also exists within the aged care sector in relation to diverse sexual orientations which perpetuates the mantra "we treat everyone the same" (Barrett, Harrison, and Kent 2009. 55). The issue is that not everybody is the same. People are individuals with different historical and cultural experiences (including their sexual orientation, past experiences, race, gender, etc) which influence their beliefs, behaviour and interactions with health professionals.

Older GLBTI Australians grew up during a time where homosexuality was illegal and those found to be engaging in homosexual activities were prosecuted. The attitudes of society in general, towards homosexuality were ones of persecution, condemnation, hatred and discrimination, with homosexuality commonly viewed as a "sickness, sin and disgrace" (Kimmel, Rose, and David 2006. 1). Consequently the GLBTI population was concealed from the general population with few people disclosing their sexual orientation for fear of reprisal and/or prosecution (Kimmel, Rose, and David 2006).

As a result, getting older for many GLBTI people can mean increased fear of being 'outed' after a lifetime of avoiding disclosure of their sexuality, or fear of lack of understanding and support as they age and seek supported care. Concealment of identity renders older GLBTI people invisible and may

result in service providers unintentionally failing to address their needs which extend beyond the physical.

Some older GLBTI people fear that going into residential aged care will render them socially and emotionally isolated from their communities. They will no longer be able to mix with other GBLTI people, access GLBTI services and activities, or celebrate/attend special events and festivals (Chandler et al. 2005; Birch 2004; Chamberlain and Robinson 2002). Encouraging participation in GLBTI community activities of older GLBTI people in residential care facilities can be challenging due to their invisibility and identity concealment (Brotman, Ryan, and Cormier 2003). However encouraging GLBTI elders to access and remain connected to their GLBTI community and social support groups is important, as it can impact significantly on emotional well being, and contribute to positive health outcomes (Birch 2009).

Of particular social and economic interest, is the potential impact the GLBTI baby boomers will have in the future on providers of accommodation for older people. In addition to overall expectations of availability and adequate level of service provision, this demographic is the first generation who are more open about their sexuality.

Evidence

There is a growing body of research around GLBTI gerontology both within Australia and internationally. Despite this, there is still limited research and data collected on the diversity within GLBTI populations, particularly older GLBTI people (Grant et al. 2010). The findings of available studies are specific to the context in which they have been carried out, however recurrent key themes can be identified across the literature. These are:

- historical experiences of homophobia/discrimination;
- current experiences of homophobia/discrimination;
- concealment of identity/invisibility;
- ageism within the GLBTI and wider communities;
- impact of homophobia/discrimination on the quality of care delivered;
- heteronormativity; and
- social isolation.

Research project

The purpose of this research project was to understand the issues and the current industry responses to the specific needs of older GLBTI people. One of the outcomes of this study was to develop best practice guidelines for the retirement and residential aged care sector in WA, to facilitate the provision of GLBTI-inclusive services. The data collected from this study were used to develop these guidelines as well as identify further research areas.

The study aimed to:

- explore existing organisational and facility attitudes, knowledge and current practices towards older and ageing GLBTI people; and
- ascertain current responses from the retirement and residential aged care sector in Western Australia to the needs of older and ageing GLBTI people.

An industry advisory group (IAG) was established upon commencement of the project. The IAG, a sector based representative group, encompassed the following peak bodies: Carers WA, Aged Care Association Australia (WA), Council on the Ageing (WA), Retirement Villages Association (WA) and Aged and Community Services (WA).

The Industry Advisory Group (IAG) was extensively involved throughout the project. They acted as an industry feedback mechanism to inform the project and provide insight into the potential and/or perceived implications of the provision of retirement and residential aged care services to GLBTI populations. The IAG also provided feedback on the research schedules, industry questionnaires, best practice guidelines – accommodating older GLBTI people and the final project report.

Organisational data were collected through a self administered postal CEO Survey sent to 40 CEOs of retirement and residential aged care organisations in WA with multiple facilities. A response rate of 32.5% (n=13) was received. The CEO Survey was also sent to single entity organisations and a 14.5% (n=23) response rate was achieved. The higher response rate from CEOs of multiple facilities may be attributed to direct phone contact made prior to them receiving the survey. Appendix D and Appendix G outline the recruitment process in detail. Operational data were collected through a state-wide Facility Survey sent to 320 retirement and residential aged care providers in WA. A response rate of 26% (n=83) was achieved.

Over half the facility based respondents (53%) were from the Perth metropolitan area, 40% were from rural Western Australia and 7% were from remote Western Australia. The size of respondent facilities varied, with the majority (61%) having less than 25 full-time equivalent (FTE) staff members. The majority were not-for-profit run organisations (55.6%).

Several focus groups with both senior management of retirement and residential aged care facilities and members of the GLBTI community were held. The aim of these focus groups was to gather more in-depth information on the experiences, issues and challenges facing residential aged care providers when accommodating older GLBTI people. They were also used as an opportunity to further expand on two of the themes emerging from of the survey, namely ‘we treat everybody the same’ and ‘sexuality is none of our business’. Perceptions of what constitutes best practice in the delivery of retirement and aged care accommodation for GLBTI people was explored with members of the GLBTI community as well as gathering their opinions regarding the content of the guidelines, along with views and expectations of such guidelines.

Findings

State and federal legislation guide the practices of residential aged care service providers. As such, practices across the industry work within similar governance frameworks. While there are good practices in some facilities, particularly with those who are GLBTI-supportive, the providers of retirement and residential aged care are not a uniform group and consequently differences in practices and attitudes do exist. The findings from this study confirm the formative work undertaken by GRAI in addition to other national and international research findings.

- **Experiences and attitudes**

Eighty six percent of Facility Survey respondents were unaware of any GLBTI residents within their facility with only 30% of respondents agreeing that their facility recognises that GLBTI residents have specific needs. The majority of Facility Survey respondents (79%) agreed and strongly agreed that a resident’s sexuality was not their concern, however over half (88%) indicated that a residents’ beliefs and personal diversity were promoted within their facility’s policies and procedures. The majority of

Facility Survey respondents (66%) felt that they provided a GLBTI-friendly and trusting environment which 'treated everyone the same'.

No facilities provided staff training specific to GLBTI issues. Two however had provided staff training around sexual needs for older people in general however this was not GBLTI specific.

- **Organisational policy**

There was generally poor inclusion of GLBTI issues in policy frameworks. Ninety eight percent of CEO Survey respondents had an established complaints process and the majority (77%) of them were aware that residents could lodge a complaint regarding discrimination based on sexual orientation and/or gender identity. However few CEO Survey respondents' (37%) organisational policy and procedures made specific reference to GLBTI people, and issues of sexuality were dealt with under general equal opportunity and antidiscrimination policy.

Of the 18% of Facility Survey respondents who were aware of state and/or federal legislation relating to GLBTI people being incorporated into their facility's policy, only 21% made reference to same-sex law reforms.

- **Current practices**

Twenty eight percent of Facility Survey respondents indicated that their facility promotes a welcoming and accepting atmosphere for GLBTI people. Strategies cited included: treating everyone equally, employing gay and lesbian staff and making everyone feel welcome. Having said this, only 5% used any means of indicating an inclusive environment to GLBTI people; 6% had a nominated GLBTI support person and no facilities had partnerships with GLBTI community organisations.

The majority of Facility Survey respondents indicated that the data and information collection forms used by their facility did not allow a person to self-identify as GLBTI. Nor did they include the term 'sexual orientation' or similar terminology on their resident admission form.

- **Future directions**

Over half of the Facility Survey respondents (59%) did not perceive any challenges by staff when accommodating GLBTI people. Fourteen percent thought there would be some challenges by staff due to lack of knowledge and education of GLBTI issues, and personal attitudes and beliefs. This was similar when asked about perceived challenges by other residents. Of the 19% who thought there would be some challenges, they cited personal attitudes and beliefs of other residents as the most likely cause.

When asked about training needs, most Facility Survey respondents agreed the impact of staff beliefs and values in the delivery of care, and safeguarding GLBTI individuals from discrimination by other residents were important training topics. Having organised sessions, qualified trainers, accessibility, funding and human resources were seen as more likely to lead to training. Barriers included limited funding, time and human resources, staff and residents' attitudes and beliefs, accessibility and that fact that such training was not applicable to their facility.

Best practice guidelines

The development of best practice guidelines for retirement and residential aged care providers was one of the outcomes of this project. Best practice guidelines aimed to encourage management and staff to adopt practices to create an inclusive environment, which is accepting and welcoming of all GLBTI people. They aimed to provide an operational context whereby providers of retirement and residential aged care are better able to recognise, understand and meet the specific needs of GLBTI people.

To achieve best practice for accommodating older GLBTI people, five principles were identified:

1. inclusive and safe environment;
2. open communication;
3. GLBTI sensitive practices;
4. staff education and training; and
5. GLBTI inclusive organisational policies and procedures.

In the guidelines each principle is expanded with an explanatory statement and a 'how to' section, which provides simple low cost strategies for achieving the principle. This is then followed by a brief scenario, providing operational context.

Implications for service providers

The findings of this research have a number of implications for providers of retirement and residential aged care if they are to adequately meet the unique needs of older GLBTI people.

- **Invisibility and disclosure**

Older GLBTI people currently accessing retirement and residential aged care are a hidden population, as demonstrated in this and other studies. As a result of concealment and invisibility, providers tend to be unaware of the existence of older GLBTI residents within their facilities and are therefore unable to address unique needs adequately. Furthermore staff must be trained and have the skills to deal with disclosure to ensure that the person disclosing is safe from discrimination by staff and other residents.

- **Personal attitudes and beliefs in the delivery of care**

Heteronormativity and homophobia exist within the broader community and are therefore likely to exist in retirement and residential aged care facilities (Barrett, Harrison, and Kent 2009; Roach 2004). Standards of care can be compromised when staff hold negative personal attitudes towards GLBTI people. It is the responsibility of care providers to ensure staff receive adequate training which addresses sexuality in older people including diverse sexuality groups.

- **Inclusive communication**

It is important that staff use appropriate language that is respectful and aligned with how a person identifies themselves. The use of gender-neutral and non-discriminatory terminology can make GLBTI people feel comfortable and safe to disclose information that may impact on their quality of care.

- **GLBTI-sensitive practices**

Older GBLTI people in general do not feel safe to disclose their sexual or gender identity to aged care providers as a result of their past experiences of discrimination (Barrett 2008). This stems from a time when disclosure could have resulted in imprisonment, ostracism, job losses and medical interventions. Additionally concerns are raised as a large number of residential facilities are run by religious organisations (McNair and Harrison 2002). The use of GLBTI-sensitive practices enables older GLBTI people to disclose information if they so choose, which may impact significantly on having their needs met.

- **GLBTI-inclusive organisational policies and procedures**

Through specifically addressing GLBTI issues in organisational policy and procedures, organisations demonstrate their intent in having a GLBTI-inclusive environment and articulate what is expected of staff. It also limits unintentional and indirect marginalisation and discrimination of GLBTI people which can result from specific needs not being consciously considered, and a lack of awareness of relevant GLBTI issues (Irwin 2007; Tolley and Ranzijn 2006).

Service providers are urged to examine their organisational culture, practices and policy and work towards ensuring all people of minority sexualities are better understood and accepted as valued members of the community. GLBTI individuals deserve to feel safe and well accommodated in the latter part of their life. Adopting a GLBTI-inclusive framework is necessary for retirement and residential aged care service providers to achieve equity of care for all.

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ABBREVIATIONS

ABS	Australian Bureau of Statistics
ACAP	Aged Care Assessment Programme
ACAT	Aged Care Assessment Team
AIHW	Australian Institute of Health and Welfare
CACP	Community Aged Care Package
CRA	Centre for Research on Ageing (Curtin University)
DoHA	Department of Health and Ageing
DSG	Diverse Sexuality Groups
EACH	Extended Aged Care at Home
EACHD	Extended Aged Care at Home Dementia
FTE	Full Time Employment
GLBTI	Gay, Lesbian, Bisexual, Trans and Intersex
GRAI	GLBTI Retirement Association Inc
HACC	Home and Community Care
NMDS	National Minimum Data Set
PIAC	Pathways in Aged Care
RRMA	Rural, Remote and Metropolitan Areas
RAC	Residential Aged Care
TCP	Transition Care Place(s)
UN	United Nations
VHC	Veteran's Home Care
WACHPR	Western Australian Centre for Health Promotion Research (Curtin University)

GLOSSARY OF TERMS

Ageism	Stereotype of an older person based on their age rather than their individual abilities; discrimination based on age.
Ageing in place	In an Australian context, ageing in place refers to low care residents being able to remain in a low care facility as their dependence increases.
Bisexual	A person who is sexually and emotionally attracted to both males and females.
Closeted, in the closet	Concealment of one's non-heterosexual orientation. There are varying degrees of being 'closeted'. Someone may disclose their sexual orientation in their personal life however may be 'closeted' in their public life, such as at work or with their family.
Gay	Includes men whose primary sexual and emotional attraction is towards men. Can also be used as a general term for homosexual people of either sex.
Gender identity	A person's sense of being male, female, somewhere in between or neither.
Heteronormativity	Assumes that heterosexual orientation and heterosexual perspectives are the norm, and therefore disregards diverse sexual orientations and gender identity.
Heterosexual	A person whose sexual and emotional attraction is primarily towards the opposite sex.
Homosexual	A person whose sexual and emotional attraction is primarily towards the same sex.
Intersex	A person born with sex chromosomes, external genitalia or an internal reproductive system that is not exclusively male or female.
Lesbian	A female whose primary sexual and emotional attraction is towards females.
Sexual orientation	Enduring emotional, romantic, sexual and relational attraction to another person; may be a same-sex orientation, opposite sex orientation or a bisexual orientation.
Sexuality	Sexuality is about sexual feelings (who we are emotionally and sexually attracted to), sexual behaviour (how we express our sexual feelings) and sexual identity (who we say we are to ourselves and others based on our internal beliefs).
Trans	A person whose identity is at odds with their biological sex. A person who does not identify with the gender assigned to them at birth.
Transgender	An overarching term used to describe people who are non-conforming in their gender identity and expression. Transgender generally includes all trans people, however some transsexuals prefer not to use this.
Transexual	A person whose gender identity opposite to their biological sex. Many transsexuals will change their bodies through hormones and possibly surgery to better match their gender identity.

1.0 BACKGROUND

1.1 Ageing population

Australia's future population growth, distribution and age structure has significant implications for long-term policy, including service provision for health and aged care.

Defining Ageing

In this report, where relevant, age in years will be used however where age is not specified it can be assumed that in line with the Australian Bureau of Statistics' (ABS) definition of 'older people', the age of 65 years and over is inferred. Additionally the terms old and older, in line with terminology used by gerontologists, will be used interchangeably to define the target population (Shankle et al. 2003). It is important to note the possibility that some GLBTI people may require access to ageing facilities and support services earlier than the non GLBTI population as a result of their health situation. This has significant implications for Government policy and service providers (Berry 2006).

Australian ageing statistics

In line with global trends, Australia's population is ageing in both size and proportion (Drabsch 2004). In 2007 13% of the Australian population was 65 years or older. It is estimated that the proportion of people aged 65 years and older is projected to increase to between 23% and 25% by 2051 (Australian Bureau of Statistics 2008b).

Comparatively, in June 2007, 11.9% of Western Australia's population was aged 65 years and over. By 2051 it is estimated that 22.2% of the population will be aged over 65 years (Australian Bureau of Statistics 2007a).

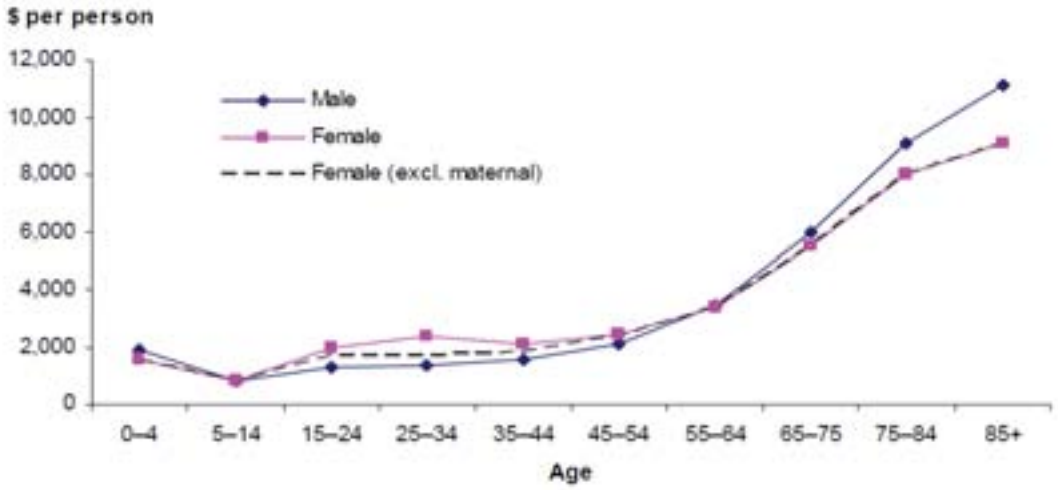
Implications of an ageing population

An increasing ageing population will impact on the world's economic and social sectors, influencing family composition and living arrangements, healthcare services, and housing requirements (United Nations 2001). One significance of such population trends is their impact on government policy and planning (United Nations 2001).

The economic impact of an ageing population in Australia is that projected spending in general is expected to exceed revenue, placing increased pressure on government expenditure in the areas of health, healthcare and aged care (The Parliament of the Commonwealth of Australia 2005). Figure 1 highlights the dramatic increase in health care expenditure per person from the age of 60 years and over and Figure 2 demonstrates the exponential rise in hospital (both admitted and out patient costs) and medication costs from the age of 60 years onwards (Australian Institute of Health and Welfare 2010).

As the Australian population ages and the number of older people increases, there will be a greater prevalence of chronic conditions with the likelihood of people living with more than one chronic illness concurrently, putting further pressure on the cost of health care (The Parliament of the Commonwealth of Australia 2005). Additionally health care costs of technological advances in treatment, techniques and equipment will increase as the population ages (The Parliament of the Commonwealth of Australia 2005).

Figure 1 Allocated health expenditure per person by age and sex, Australia 2004-05 ($)

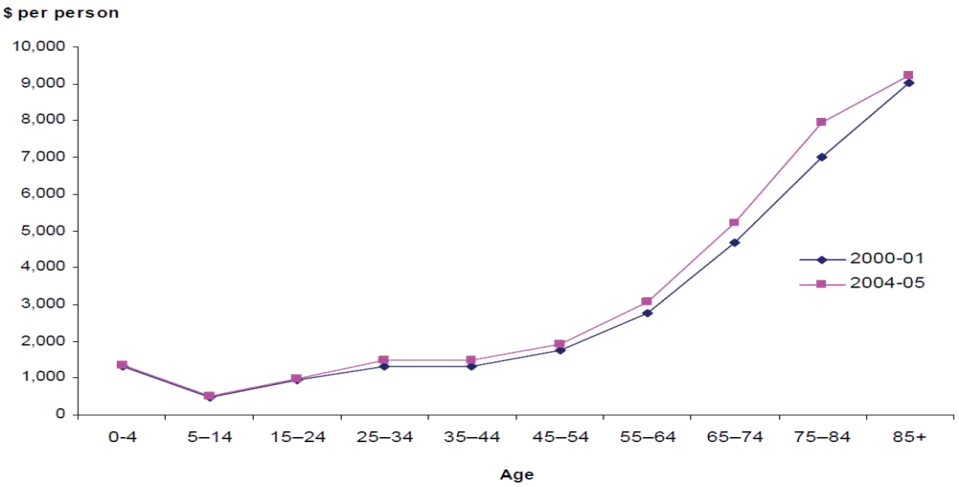


Source: Australian Institute of Health and Welfare (2010. 16)

Living arrangements and housing requirements will also be impacted. Demand for affordable, accessible and suitable housing options will increase along with the need for 'age friendly communities' which foster and support connectedness and social networks (The Parliament of the Commonwealth of Australia 2005). Furthermore, Drabsch (2004) postulates a greater number of elderly people will require accommodation with a variety of support mechanisms and there will be a greater number of people living independently in the community with family and community support. Consequently the need and demand for both formal and informal care arrangements will increase.

Currently, family and friends constitute the majority of informal (unpaid) carers (The Parliament of the Commonwealth of Australia 2005). As family structures change and people, particularly women, stay in the workforce longer, an impact on the supply of informal carers is expected into the future. This may prove problematic as there is likely to be a gap in the availability of carers compared to the number of people requiring care (The Parliament of the Commonwealth of Australia 2005).

Figure 2 Cost of hospitals admitted patients, out-of-hospital medical services, and prescription pharmaceuticals and pharmaceuticals by age



Source: Australian Institute of Health and Welfare (2010. 19)

1.2 GLBTI population

1.2.1 Historical Context

Ageing social history in Australia

Historically, the notion of older age and ageing has been an important cultural aspect for most societies, including Australia (Walker and Garton 1995). Of particular interest is how Australian's in general perceive older age, how they behave towards older people, their behaviour in their own older age and the value that older age has in Australian society (Thane 1995).

Some argue that the notion of a 'young Australia' which emerged during colonial times as a result of the nuclear family, was the beginning of ageism in Australia (Thane 1995; Peel 2001). The introduction of the 'old aged pension' in 1909 was a result of an emerging demographic known as the 'aged poor' and played a significant role in defining *old age* in Australia, as well as associating retirement with old aged (Davison 1995).

The emergence of 'the aged poor' instigated Australia's first major crisis in aged care (Davison 1995). This was a result of lower socioeconomic groups, such as manual workers, being retired from paid work between 50 and 60 years of age, as they were perceived to be unproductive beyond that, in a highly competitive market. As such it was common for ageism to exist toward people from lower socioeconomic groups (Davison 1995; Peel 2001).

Gay social history in Australia

Rosenfeld (2006) noted the importance of understanding the historical context of homosexuality, and how particular events influenced and shaped social relations, political reforms, sexuality and personal identity as we know it today. Additionally, knowledge of the impact of past experiences of homophobia provides a better understanding of the issues and unique needs of GLBTI individuals, and sets the social context for GLBTI ageing (Barrett 2008; Rosenfeld 2006).

Australia inherited its homosexual laws from the United Kingdom upon its colonisation in 1788 making homosexuality illegal in Australia and those found to be engaging in homosexual activities were prosecuted (Freeman 2004). The attitudes of society in general, towards homosexuality were ones of persecution, condemnation, hatred and discrimination, with homosexuality commonly viewed as a 'sickness, sin and disgrace' (Kimmel, Rose, and David 2006, 1). Consequently the 'gay scene', although growing, was concealed from the general population with few people disclosing their sexual orientation for fear of reprisal and/or prosecution (Kimmel, Rose, and David 2006).

Homosexuality continued to be an illegal act in Australia until 1972, when South Australia was the first Australian state or territory to decimalise male homosexuality (Bull, Pinto, and Wilson 1991). Other states followed over the next two decades, and finally in 1997 Tasmania became the last Australian state to decriminalise sex between consenting adult men in private (Bull, Pinto, and Wilson 1991).

In 1973 both the American Psychiatric Association and the American Psychological Association removed homosexuality from the Diagnostic and Statistical Manual of Mental Disorders (Kirby 2003). In late 1973, the Federal Council of the Australian and New Zealand College of Psychiatrists approved a clinical memorandum stating that homosexuality was not a psychological illness (Barr and Catts 1976). This was a significant breakthrough as homosexuality was no longer labelled as a psychiatric disorder which needed to be 'cured', although there remained a minority of practitioners who continued to offer a 'cure'. Today there are still a number of organisations, who promote reparative or conversion therapy. The majority of these tend to be religious groups such as "Homosexuals Anonymous, Metanoia Ministries, Love in Action, Exodus International and EXIT of Melodyland" (Kenji 2002. 800). The main secular organisation in the US advocating conversion

therapy is the mental health organisation National Association for Research and Treatment of Homosexuality (Kenji 2002).

Of significance was the impact of HIV/AIDS in the 1980s on active homosexual males and gay communities worldwide. This redefined the notion of activism to include 'the care and support of the ill, and the mourning, celebrating and commemorating the impact of the disease upon the community' (Willett 2000, p192). Activism also took on lobbying for more research into HIV/AIDS. During this time gay activism in the form of protest changed to celebration, although occasionally marked with violent clashes with police, and gave rise to what is now known as Mardi Gras.

Considerable progress has been made in regard to law reform and broader gay and lesbian rights into the 21st century, as well as a shift in the general population's attitudes and acceptance of diverse sexual orientations. For trans and intersex individuals progress has been limited. In Australia, the Federal Government recently amended its laws to legally recognise same-sex de facto couples, however have not progressed further to allow same-sex marriage. Nor has the Federal Government provided comprehensive protection from discrimination based on sexual orientation, gender identity or relationship status.

Notwithstanding the advances made in the last 40 years, there is still a considerable amount of work to be done in building understanding, tolerance and acceptance of diversity by the general population.

There also remains to be considerable work in understanding the specific health difference between people of a diverse sexual orientation or gender identity, compared with the general population. These health indifferences are discussed further in section 2.4 of this report.

This was illustrated globally when the United Nations, in December 2008, announced that 66 nations supported the inclusion of sexual orientation and gender identity in its Universal Declaration of Human Rights. However it is estimated that there are over 76 countries which still retain laws where consensual sex between same-sex adults is a criminal offence (Ottosson 2010). In Iran for example, punishment of a homosexual act is death. In 2005 two men were executed for acts of homosexuality and three men under the age of 18 years are awaiting execution for carrying out homosexual acts in 2009 (Human Rights Watch 2009). In Malawi in May 2010 a gay male couple were sentenced to 14 years imprisonment with hard labour after they undertook a symbolic wedding ceremony. They were charged with sodomy and indecency for committing unnatural acts but later received a presidential pardon (Geoghegan 2010).

A more comprehensive overview of gay social history in Australia is outlined in Appendix A.

Peel (2001) noted the existence of ageism in the general population however there is limited research in Australia concerning the existence of ageism within the GLBTI population. The limited existing research highlights contradictions to the assumptions and stereotypes of GLBTI people growing old alone and without social and support networks (Kean 2006). Harrison (2004) suggests that some research indicates the existence of ageism within the GLBTI population, however also identifies other findings which challenge the notion. According to Harrison (1999) this highlights the fluidity and complexity of ageism within the context of the GLBTI population.

1.2.2 Defining the GLBTI population

For the purposes of this report, the GLBTI population refers to diverse sexuality groups whose "sexualities and/or gender identities fall outside the traditional heterosexual norm" (Zirngast 2002. 1). It is recognised that the GLBTI population is not homogeneous and that sub populations and diversity exist. Other terminology used include: queer, transsexual, gender queer, gender non-conforming and minority sexuality groups (Couch et al. 2007). For the purposes of this report the term GLBTI will be used as a representation of all sub groups within this target group.

It is difficult to estimate accurately the proportion of the population who identify as GLBTI for a number of reasons. There is very little data being collected on sexual identity within current research (Berry 2006). The Australian 2006-07 Census identified 27,000 same-sex couple families living in Australia during that period (Australian Bureau of Statistics 2009b). The Australian Government (2009) cautions that this figure may under report the number of same-sex couples living together and noted that identifying the number of same-sex couples is not representative of the GLBTI population. Additionally, many GLBTI individuals may not feel comfortable identifying in a public arena due to fears of discrimination and homophobia. Consequently, the entire GLBTI population as a whole remains relatively invisible.

In the USA, studies from the Kinsey Institute estimate that 10% of the male population identify as gay and 5%-6% of the female population identify as lesbian (McNair and Harrison 2002). The Study *'Sex in Australia: Australian study of health and relationships'* approximates that 97% of Australian males identify as heterosexual, 1.6% as homosexual and 0.9% as bisexual, and 97.7% of females identify as heterosexual, 0.8% as lesbian and 1.4% as bisexual (Smith et al. 2003).

These figures do not include those who are transgender, transsexual or intersex.

Peerson (2009) estimates that in the United States (US) 1 per 30,000 adult men and 1 per 100,000 adult women seek gender reassignment surgery and that the rates are higher in other countries such as the Netherlands. These figures exclude those trans individuals who do not undergo or seek reassignment surgery. The number of intersex individuals in the US is difficult to estimate due to the invisibility of this population and the inconsistent criteria used to define intersex (Fausto-Sterling 1999). For example Fausto-Sterling (1999) estimate 1.7% of the population in the US are intersex individuals, however using a different criteria to evaluate intersex, Sax (2002) claims the truer figure is much lower at 0.018%. Furthermore, GLBTI populations have been categorised through self identifying, adding to the challenge of accurate data collection.

The fluidity of sexuality further complicates data collection as identity, attraction and behaviour are complex and changing; and there is not always consistency between the three (Hillier, Turner, and Mitchell 2005; McNair and Harrison 2002; Smith et al. 2003). Despite the difficulty in ascertaining accurate data on the size of the GLBTI population, it is feasible to suppose that the number of ageing GLBTI people will increase in line with global and national ageing trends. Using the generally accepted figure from the Kinsey Institute, it can be extrapolated that between 492,300 and 1.7 million people in Australia identify as GLBTI (approximately 8% of older adults)[1].

1 These figures have been extrapolated based on the Australian population of 22 million with males accounting for 49.5% and females 50.5%. The lower prevalence has been calculated using the Sex in Australia study where 3% of males and 2.3% of females identified as non-heterosexual. Also included is the US prevalence of those males and females seeking gender reassignment. Those identifying as intersex have not been included.

The higher prevalence has been calculated using the Kinsey Institute's estimate of 10% of the males and 5.5% of the females identifying as gay and lesbian. The higher prevalence does not account for those identifying as trans and intersex as this data is difficult to ascertain.

1.2.3 Implications of an ageing GLBTI population

It is important to note, that as diversity exists within the older GLBTI population stereotypical characteristics of older gay people (loneliness, isolation, mental health issues, exclusion) may exist for some older gay people, however they may not apply to the GLBTI population as a whole.

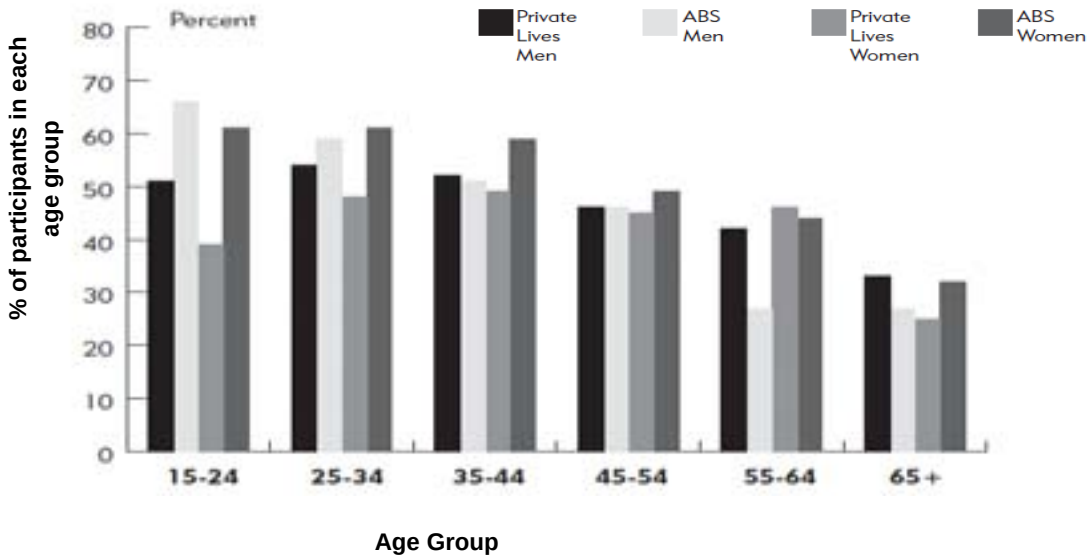
In addition to the usual issues facing older adults, such as loneliness, isolation, loss of autonomy and increasing dependence, older GLBTI individuals may experience additional stressors (Meyer and Northridge 2007). These are usually associated with sexual orientation, disclosure to health care providers, discrimination, lack of legal recognition, little if any protection of lifetime partnerships, and limited opportunities to meet other older GLBTI people (Equality South West 2006; Meyer and Northridge 2007).

This is evident in the report *Private Lives: a report on the health and wellbeing of GLBTI Australians*, where Pitts et al. (2006) compare the general health of the wider population using the *ABS National Health Survey 2001* with the participants of the *Private Lives* study. The disparity in self rated health status as excellent/very good, between GLBTI and the wider population was significant particularly in the 15-24 year age group. Interestingly as participants became older, the disparity between the two groups converges (Figure 3). The *Private Lives* study supposes that this is due to participants establishing social support networks and developing confidence in their sexual orientation over time. This notion was supported by findings in the *Gay and Grey in Dorset* report (Equality South West 2006) where the majority of participants felt that as they became older their confidence increased when discussing their sexuality and they had developed good social networks and friends to support them.

However, the same participants did report that there are some negative aspects of becoming older and these were the continuing fear of homophobia and consequently the fear of being isolated as a result (Pitts et al. 2006). Other research supports this, highlighting that in comparison to older heterosexuals, older GLBTI people are two and a half times more likely to live alone, twice as likely to be single and over four times as likely to not have children (Keogh, Reid, and Weatherburn 2006). As a consequence older GLBTI individuals may experience greater isolation, loneliness, lack of traditional family support and lack of recognition of partners (Keogh, Reid, and Weatherburn 2006). Many older GLBTI people have been exposed to ongoing discrimination and homophobia as a result of their sexual orientation, and as a consequence do not access health care services as they fear disclosing their sexuality to health professionals (Gay and Lesbian Medical Association 2001).

As with the general population, a greater number of older GLBTI people will require accommodation with a variety of support mechanisms and there will be a greater number of GLBTI people living independently in the community. Consequently the need and demand for both formal and informal care arrangements for GLBTI people will also increase. While GLBTI people may have strong social networks, they may not have the same family support as their heterosexual counterparts and consequently may have a greater reliance on service providers for the provision of aged care (Keogh, Reid, and Weatherburn 2006).

Figure 3 GLBTI self rated health status as good/very good compared to the Australian population



Source: Pitts et al. (2006. 29)

1.3 Accommodation and housing

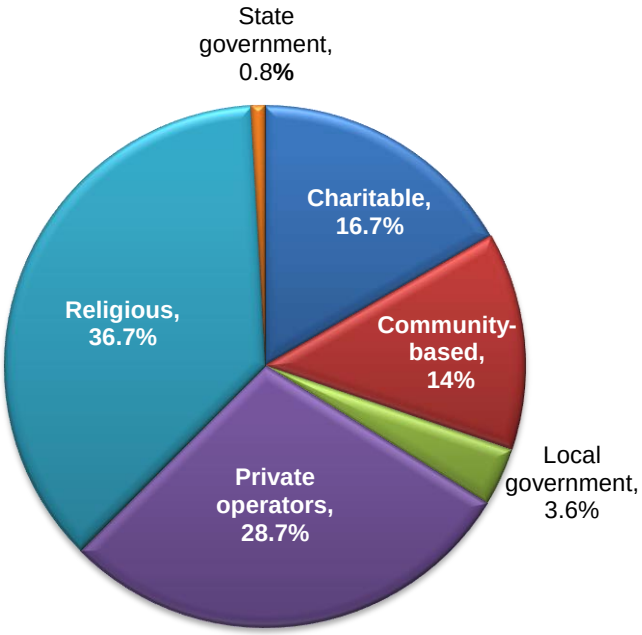
1.3.1 Current aged care accommodation options

Service providers

The Australian Government, private enterprise and non government agencies provide accommodation options for older Australians. Currently the Australian government funds over 17 different age related community care programmes, in addition to residential and respite accommodation (Australian Institute of Health and Welfare 2009a). Private enterprise providers also offer community care, residential care and respite services.

Nationally, the providers of residential care services are: religious organisations (28.5%), private operators (27.9%), community-based providers (16.8%), charitable organisations (15.5%), local government (2.3%) and state government (9%) (Australian Institute of Health and Welfare 2009b). Comparatively, residential care services in Western Australia are provided by: religious organisations (36.7%, private operators (28.7%), charitable organisations (16.7%), community-based providers (13.5%), local government (3.6%) and state government (0.8%). Figure 4 demonstrates the providers of residential aged cares in Western Australia.

Figure 4 Type of organisation providing residential aged care services in Western Australia as at 30 June 2008



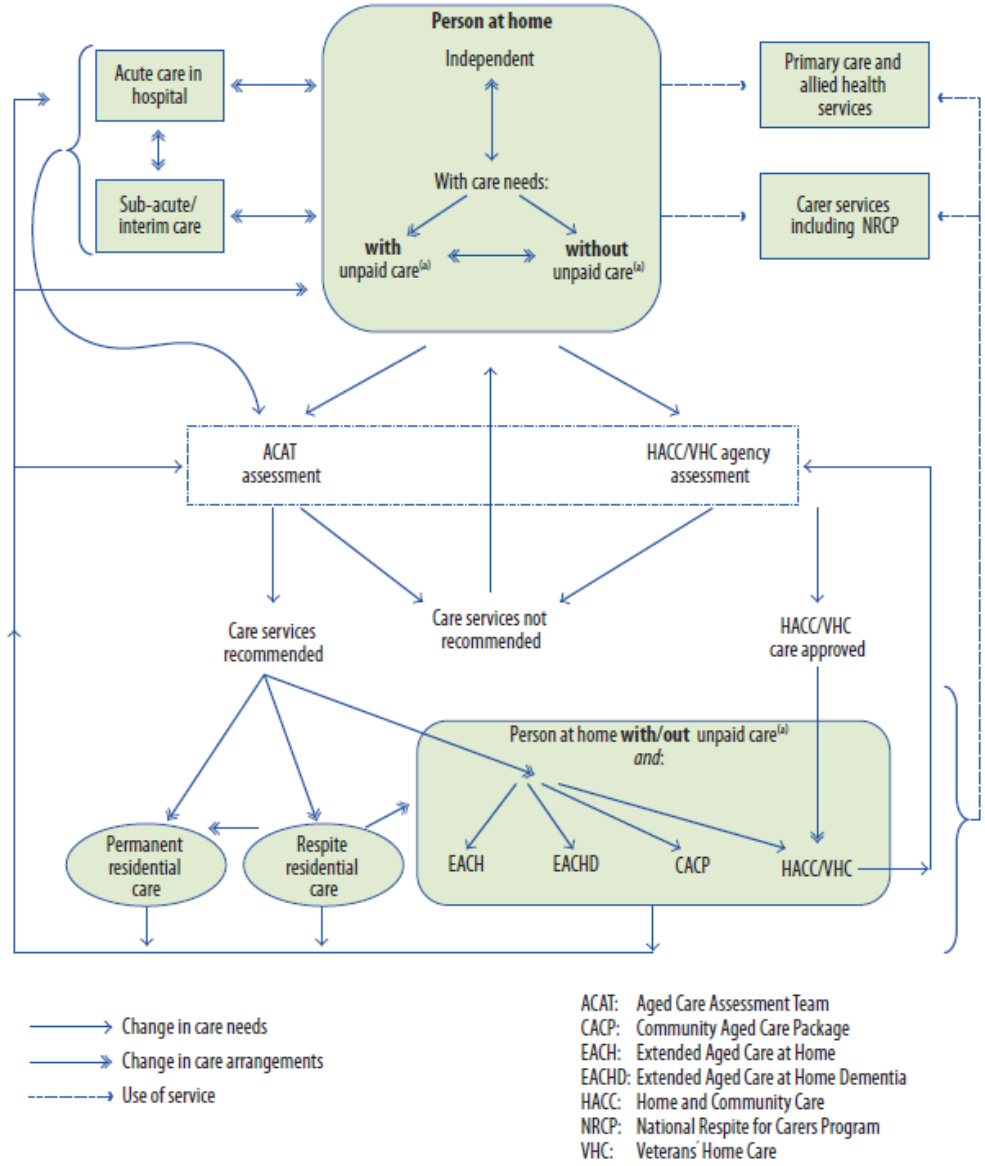
Source: Australian Institute of Health and Welfare (2009b).

Possible pathways

Accessing of aged care services is fluid according to changing needs. This coupled with the diversity of available care programmes make pathways to accessing aged related services complex (Australian Institute of Health and Welfare 2009a). Figure 5 captures the complexity of the possible pathways to aged care services through the Australian aged care system.

The number of community care packages available to older people is designed to make it possible for individuals to reside in their own home for longer (Australian Institute of Health and Welfare 2009a). Further to community care options, other pathways available to older Australians are through independent living accommodation, such as retirement villages and residential care. Residential care services include permanent accommodation (offering both high and low care) and temporary accommodation (respite). According to the Australian Institute of Health and Welfare (AIHW) (2009a) the most common pathway chosen by older people in their study was the 'no change' path, where accommodation status remained unchanged, that is to remain at home. They also found that other major pathways used by a large proportion of their cohort were that of permanent residential care only (23%) and access to community care services (14%). Access to age care programmes increased as a person became older however 8% of the cohort did not access any programme services prior to dying (Australian Institute of Health and Welfare 2009a).

Figure 5 Possible movements through the Australian health and aged care system (2003–04)



(a) Excluding payments from government pensions and benefits.

Note: Figure includes selected government-funded programs only, for 2003–04.

Source: Australian Institute of Health and Welfare (2009a. 4).

Usage of services

Understandably, usage of residential aged care services increases as people become older and their health fails. The AIHW (2009b) state that in 2008, in the 85 years and older age group there were approximately 235 persons per 1,000 people accessing permanent residential aged care and represented over half of the people accessing residential aged care (55%). Of these, 71% were female and those females in permanent care were twice as likely to be widowed and less likely to be married or in a de facto relationship, compared with males in permanent care (Australian Institute of Health and Welfare 2009b).

Nationally 65% of people using community aged care packages (CACP) in 2008 were aged 80 years and over and 16% were aged 90 years and over (Australian Institute of Health and Welfare 2009c). As with residential care, a greater proportion of CACP's were accessed by females aged 75 years and over (59%). Females also tended to be older than their male counter parts with a median age of 84 years compared to 82 years (Australian Institute of Health and Welfare 2009c).

Usage trends

The number of available services in both residential and community aged care is increasing in line with Australia's increasing ageing population. This is also reflected in the length of time services are used. The length of stay in residential aged care accommodation continues to increase from 131 weeks in 1998-1999 to 148 weeks in 2007-2008, with women spending more time in residential aged care (170 weeks) compared with their male counterparts (110 weeks) (Australian Institute of Health and Welfare 2009b).

1.3.2 Australian aged care policy and legal issues

Aged care policy

Australia's ageing policy aims to provide a range of support services for older Australians, as well as encourage individuals to be financially independent as they become older (Department of Health and Ageing 2008). It has been developed in the context of "retirement income support, workforce, housing, social inclusion and medical, health and aged are services" (Department of Health and Ageing 2008). The two main pieces of federal legislation governing aged care services and programmes in Australia are the Aged Care Act (1997) and Home and the Community Care Act (1985).

These Acts govern the provision of residential aged care plus home and community services. They also address issues such as planning, approval and responsibilities of service providers, subsidies, funding for service providers and financial assistance for recipients. Furthermore new places are allocated to service providers based on their ability to meet the care needs of the community, including those with special needs (Department of Health and Ageing 2008).

The legislation identifies community groups considered as having special needs as:

- people from Aboriginal and Torres Strait Islander communities;
- people from non-English speaking backgrounds;
- people who live in rural or remote areas;
- people who are financially or socially disadvantaged; and
- a veteran of the Australian Defence Force or of an allied defence force; or their spouse, widow or widower (Department of Health and Ageing 2008).

Of note is the absence of GLBTI individuals in the legislation's definition of special needs groups. Consequently older GLBTI individual's rights are protected under the general sections of the legislation. The Charter of Residents' Rights and Responsibilities protects a person's "personal

privacy" and stipulates the right to "select and maintain social and personal relationships with any other person without fear, criticism, or restriction" (Department of Health and Ageing 2007a). The Guidelines for Compiling Assessment Data outlined in the DoHA's Documentation and Accountability Manual, assist nursing staff to identify residents' needs, wants and expectations. Items listed to be reviewed include sexuality, gender sensitivities and the need for intimacy/privacy (Department of Health and Ageing 2007b). Ironically, as Bauer, Nay and McAuliffe (2009) highlighted, even though these issues should be considered by nursing staff carrying out assessments, guidance is not provided to staff on how to respond to, or consider these specific needs in the daily provision of care.

Additionally, the National Programme Guidelines for Health and Community Care (HACC) 2007 identified community groups deemed to have specific needs. Once again GLBTI people were omitted.

Issues of equity and access to HACC services are addressed through principles which service providers should follow. Relevant to GLBTI individuals is the principle of 'without discrimination' – indicating that eligible people have access to services without discrimination on the grounds of sexual preference (Commonwealth Government 2007a).

Adding to the invisibility of GLBTI individuals in aged care policy is the exclusion of discrimination based on sexuality in the Australian Government's Code of Ethics and Guide to Ethical Conduct for Residential Aged Care (Harrison 2002). The committee responsible decided individual providers could add a non-discriminatory clause based on sexuality, sexual preference and expression, at their own discretion (Harrison 2002).

Legal Issues

Ageing policy and legislation in Australia generally disregard the unique needs of GLBTI people. Where mentioned, GLBTI issues are addressed under general non-discriminatory and equal opportunity policies, rather than in the context of a specific needs group.

GLBTI legislative reform has occurred over a number of years with the first significant change being the decriminalisation of male homosexuality in South Australia in 1972 and the declassification of homosexuality as a psychiatric disorder by the American Psychiatric Association and Australian and New Zealand College of Psychiatrists in 1973. Female homosexuality was not formally recognised or illegal, however lesbians did experience homophobic abuse and discrimination (Ministerial Advisory Committee on Gay and Lesbian Health 2003). Following the decriminalisation of male homosexuality, amendments to anti-discrimination laws began with the outlawing of discrimination based on sexual orientation and gender identity. Male homosexuality was removed from the International Classification of Diseases register in 1999, however transexualism and gender identify disorders still remain (Ministerial Advisory Committee on Gay and Lesbian Health 2003).

In 2009 the Australian Government introduced the Same-sex Relationships Act, which removed discrimination against same-sex couples, ensuring the same rights as opposite-sex couples (Department of Health and Ageing 2009).

Changes occurred in the following health and ageing legislation:

- Aged Care Act 1997,
- Health Insurance Act 1973,
- National Health Act 1953,
- Prohibition of Human Cloning for Reproduction Act 2002; and
- Research Involving Human Embryos Act 2002.

These changes impact on tax, superannuation, social security and family assistance, aged care, Medicare, child support, immigration, citizenship and veterans' affairs (Department of Health and Ageing 2009).

Despite the introduction of the Same-sex Relationships Act, it is still not possible for same-sex couples to legally marry under Australian law. A number of states however have made legislative changes to allow commitment ceremonies and the listing of same-sex relationships on the state's relationship register (Attorney-General's Department 2009).

Centrelink

Up until the introduction of the Australian federal government's Same-sex Relationships Act in 2009, same-sex couples were unrecognised and consequently ineligible to claim the same government benefits as opposite-sex couples.

Progress has been made with the introduction of the Same-sex Relationships Act. Advocates and GLBTI elders argue however that the implementation process of the Act has been unsympathetic to the needs of older GLBTI people who are already receiving or about to apply for the Aged Pension. Some argue that the government's implementation process and lack of a grandfather clause, ironically continues to discriminate against GLBTI individuals (Horin 2008). As Horin (2008) highlights other significant changes to social security legislation has included a grandfather clause which protects those people already in the system from negative consequences of legislative change. In the case of the Same-sex Relationships Act, this means that GLBTI couples already on an aged pension will be substantially financially disadvantaged as their income is reduced. Additionally, as the legislation is being implemented without an extended phase-in period, older GLBTI couples entering into retirement will not have time to adjust their plans to ensure their financial security (Horin 2008). Also of concern is the stress and anxiety which older GLBTI people may now experience as a result of the new legislation. Having lived their lifetime concealing their sexual identity, they and are now required to disclose their sexual identity to government agencies (Birch 2009).

Some general legislative progress has been achieved albeit it slowly. However future development of aged care policy and legislation in Australia must recognise GLBTI individuals as a group with specific needs. Only then can any real progress be made to meet the needs of an ever growing older GLBTI population (Harrison 2002).

2.0 RETIREMENT AND RESIDENTAL AGED CARE FOR OLDER GLBTI PEOPLE

2.1 Major studies

International studies

Historically, the United States of America (US) has led the way in GLBTI research. As a consequence, the US has been instrumental in undertaking research which explores the needs of ageing GLBTI individuals. Despite this, there is still limited research and data collected on the diversity within GLBTI communities, particularly older GLBTI people (Grant et al. 2010). It is important to note the diversity that exists in the GLBTI community and that findings across major studies will be specific to the context in which they have been carried out in. However, upon close examination of some of the major studies (Table 1), emerging key themes can be identified. These key themes can be found in Table 1 in italics and include the impact of historical experiences of discrimination and homophobia, current experiences of discrimination, invisibility, ageism, access to care, concealment of identity and quality of care.

Good social support is vitally important for older people. This is even more so for ageing GLBTI individuals as they are often estranged from their biological family and are more likely to live alone (Grant et al. 2010). Consequently social support often comes from close friends, frequently referred to as 'families of choice' (Equality South West 2006; Grant et al. 2010; Heaphy, Yip, and Thompson 2004).

Ageism in the general community is prevalent. Younger people are portrayed as being innovative, productive and contributors to society, whereas older people are often perceived as being a drain on resources with their skills and contributions undervalued (Grant et al. 2010). The GLBTI population is no different, and according to Grant et al. (2010), ageism in the gay and bisexual male domain has a significant impact on self esteem and self worth.

Another theme which strongly emerges from the literature is the impact of historical experiences of discrimination. GLBTI people who are currently accessing aged care services have lived in an era where there was a real threat of losing their job, family and friends, and risking imprisonment and 'medical cures' if they disclosed their sexual identity (Barrett 2008). Consequently identity concealment and invisibility is a real issue and manifest as ongoing fear of discrimination and suspicion of government institutions (Brotman, Ryan, and Cormier 2003). This creates further marginalisation and stress on individuals as they continually conceal their sexual identity (Barrett 2008).

Also emerging from the literature is the notion that GLBTI individuals are less likely to access health care services for fear of discrimination and homophobic attitudes by providers and carers. Consequently some older GLBTI do not seek health care or disclose their sexual identity to health care providers which can result in their medical needs remaining unmet.

Finally the research highlights that older GLBTI people fear that homophobic attitudes by health care service providers will impact on the quality of care they receive. Barrett (2008) concludes that inadequate quality of care can result from: staff's personal value and belief systems impacting on their service delivery, lack of knowledge of anti-discrimination laws and legal responsibilities, and insufficient support/guidance from management.

Table 1 Key International GLBTI Ageing Studies

Author(s)/year	Title	Key Findings
Hays, T. V. Fortunato V. Minichiello (1997)	Insights Into The Lives of Gay Older Men: A Qualitative Study With Implications For Practitioners	• Few participants had positive relationships with their families and relied on friends and partners for support • Gay males are a growing visible minority group • Participants rarely disclosed their sexuality with health care providers as a result of their past experiences of discrimination by health care providers
Herdt, G. J. Beeler,& T. Rawls (1997)	Life Course Diversity Among Older Lesbians and Gay Men: A Study In Chicago	• *Historical experiences of homophobia* – a number of participants, particularly those over 51 years of age had some lingering impact of homophobia • *Current experiences of discrimination* – many participants experienced discrimination as a result of their sexual identity • *Invisibility* - 2/3 of participants hide their sexual identity at work • 2/3 of participants identified that they have a 'family of choice' rather than a biological family
Beeler, J. T. Rawls, G. Herdt & B. Cohler (1999)	The Needs of Older Lesbians and Gay Men in Chicago	• 68% of respondents had a 'family of choice' • 18% of respondents had experienced homophobic employment discrimination • 47% of respondents had experienced homophobic verbal abuse • 59% of respondents were either moderately or highly involved in the gay/lesbian community • Diversity within the older gay man and lesbian population needs to be recognised by service providers • The social context in which services are provided is an important consideration as the 'gay/lesbian community' is not always united and is heterogeneous
Brotman. S, B. Ryan & R. Cormier (2003)	The Health and Social Service Needs of Gay and Lesbian Elders and Their Families in Canada	• *Historical experiences of discrimination* – older gay men and lesbians often mistrust health care providers as a result of experiences throughout their life of marginalisation and oppression • *Current experiences of discrimination* – participants reported overt homophobia towards gay men and lesbians, consequently making them fearful of victimisation and discrimination within aged care 'systems' • *Invisibility* – past and current experiences of discrimination manifest in older gay men and lesbians concealing their identity, consequently further marginalising them and excluding them from social policy development • *Ageism* – participants reported that there was a perception that older people are asexual therefore making it more difficult to talk about older peoples sexual activity and sexuality
Heaphy, B. A. Yip & D. Thompson (2004)	Ageing in a Non-Heterosexual Context	• 52.9% of the women and 48.8% of the men agreed with the statement that 'my friends are my family' • 41% of female and 65% of male participants lived alone – this figure increased slightly with age • 50% of female and 30% of male participants indicated that their partners would be the primary care providers when the need arose – very few expected family members to take on this role

Author(s)/year	Title	Key Findings
MetLife Mature Market Institute (2006)	Out and Aging: The MetLife Study of Lesbian and Gay Baby Boomers	• 1/3 of participants said they were unaware of who would care for them as they aged • More than 3/4 of participants had important connections with 'families of choice' • 27% of respondents were concerned about discrimination as they aged • Participants were concerned about discriminatory and insensitive treatment by health care providers
Jackson, N. M. Johnson & R. Roberts (2008)	The Potential Impact of Discrimination: Fears of Older Gays, Lesbians, Bisexuals and Transgender Individuals Living in Small-To Moderate-Sized Cities on Long-Term Health Care	• *Current experiences of discrimination* – both heterosexual and non-heterosexual respondents acknowledged homophobic discrimination existed in long term care facilities • *Access to care* – 39% of GLBT respondents believed that there was equal access to care for GLBT and heterosexual individuals • The overall finding was that GLBT individuals fear discrimination and anticipate discrimination against them in health care settings
Meri-Esh, O. & I. Doron (2009)	Aging With Pride in Israel: An Israeli Perspective on The Meaning of Homosexuality in Old Age	• *Concealment of identity* – participants felt oppressed and isolated as a result of having to conceal their identity and pass as heterosexual • *Ageism within the general community* – there is a general negative attitude towards older people in Israel. Participants in the study felt that they were doubly discriminated against as a result of ageism in the general community as well as homophobia • *Ageism within the gay community* – participants felt rejected and alienated when they mixed with the gay community at large, for example when attending mixed age events and gay clubs
MetLife Mature Market Institute (2010)	Still out, still aging: MetLife study of lesbian, gay, bisexual and transgender baby boomers	• GLBT baby boomer's fears about ageing include: finances, end of life care, ageing in place and care giving. • Few feared discrimination based on sexual orientation and/or gender identity by care providers • Family acceptance of their sexual orientation and/or gender identity is high • Relationship recognition in terms of marriage are important to couples • 'families of choice' are important to GLBT people and often supplement 'biological families' • Over half of the participants indicated that they are confident that health care professionals will treat them with respect and dignity regardless of their sexual orientation and/or gender identity • Gay, bisexual and transgender men are nearly twice as likely to provide weekly care than their heterosexual counterparts • Experiences of bisexual men and women differ from those of lesbian, gay and transgender people

Australian studies

Historically in Australia, GLBTI ageing issues have received little attention in gerontology research, aged care policy, training, education, and interventions (Harrison and Riggs 2006). Recently however a growing body of research has emerged from Australia which is grounded in the perspectives and experiences of older GLBTI people (Harrison and Riggs 2006). Of significance is the ability for interventions (advocacy, education and training, policy) to address the real issues experienced by GLBTI people, and not the heterosexual assumptions made by researchers and policy makers (Harrison and Riggs 2006).

In line with international studies, a major theme identified in Australian studies is that past experiences of homophobia and discrimination play a significant role in a GLBTI person's health seeking behaviour and interactions with aged care service providers (Addis et al. 2009). Additionally some older GLBTI adults experience ageism from both within the GLBTI population and the general population, which further contributes to marginalisation and invisibility (Addis et al. 2009). Furthermore, heteronormativity has a strong presence within aged care policy making which promotes invisibility and marginalisation of GLBTI people (Phillips and Marks 2006).

Table 2 identifies some of the major studies in Australian GLBTI gerontology and summarises the key findings. Themes which strongly emerge from the key findings and issues can be summarised as: heteronormativity, homophobia/discrimination, ageism, invisibility, quality of care and accessing of health services. Recurring themes in Table 2 are italicised.

Table 2 Key Australian GLBTI ageing studies

Author(s)	Title	Key Findings
Harrison, J. (1999)	A Lavender Pink Grey Power: Gay and Lesbian Gerontology in Australia	• *Heterosexism/homophobia* – gay and lesbian participants experienced heterosexist and homophobic attitudes within the aged care sector in addition to in the general population • *Ageism* – gay and lesbian participants indicated that to an extent there were negative attitudes toward ageing in gay and lesbian communities • *Invisibility* – participants made reference to current invisibility of older gay and lesbians in the aged care context
Chamberlain, C. & P. Robinson (2002)	The Needs of Older Gay, Lesbian and Transgender People	• *Heterosexism/homophobia* – most of the GLBTI population surveyed believe that GLBTI people have specific needs • *Ageism* – Respondents who were single, working class and male experienced isolation and loneliness, as well as ageism in the gay sub-culture
Harrison, J. (2002)	What Are You Really Afraid Of? Gay, Lesbian, Bisexual, Transgender and Intersex Ageing, Ageism, and Activism	• *Invisibility* – as a result of invisibility, GLBTI issues remain unacknowledged and hidden. Invisibility is also contributing to GLBTI elder abuse in supported aged care service • *Concealment of identity* – disclosure of sexual orientation and identity in unsympathetic environments is an underlying theme throughout Australian literature

Author(s)	Title	Key Findings
Ministerial Advisory Committee on Gay and Lesbian Health (2003)	Health and Sexual Diversity: A health and Wellbeing Action Plan for Gay, Lesbian, Bisexual, Transgender and Intersex (GLBTI)	• *Current experiences of discrimination* – the impact of heterosexism on GLBTI include: violence, discrimination and social marginalisation, isolation and invisibility • *Historical experiences of discrimination* – can lead to health problems and access to quality health care
Birch, H. (2004)	About time!: GLBT seniors ALSO matter	• *Historical experiences of discrimination* – impact on GLBTI individuals accessing health, housing, community and aged care services. Experiences of homophobia displayed by health care providers negatively impacts on GLBTI individual's accessing health care • *Quality of care* – the assumption of heterosexuality and gender identity impacts on the service of care provider to GLBTI older people as their unmet needs remain unaddressed
Harrison, J. (2005)	Pink, Lavender and Grey: Gay, Lesbian, Bisexual, Transgender and Intersex Ageing in Australian Gerontology	• GLBTI issues include: *invisibility*, *isolation*, support networks, homophobic services, policy and law reform, training of staff, ageism and activism
Hughes, M. (2005)	Sexual Identity In Health and Aged Care	• *Historical experiences of discrimination* – impact on GLBTI older people's preparedness to access health and aged care services • As a population GLBTI people experience higher rates of chronic illness • Gay men experience higher rates of HIV and other STIs than the general population • GLBTI people have expressed concerns about *social isolation* as they become older
McNair, R. & N. Thomacos, (2005)	Not Yet Equal	*Current experiences of discrimination* • Almost 20% of the GLBTI respondents in this survey had received explicit threats • 20% of respondents experienced discrimination from health care providers as a result of their same-sex relationship

Author(s)	Title	Key Findings
GRAI (2007)	Older Gay and Lesbian People: Establishing the Needs	• *Heterosexism/homophobia* – there is a perception among GLBTI individuals that aged care facilities have homophobic attitudes • *Invisibility* – participants made reference to feeling like they would need to be constantly 'on guard' if they were living in aged care facilities • *Specific needs* – participants mentioned that accommodation facilities must be prepared to acknowledge differences and cater for needs of older GLBTI people • *Quality of care* – participants believed there was insufficient training of staff on specific needs of GLBTI residents
Barrett, C. (2008)	My People	• *Historical experiences of discrimination* impact on GLBTI elders. They have lived in an era where disclosing their sexuality could have resulted in imprisonment, loss of employment, ostracism by community family and/or friends, and the possibility of being subjected to curative medical treatment • *Current experiences of discrimination* can result in invisibility as GLBTI older people are likely to hide their sexuality/gender identity as a result of being fearful of discrimination, sub standard quality of care and misunderstanding by health care service providers • *Concealment of identity (invisibility)* can have negative impacts on GLBTI older people, manifesting as depression, anxiety, stress and the feeling of being undervalued • Inadvertent visibility impacts on older GLBTI people who cannot conceal their gender identity. Subsequently they need to be in a safe space free from discrimination by staff, other residents and visitors • Dementia – older GLBTI people need to be in a safe space where staff understand that they experience the same sense of loss and grief as heterosexual elders • Sexual and cultural expression is important for positive mental health, and older people need to be enabled to have privacy, sexual expression and physical touch • *Quality of care* – inadequate quality of care can result from staff being unaware or their legal obligations; their personal values and belief systems; lack of knowledge of anti-discrimination laws and lack of support/guidance from management • *Creating a safe space* – can result in GLBTI older people feeling valued, understood and safe

Author(s)	Title	Key Findings
Barrett, C., J. Harrison & J. Kent. (2009)	Permission to Speak	• *Ageism and homophobia* – perceived by the GLBTI community is reflected in the views of aged care service providers interviewed • *Sexuality* – aged care service providers view older people as asexual and they are not expected be sexually diverse. It is not uncommon for libido suppressants to be used within residential care facilities to curb sexual expression • *Specific needs* – service providers did not expect older GLBTI people to have any specific needs • GLBTI older people in residential services – care providers were unsure of how to manage and support GLBTI residents in shared accommodation facilities • Transgender – service providers expressed their concerns about the industry's readiness to support older trans people to maintain their identity
Hughes, M. (2010)	Expectations of Later Life Support Among Lesbian and GAY Queenslanders	• *Emotional support* in later life for most respondents was expected to come from partners, LGBT friends and heterosexual friends; extended family (29.4%); 25.6% from siblings; 15.1% from children and 4.9% from neighbours • *Physical support* in later life for most respondents was to come from partners (53.6%); LGBT friends (36.4%); heterosexual friends (24.8); extended family (19.7%); siblings (15.9%); children (12.7%) and neighbours 3.5%. • Most respondents anticipated being self reliant in terms of *financial support* in later life (62.3%); 46.6% anticipated relying on government support, 36.9% from partners; 6.2% from siblings; 7% from extended family; 4.9% from their children; and 2.4% from LGBT friends or heterosexual friends(1.9%) • *Socialisation* – 69.3% identified LGBT friends as those who the expected to socialise with in later life; 62% with heterosexual friends; 56.9% with their partner; 33.4% with extended family; 25.9% with siblings; 17.8% with their children; and 8.4% expected that they would have no one. • *Living arrangements* - 59.3% identified their partners as the most likely person they would be living with in older age; 25.1% identified LGBT friends; 10% with heterosexual friends; 4.6% with their children; 3.2% with their extended family and 0.5% with their neighbours

2.2 Current practices and attitudes - aged care industry

State and federal legislation guide the practices of residential aged care service providers. As such, practices across the industry work within similar governance frameworks. While there are good practices in some facilities, the providers of residential aged care are not a uniform group and consequently differences in practices and attitudes will exist.

Generally speaking, Australian gerontology and the aged care industry operate within a heteronormative framework, disregarding diverse sexual orientations and sexual identity (Harrison 2005; Phillips and Marks 2006). Additionally the aged care industry generally employs the notion that older people are asexual and that matters of sexuality are private (Hamburger 1997; Hughes 2004).

Heteronormativity

Heteronormativity assumes that heterosexual orientation and heterosexual perspectives are the norm, and therefore disregards diverse sexual orientations and gender identity (Tolley and Ranzijn 2006). Current policy governing the aged care industry is framed in a heterosexual context and can unintentionally and indirectly marginalise and discriminate against GLBTI people (Irwin 2007). This results from specific needs not being consciously considered by providers as well as the lack of awareness of relevant GLBTI issues (Tolley and Ranzijn 2006).

Older GLBTI people are not considered as a specific needs group in the Aged Care Act which reinforces their invisibility and further marginalises them (Phillips and Marks 2006). Admission and intake forms into residential aged care services often use heteronormative language such as: husband, wife, married, divorced and family (Irwin 2007). Rarely do they provide an opportunity for individuals to declare same-sex partners, nor do they employ a broader definition of 'next of kin' to encompass 'families of choice' rather than biological families (Irwin 2007). This is significant as visiting rights, access to client information and involvement in client decision making is determined by such information (Irwin 2007). Furthermore, marketing material used by the aged care industry is also based on heteronormative assumptions with opposite-sex couples depicted on brochures, to the exclusion of same-sex couples (Phillips and Marks 2006; Tolley and Ranzijn 2006).

Tolley and Ranzijn (2006) theorise that the aged care industry is not immune from heteronormative assumptions as staff working within this industry are likely to hold heteronormative assumptions in line with the general population. Consequently, older GLBTI people are not usually perceived by staff and service providers to have specific needs.

Homophobia

Homophobia transpires from an irrational fear and/or dislike of people who are homosexual, and manifests discrimination and/or violence (Barrett, Harrison, and Kent 2009). As with heteronormativity, homophobia exists within the broader community, and therefore is likely to exist within the aged care industry (Barrett, Harrison, and Kent 2009; Roach 2004). Homophobia when experienced in the broader community impacts negatively on GLBTI people, particularly those in rural communities (Barrett, Harrison, and Kent 2009).

However acts of homophobia within aged care services have greater consequences for older GLBTI people as they are dependent on such services and may be constantly in contact with homophobic health care workers (Barrett, Harrison, and Kent 2009; Irwin 2007; Roach 2004). Resident's rights are protected by anti-discrimination laws, however Irwin (2007) suggests that this may only be useful in overt situations, and that covert institutionalised homophobia does exist and often goes unchallenged.

Sexual activity and sexual identity

Older people are generally viewed as being asexual and sexual expression within aged care facilities is perceived to be problematic (Barrett, Harrison, and Kent 2009). A study by Barrett, Harrison and Kent (2009) found that carers were surprised that older heterosexual couples were sexually active. They also found that a mono culture existed within the aged care sector in relation to diverse sexual orientations which perpetuated the "mantra that we need to treat everyone the same" (Barrett, Harrison, and Kent 2009. 55).

The aged care industry and perhaps much of the wider community, generally do not perceive older people as sexually active. Consequently, issues relating to sexuality are often left unaddressed by aged care providers. In line with perceptions of the general older population, older GLBTI people are also considered to be asexual. They are therefore perceived by aged care providers as being no different than their counterparts when it comes to sexuality and sexual activity (Barrett, Harrison, and Kent 2009).

This is problematic as sexuality encompasses a much broader notion than sexual activity per se, and includes many dimensions of identity, which Harrison (2001) likens to that of culture. This narrow understanding of sexuality employed by aged care service providers renders GLBTI elders invisible, further marginalising them and creating unmet needs.

Privacy

Hughes (2004) posits that the notions of public and private spheres are not mutually exclusive and when applied in the context of aged care provision, can be conflicting. This is evident in aged care services in Australia, where at the policy level, client privacy is afforded utmost importance with providers being required to meet privacy standards to maintain their accreditation (Hughes 2004). A person's privacy is protected under the Privacy Act and when applied to an aged care setting, such policy can facilitate the provision of a safe environment where older GLBTI may feel comfortable in disclosing their sexuality (Hughes 2004).

However, Bauer (1999) argues that even though the right to privacy is one of the fundamental responsibilities of aged care providers, in reality it is difficult to achieve. This is partly due to the fact the residential care facilities are constructed around the notion of 'shared space', making it difficult for residents to distance themselves from others (Bauer 1999). Privacy is also difficult to maintain when: rooms are shared, regimented routines are enforced, there is limited available space, surveillance of residents is used as a risk reduction strategy and client information is readily exchanged/discussed by staff (Bauer 1999; Hughes 2004).

The Privacy Act while potentially facilitating a safe environment for residents may on the other hand be used by providers to disregard sensitive issues such as sexuality as a 'private matter' (Hughes 2004). Harrison (2001) likens privacy in aged care settings to the notion of taboo and that aged care providers and staff use privacy to avoid sensitive issues such as sexuality. This keeps GLBTI elders invisible and their specific needs unmet, as staff and providers are unable to gain an understanding of their GLBTI client's experiences and issues (Harrison 2001).

2.3 Concerns of older GLBTI people

Institutionalised aged care

McNair and Harrison (2002) found that major concerns for older GLBTI people were not about their health per se, but rather about institutionalised discrimination pertaining to sexual and gender identity. Concerns were also raised about how homophobic attitudes of institutionalised aged care facilities would impact on the quality of care delivered and the fear that this could result in elder abuse.

Older GBLTI people in general do not feel that it is safe to disclose their sexual orientation and/or gender identity to aged care providers as a result of their past experiences of discrimination (Barrett 2008). This stems from a time when disclosure could have resulted in imprisonment, ostracism, job losses and medical interventions. Additionally concerns are raised as a large number of residential facilities are run by religious organisations (McNair and Harrison 2002).

Concealment of identity

As a result of fears of institutionalised homophobia, some older GLBTI people believe that they need to conceal their sexual orientation and/or gender identity from aged care service providers (Barrett, Harrison, and Kent 2009). Consequently, they may be forced 'back into the closet' and have to continuously maintain a facade of heterosexuality, placing them under immense stress and anxiety (Barrett, Harrison, and Kent 2009). Furthermore, concealment of identity renders older GLBTI people invisible and may result in failings to address or meet their needs.

The heteronormativity of aged care facilities is also of concern to many older GLBTI people. Heterosexual assumptions coupled with the notion of older people being asexual, can make GLBTI people feel that their same-sex relationships are not valued or understood and that partners will be excluded in care planning and decision making (Irwin 2007). Additionally Addis (2009) reports some older GLBTI people fear a lack of recognition and support of their 'families of choice' from service providers.

Social networks

Some older GLBTI people fear that going into residential aged care will render them socially and emotionally isolated from their communities. They will no longer be able to mix with other GBLTI people, access GLBTI services and activities or celebrate/attend special events and festivals (Chandler et al. 2005; Birch 2004; Chamberlain and Robinson 2002). Encouraging participation in GLBTI community activities of older GLBTI people in residential care facilities can be challenging due to their invisibility and identity concealment (Brotman, Ryan, and Cormier 2003). However encouraging GLBTI elders to access and remain connected to their GLBTI community and social support groups is important, as it can contribute to positive health outcomes (Birch 2009).

Financial security

As with older heterosexual people, older GLBTI people are concerned about their financial security as they age. In the report *Out and Aging* older gay men were concerned about becoming dependent on others (MetLife Mature Market Institute 2006). On the other hand lesbians were more concerned that their finances were insufficient to last their lifetime. This was partly due to older women generally having a lower earning capacity over their working years than men, and a generational factor where women were not expected or taught to be financially self sufficient (MetLife Mature Market Institute 2006). Although this report is specific to the US population, it is likely to be applicable in the Australian context.

Cultural and sexual expression

Of concern to some older GLBTI people is the limited opportunity residential aged care facilities provide for cultural and sexual expression (Barrett 2008). They may unable to display GLBTI related materials such as photos, community newspapers and watch gay TV without 'outing themselves' (Barrett 2008). Additionally the lack of opportunity for physical touch such as holding hands, kissing and hugging as well as physical intimacy is also a concern of some older GLBTI people (McNair and Harrison 2002).

The GLBTI population is heterogeneous and exists in all parts of society, encompassing a diverse range of individual health needs, issues and behaviours (Hyde et al. 2007). Individuals within the GLBTI population experience differing degrees of optimum health and health issues and it is imperative that generalisations are avoided. When discussing GLBTI health, it is important to recognise and consider that there are many healthy and happy GLBTI individuals. However as a population, overall disparities exist in contrast to the heterosexual population.

Such discrepancies tend to manifest in the form of poor mental and physical health and result from barriers related to sexual orientation and/or gender identity, which include heterosexism, homophobia, societal marginalisation and stigmatisation (Meyer and Northridge 2007). Furthermore service providers' limited knowledge of GLBTI health issues can lead to the provision of inappropriate advice and care. This along with homophobic attitudes of some health care providers impacts on GLBTI individuals' health seeking behaviours, making them less likely to seek early intervention (Dunn, Wilson, and Tarko 2007; Gay and Lesbian Medical Association 2001; Hyde et al. 2007).

2.4 GLBTI health issues

The GLBTI population, relative to the heterosexual population, experience elevated occurrences of obesity; tobacco, alcohol and substance misuse; poor sexual health practices; mental illness; injury and violence; and limited access to health care. These factors can lead to poorer health outcomes and shorter life expectancies (Makadon et al. 2008).

People of a diverse sexual orientation or gender identity are "4 times more likely to have ever been homeless (12% 'homosexual/bisexual' v. 2.9% 'heterosexual'), twice as likely to have no contact with family or no family to rely on for serious problems (11.8% v. 5.9%), more likely to be a current smoker (35.7% v. 22%), twice as likely to have used illicit drugs (64.6% v. 33.2%), more likely to have had a chronic condition in the last 12 months (51.3% v. 46.9%), twice as likely to have a high/very high level of psychological distress (18.2% v. 9.2%), almost 3 times as likely to have had suicidal thoughts (34.7% v. 12.9%), 5 times as likely to have had suicidal plans (17.1% v. 3.7%) and 4 times as likely to have attempted suicide (12.6% v. 3.1%) (Australian Bureau of Statistics 2007b). Several of these factors are explored further below.

Alcohol, tobacco and other drug misuse

The elevated level of alcohol, tobacco and other drug misuse in the GLBTI population, compared to their heterosexual counterparts, is well documented. For example in Australia, *Private Lives: A report on the health and wellbeing of GLBTI* Australians by Pitts et al. (2006) found 37% of survey participants used tobacco on more than five occasions in the previous month compared to 24% of the general population. Hyde et al. (2007) further highlighted disparity by reporting that lesbian and bisexual women were nearly twice as likely to use or have used tobacco than heterosexual women.

Participants in the *Private Lives* study (Pitts et al. 2006) reported elevated patterns of illicit drug use in line with international and national research findings compared to their heterosexual counterparts. This was consistent with findings by Hyde et al (2009) who report 33% of lesbian and bisexual women had used illicit drugs within the previous six months, compared to 11.5% of Australian women

surveyed in the *2007 National Drug Strategy Household Survey* (Australian Institute of Health and Welfare 2008). In a recent paper based on data from the US National Epidemiologic Survey on Alcohol and Related Conditions, McCabe et al. (2009) reported that in their study 5.7% of lesbians and 3.0% of bisexual women had a drug dependency in the last year compared to 0.4% of heterosexual women. Levels were also elevated for gay and bisexual males (3.2% and 5.1% respectively) compared to heterosexual males (0.5%) (McCabe et al. 2009)

Disparities in levels of alcohol consumption between GLBTI and heterosexual populations also exist, with some researchers suggesting that lesbian and bisexual females consume alcohol at similar, if not higher levels than males in general. This was validated by McCabe et al. (2009) who found that 20.1% of lesbian women and 25.% of bisexual women reported drinking heavily in the past year compared to their heterosexual counterparts (8.4%). Eighteen percent of gay males and 16.4% of bisexual males reported heavy drinking in the past year compared to 13.7% of heterosexual males.

Mental health

Individuals within the GLBTI population experience stigma, discrimination, marginalisation and violence (Meyer and Northridge 2007). These factors are referred to as minority stressors and can have adverse effects on mental health (Meyer and Northridge 2007). In addition to general stressors experienced by the population as a whole, the GLBTI population in general, experience greater levels of minority stressors and consequently are at greater risk of adverse mental health outcomes (Meyer and Northridge 2007).

Both national and international studies highlighted elevated mental health problems amongst GLBTI people. King et al. (2003) in their study of gay and lesbian people in the UK, found that gay men had 1.24 times greater risk of psychosocial distress than heterosexual men; and lesbian women had 1.30 times greater risk than heterosexual women. A study in New Zealand investigating the risk of psychiatric disorder and suicidal behaviours in young gay, lesbian and bisexual individuals, found that participants had 4 times greater risk of developing depression, 5.4 times greater risk of suicidal ideation and 6.2 times greater risk of suicide attempts, than their heterosexual counterparts (Fergusson, Horwood, and Beautrais 1999).

Transgender people also experience elevated levels of suicide attempts. This was reported in a study by Clements-Noelle et al. (2001) whose survey sample had much higher rates of suicide attempts than the general US population. A study in the Netherlands by Kesteren et al. (1997) also supports these findings.

In Western Australia (WA), Hyde et al. (2007) found that over a third of lesbian or bisexual women in their study (34.85%) had clinically diagnosed depression compared with 22.8% of women in the WA population. They also found elevated rates of anxiety (22.9%) of survey participants compared with 20.5% of WA women. Pitts et al. (2006) reported elevated rates of depression in their study on the well being of GLBTI Australians (48.6% of male respondents and 44.4% of female respondents). Over 15% of their respondents also indicated they had suicidal ideation in the two weeks prior to participating in the study.

Diet and physical activity

The GLBTI population are at greater risk of eating disorders, and being overweight and obese (McNair and Medland 2002). A greater number of homosexual males experience eating disorders than their heterosexual counterparts, with homosexuality being a probable risk factor for eating disorders in men (Russell and Keel 2002). In their study of homosexuality and disordered eating, Russell and Keel (2002) found that gay male participants had greater dissatisfaction with their bodies and increased levels of bulimia and anorexia than heterosexual males. Twenty five percent of gay males in the study reported binge eating compared to 10% of heterosexual males and 11.7% reported

purging in comparison to 4.4% of heterosexual males. Interestingly Pitts et al. (2006) found male participants were less likely to be overweight and obese (43%) compared to all Australian males (54%), and cited body image as a possible reason. This however was not the finding with lesbian and bisexual women.

Eating disorders, overweight and obesity are more common among lesbian and bisexual women compared to heterosexual women (Valanis et al. 2000). Pitts et al. (2006) found that 49% of lesbian and bisexual women in their study were overweight or obese compared to 38% of all Australian women. These disparities have also been found in a study on overweight and obesity in sexual minority women in the US by Boehmer, Bowen and Bauer (2007). They reported that lesbian women were more than twice as likely to be obese and overweight as heterosexual women, and conclude that lesbian sexual orientation significantly increased the risk of obesity and overweight.

Sexual health

HIV/AIDS, hepatitis A and B, gonorrhoea, chlamydia, human papilloma virus, herpes, syphilis and pubic lice are the most common Sexually Transmitted Infections (STIs) associated with men who have sex with men (McNair and Harrison 2002). Pitts et al. (2006) found that nearly 40% of males in their study had contracted pubic lice and 19% reported having gonorrhoea. This compares with 9.8% of Australian males reporting ever having pubic lice and 2.2% having had gonorrhoea (Grulich et al. 2003).

Lesbians have traditionally been perceived as a low risk group with regards to contracting STIs (Valanis et al. 2000). However Grulich et al. (2003) found that STIs became more prevalent in lesbian and bisexual women with the risk increasing as the number of sexual partners increased. Fethers et al. (2000) found that the prevalence of chlamydia, genital herpes, gonorrhoea and HIV was low in women who have sex with other women in line with rates in heterosexual women. However lesbian and bisexual women had higher rates of genital warts (5%), hepatitis C (5%) and hepatitis B (5%) than their heterosexual counterparts (8%, 1% and 3% respectively). Lesbian and bisexual women were also found to have increased prevalence of bacterial vaginosis (8%) compared to heterosexual women (5%).

STIs in same-sex attracted youth are also of concern. There is evidence of elevated levels of STIs in 15-18 year old same sex attracted youth. Hillier et al. (2005) in their second national report on *The Sexuality, Health and Well-Being of Same-sex Attracted Young People in Australia*, found that 10% of their participants reported having been diagnosed with a STI. This compared to 2% of participants within the same age group in a national secondary school study.

In a study by Clements-Nolle et al. (2001) examining the prevalence of HIV, risk behaviours, health care use and mental health status of transgender people, elevated rates of HIV were found. Of the male-to-female participants, 35% were living with HIV as well as 2% of female-to-male participants. Intersex people were excluded from this study as they did not meet the study participation criteria.

Access to healthcare

Research indicates that some GLBTI individuals have experienced discrimination from health care providers and generally access health care less than the heterosexual population. The Victorian Gay and Lesbian Rights Lobby reported in 2000 that 23% of GLBT Victorians accessing health care experienced discrimination. This was further validated in 2005 in their *Not Yet Equal* report which found 27.4% of lesbians, 11.8% gay men and 11.5% of bisexual people had experienced discrimination in a health care setting (McNair and Thomacos 2005). As a result, McNair and Thomacos (2005) claimed that GLBTI individuals were more likely to conceal their sexual orientation from their health care provider, which could impact on the quality of care they received. Additionally

GLBTI individuals were less likely to be screened for common health conditions and tended to present later for treatment (McNair and Harrison 2002).

GLBTI Health conditions

Some GLBTI people are faced with specific health issues as a consequence of their elevated levels of risky health behaviours, coupled with limited access to healthcare. Research has shown that GLBTI individuals may have an increased risk of certain cancers including breast and cervical cancer, AIDS related cancers and lung cancer (Gay and Lesbian Medical Association 2001).

Valanis et al. (2000) found that 14% of lesbians and 17.6% of bisexual women had experienced some type of cancer compared to heterosexual women (11.9%). This could be attributed to higher rates of obesity and alcohol consumption, lower rates of pregnancy and births, and lower uptake of health screenings (Gay and Lesbian Medical Association 2001).

Disparities in the prevalence of breast and cervical cancer also exist. Valanis et al. (2000) reported fewer than 5% of heterosexual women having had breast cancer compared to 8.4% of bisexual women, 5.8% of lifetime lesbians and 7% of adult lesbians. A greater number of bisexual and lifetime lesbians reported having cervical cancer (2.1% and 2.2%) compared to 1.3% of heterosexual women. Another disparity of note reported by Valanis et al. (2000) was elevated myocardial infarction by lifetime lesbians (3.1%) and adult lesbians (4.3%) compared with heterosexual women (2%).

Transgender health

Much of the research to date is focused on gay, lesbian and bisexual (GLB) individuals, however Meyer and Northridge (2007) indicated that some transgender health issues, particularly those associated with psychological, social and economic factors overlap with GLB health issues. Issues specific to transgender individuals relate to “hormone therapy, masculinising and feminising surgery, and liquid silicone injection” which all aim to transition individuals across specific genders (Meyer and Northridge 2007. 493). Additionally, the experiences of GLB individuals outlined above may be amplified for transgender individuals as they are more likely to be marginalised from society, omitted from legislation and confronted with issues relating to gender reassignment such as the challenges of changing identity on legal documents (Levy, Crown, and Reid 2003).

Intersex health

As with transgender health, although much of the research has focused on GLB individuals, some intersex health issues overlap with GLB health issues. Additionally issues specific to transgender individuals relating to gender reassignment also apply to intersex individuals. MacKenzie, Huntington and Gilmour (2009) suggested that health issues specific to intersex individuals were associated with psychological factors. Such factors manifest from the silence surrounding such a condition (that is, the child is unable to understand, but is aware that their condition is not spoken of) and a life time of managing differences (MacKenzie, Huntington, and Gilmour 2009).

Implications of the above findings, suggest that some GLBTI individuals may have poorer health outcomes than their heterosexual counterparts as they become older. Of note are those conditions arising from marginalisation (Meyer and Northridge 2007). It is difficult to ascertain the extent and enormity of such disparities due to the limited amount of research in this area and the invisibility of the GLBTI population.

3.0 PROJECT OVERVIEW

This project evolved from formative research conducted by GLBTI Retirement Association Inc (GRAI) in 2006/07, which confirmed that unmet needs and fears of discrimination existed among older and ageing GLBTI individuals accessing retirement and residential aged care services in Western Australia. Consequently, this investigative study was undertaken to explore Western Australian residential aged care service providers' practices and attitudes towards older GLBTI individuals.

Of particular social and economic interest, is the potential impact baby boomers will have in the future on providers of accommodation for older people. In addition to overall expectations of availability and adequate level of service provision, this demographic is more likely to be the first generation to be open about their sexuality. Based on the commonly accepted figure of approximately eight percent of the population identifying as GLBTI, it can be extrapolated that there is currently an estimated 1.76 million GLBTI people living in Australia. Based on statistics from the Australian Bureau of Statistics (2008b), it can be estimated that approximately 13% of these people are currently aged 65 years and over, with the figure expected to rise in line with Australia's ageing population.

This research project was supported by a Lotterywest Social Research Grant, and was a collaborative project involving GRAI and Curtin University of Technology, the WA Centre for Health Promotion Research (WACHPR) and the Centre for Research on Ageing (CRA).

A project control group (PCG) was formed to guide and monitor the completion of the project, in addition to providing academic expertise. The PCG was seen as an interface between Curtin University and GRAI. The group comprised of representatives from WACHPR and CRA, a public heath practitioner from the Curtin Health Innovation Research Institute, the project manager, the research officer and representatives from the GRAI board.

In addition to the PCG an industry advisory group (IAG) was established upon commencement of the project. The IAG, a sector based representative group, encompassed the following peak bodies: Carers WA, Aged Care Association Australia (WA), Council on the Ageing (WA), Retirement Villages Association (WA) and Aged and Community Services (WA).

The IAG acted as an industry feedback mechanism to the PCG, and was used to inform the project as well as provide insight into the potential and/or perceived implications of the provision of retirement and residential aged care services to GLBTI populations. The IAG also provided feedback on the research schedules, industry questionnaires, best practice guidelines for residential aged care providers and the final project report. The IAG met three times during the lifecycle of the project and was used to disseminate the findings of this project to their members.

Ethics approval, number SPH - 0044 – 2008 was gained from Curtin University's Ethics Committee on 18 November 2008.

Focus group participants were informed of the purpose of the study and what their potential involvement entailed by way of an information sheet (Appendix B). Ethical protocol was adhered to at all times and participants also signed a consent form.

In accordance with Curtin University's requirements, protocols were implemented which protected participant's identity and maintained confidentiality. This included: participant's identity only being made available to the research team and any audio recordings, transcribed interviews, interview notes, survey responses and field notes being securely stored.

4.0 AIMS

The purpose of the research project was to inform providers of retirement and residential aged care services of the specific needs of older GLBTI people. One of the outcomes of the study was to develop best practice guidelines for the retirement and residential aged care sector in WA, to facilitate the provision of GLBTI-inclusive services. The data collected from this study was used to develop these guidelines as well as identify further research areas. Consequently, the research project aimed to examine:

- how well existing providers of retirement and residential aged care services understand, and are currently meeting specific needs of GLBTI people;
- how can retirement and residential aged care service providers become informed about the needs of GLBTI people; and
- how retirement and residential aged care service providers can ensure excellent service provision which meets the needs of GLBTI people in line with best practice guidelines.

5.0 METHODOLOGY

5.1 Literature review

A literature review was conducted to identify previous research undertaken in this area, ascertain a better understanding of the general and GLBTI ageing issues and establish lessons learned from previous findings. Additionally the literature review aimed to build on the findings of other researchers, identify any gaps in the current knowledge and highlight the significance of historical context when researching GLBTI issues.

A range of electronic databases and search engines were used to conduct the literature review. A variety of search terms were used and the search was limited to the English language. The literature review research process is fully outlined in Appendix C.

The literature review was limited by the shortage of research in the area of GLBTI ageing within the Australian context. Despite of this, there have been several good studies undertaken within Australia, in addition to some Australian GLBTI community group websites addressing ageing issues. However, much of the progress made with regard to GLBTI ageing comes from the US. Consequently the literature review draws on findings from the US and other countries, in addition to the available Australian data. The full literature review is available as a separate document from the GRAI website www.grai.org.au or the WA Centre for Health Promotion Research website www.wachpr.curtin.edu.au.

5.2 The study

The study aimed to:

- explore existing organisational and facility attitudes, knowledge and current practices towards older and ageing GLBTI people; and
- ascertain current responses from the retirement and aged care residential sector in Western Australia to the needs of older and ageing GLBTI people.

5.2.1 Population selection and recruitment

The target group for the study was all providers of retirement and residential aged care accommodation in Western Australia. This included retirement villages, and residential aged care facilities providing low care, high care and respite services. Community care service providers were excluded. It is acknowledged that these providers will have GLBTI people, however due to the scope of this project only residential providers were eligible to participate.

A database of eligible participants was constructed from the Department of Health and Ageing's database of Western Australian aged care service providers, CRA's database of retirement village providers, the DPS Guide to Aged Care: Western Australia (2008) (hardcopy and website), the Telstra Whitepages and the Aged Care On-Line website. The total number of eligible participant facilities was 462. Of this total number, 158 were single entity organisations and the remainder (n=304) were governed by 40 corporate entities.

The entire sampling frame was the used as the sample, to aid generalisability to the Western Australian population, however is limited when generalising to the overall Australian population. Efforts were made to procure questionnaires from similar surveys conducted in Victoria and South Australia to guide the survey construction, however this was unsuccessful. It would have been useful to use some of the same measures in these previous surveys to enable comparisons across the three States.

Participants in the survey included accommodation providers ranging from independent living accommodation such as those found in retirement villages through to those providing high care residential services. Additionally there was representation from rural, remote and metropolitan areas. The Rural, Remote and Metropolitan Areas (RRMA) classification from the *Australian Institute of Health and Welfare Remote Classification Guide* (2004) was used to categorise sample locations. Appendix D outlines this classification guide and the sampling plan in greater detail.

The IAG was used to promote and inform their members of the pending survey. This strategy was employed to raise awareness of the research prior to organisations being contacted.

5.2.2 Survey design, pilot testing and dissemination

The survey design proceeded alongside the literature review. This enabled the identification of appropriate themes for which questions could be developed. Researching survey formats and scrutinising other survey formats aided the final design. Feedback from the PCG and IAG on the draft survey was integrated, producing a final draft for review. Content validity was completed by knowledgeable colleagues and professionals from the PCG, IAG and research team. Cognitive and motivational qualities were analysed in an interview with a representative from the Aged Care Association Australia (WA).

The survey collected quantitative data through forced choice answers such as yes/no/unsure and a Lickert Scale to assess attitudes. Additionally qualitative data was collected through the use of open-ended questions requiring short answers. A modified Dillman protocol (Appendix D) guided survey design, development, implementation and follow-up.

Pilot testing was conducted using the departmental management team from SwanCare Group, one of the larger residential care providers in Western Australia. The team comprised of managers from community care, independent living and the low and high care facilities. Pilot testing allowed for refinement of survey questions. A general feedback session with the pilot organisation was also useful in clarifying the intent of the research approach.

The outcome from the pilot test and final reviews rendered two surveys as necessary; the Executive Survey (Appendix E), to be completed by the Chief Executive Officer (CEO) of the organisation and the Facility Survey to be completed by the senior manager of the facility at the operational level (Appendix F).

Due to the complexity of the aged care industry, and upon the advice of the IAG it was agreed that for large corporations with multiple facilities, consent would be sought from the CEO prior to the distribution of their facility surveys. In addition to initial verbal consent, the CEO would also be able to confirm the number of facilities under their jurisdiction, enabling the correct number of surveys to be disseminated. Upon receipt of verbal consent, the Executive Survey and the correct number of Facility Surveys were sent to the CEO for written consent and distribution.

With regard to single independent entities, the Executive Survey and Facility Survey were posted directly to the CEO without prior verbal approval. All surveys were accompanied by a participant's information letter and self addressed replied paid envelope.

5.2.3 Follow-up protocol

A modified Dillman protocol, as outlined in Appendix D and the survey protocol outlined in Appendix G were used to guide the follow-up of surveys. Two weeks after the initial surveys were posted (week 3) a thank you/reminder card was forwarded to all single entities and CEOs of corporate organisations. Two weeks after this (week 5), a replacement survey and letter was posted to all single entities and corporate CEOs who had not previously completed their surveys or advised of their non-participation. One week on (week 6), a follow-up phone call was made to non-respondent CEOs of corporate organisations. No phone call was made to individual entities due to the enormity of the task. Dillman suggests telephone-follow up as an alternative to mail (Dillman 2007).

5.2.4 Limitations

According to Dillman (2007), surveying businesses and other organisations is a difficult task and presents different challenges than individual and household surveys. Challenges are experienced when "defining, sampling, contacting and obtaining responses" (Dillman 2007. 323). The researchers in this study experienced all of these challenges outlined by Dillman.

Defining the sample frame was challenging due to the lack of availability of a single comprehensive database of residential aged care facilities and retirement villages in Western Australia. The database acquired from the Department of Health and Ageing was approximately 12 months old and consequently out of date. Similarly the database of retirement villages acquired from the CRA was also 12 months out of date, as was the DPS Guide to Aged Care. Further adding to the challenges of defining the population, particularly deciphering which facilities came under the governing jurisdiction of which corporate entities, was the complexity of the aged care industry itself. Service providers were often registered under a corporate name which differed from their facilities trading name. This also added to the difficulty in identifying the size of the sample.

Difficulties were also experienced when trying to contact organisational CEOs due to the variation in the size of the organisations. Larger ones had personal assistants to the CEOs who acted as gatekeepers. Consequently, many phone calls were required during the initial stages to seek the approval of the CEO to participate in the study. When following-up non-respondents, this also created difficulties.

Furthermore, the aged care industry itself is a difficult industry to access in terms of research. The industry reports it is under resourced, extremely time poor, over surveyed and greatly regulated which

requires significant reporting. Consequently, responding to an optional survey is a low priority for most facility managers. Dillman predicts a response rate of 30% when surveying organisations or businesses. The response rate for the Executive Survey from corporate organisations with multiple facilities was 32.5% (n=13) and single entity organisations 14.5% (n=23). The higher response rate from CEOs of multiple facilities may be attributed to direct phone contact made prior to them receiving the survey. Appendix D and Appendix G outline the recruitment process in detail. The response rate for the Facility Survey was 26% (n=83), which is more in line with what Dillman (2007) estimates when surveying businesses.

Adding to the difficulty in achieving a higher response rate is the research topic itself. The aged care industry and perhaps much of the wider community generally do not perceive sexual activity and ageing as co-existing (Barrett, Harrison, and Kent 2009). They also do not see older GLBTI people as having specific needs in addition to the common needs of all older people. Consequently, issues relating to sexuality are a low priority and are often left unaddressed by aged care providers (Barrett, Harrison, and Kent 2009).

Furthermore, calculating statistical representativeness of the sample was difficult as base line data on the number of organisations within each type of service was difficult to determine as many organisations provided multiple service types. The same applied to determining representativeness of the sample based on number of beds within each type of service.

5.2.5 Focus groups

Focus Group 1 – Industry participants
The aim of this focus group was to gather more in-depth information on the experiences, issues and challenges facing residential aged care providers relative to older GLBTI people. It was also used as an opportunity to further expand on two of the themes emerging from of the survey, namely “we treat everybody the same” and “sexuality is none of our business”.

Focus Group 2 – GLBTI participants
The aim of this focus group was to explore the target group’s perceptions of what constitutes best practice in the delivery of retirement and aged care accommodation for GLBTI people. Additionally, opinions were sought regarding the content of the guidelines, along with views and expectations of such guidelines.

5.2.6 Sample selection and recruitment

Focus Group 1 – Industry participants
Participants who wished to participate further in the study indicated such on their returned facility survey. A list was constructed and all metropolitan respondents were invited to participate in the focus groups. Those from rural and remote areas were ineligible due to geographical limitations.

Recruitment was conducted via email (Appendix H) and a follow-up phone call. Participants were allocated to one of two groups and a date and time was nominated for each group.

Focus Group 2 – GLBTI participants
Recruitment of participants for this focus group took place through the gay media (Out in Perth) and through the GRAI membership. A paid advertisement (Appendix K) was used along with email invitations to GRAI members. Two reminder emails were sent to GRAI members. Additionally an invitation was sent to members of Prime Timers, a WA based community organisation providing a kinship for mature gay and bisexual men. A small financial incentive was provided to participants.

5.2.7 Focus group structure

Focus Group 1 – Industry participants
As a result of the limited number of respondents only one industry focus group was held despite having received participation confirmation from eight senior managers representing retirement villages and residential low and high care facilities. On the day of the focus group however, only three participants attended.

All participants were provided with an information sheet and consent form for the focus group which was digitally recorded and lasted approximately 90 minutes. A list of questions guided the discussion. Participants were also presented with a scenario to further investigate some of the issues which may be encountered in accommodating GLBTI people and the notions of 'we treat everybody the same' and 'it's none of our business'.

Focus Group 2 – GLBTI participants
Despite the concentrated attempts at recruiting for this focus group, only five people confirmed their participation with just three attending the evening discussion.

All participants were provided with an information sheet and consent form for the focus group which was digitally recorded and lasted approximately 90 minutes. A list of questions guided the discussion. Participants were also presented with a draft copy of the best practice guidelines – accommodating older GLBTI people.

5.2.8 Focus Group Limitations

Focus Group 1 – Industry participants
As previously mentioned the residential aged care industry is under resourced, extremely time poor and perceives the notion of sexuality in older people, let alone older GLBTI people, as a low priority. Consequently recruitment to the focus group was more difficult than anticipated. Additionally the geography of Western Australia made it impossible to hold focus groups for rural and remote participants as they were widely dispersed across the state. It is also highly likely that participation in the focus group signalled that these participants perhaps had an interest in the topic area.

Focus Group 2 – GLBTI participants
The difficulties in sampling hidden populations such as older GLBTI people are well documented. Consequently recruitment was conducted through established GLBTI networks in Perth. This however did not prove sufficient to recruit adequate numbers. Low participation rates may be attributed to older GLBTI people being apprehensive about identifying as GLBTI and/or having few connections to the GLBTI community. Furthermore those with mobility issues are less likely to participate. The focus group was open to all age groups and the lack of participation from the younger demographic may indicate their indifference to the ageing GLBTI issue.

A further limitation was that despite employing various recruitment strategies numbers who participated in both focus groups were small.

5.3 Data entry and analysis

5.3.1 Quantitative

Statistical Package for the Social Sciences (SPSS) V17 was used to analyse the survey responses. Open ended questions were coded prior to data entry and analysed quantitatively in SPSS. A data dictionary was developed along with the SPSS data file. Data entry and analysis were outsourced to Curtin University's Office of Research and Development. Data analysis included frequencies, comparing attitudes across the various organisational classifications and comparing practices according to organisational size, accommodation type and location.

5.3.2 Qualitative

Transcribing of the focus groups was outsourced. Content analysis was undertaken by systematically reading the transcripts and assigning codes to the data. The raw data from the transcripts was examined for elements and phrases. These elements were then examined for common meanings which were then combined into subthemes. Subthemes were then clustered to reveal broader themes that could be supported by examples from the raw data. This analysis was reviewed by the research team to ensure appropriate representation of the data. This enabled the researchers to identify six over arching categories as: experiences with GLBTI residents; challenges of accommodating GLBTI residents; benefits of knowing resident's sexual orientation and/or gender identity; differentiating sexual activity from sexual orientation and/or gender identity; federal and state legislation and size of the GBLTI population. Support for these findings is demonstrated with quotes from focus group participants throughout the qualitative results section of this report. The research team used NVivo 8 to organise the transcription into key themes.

Analysis of open-ended questions on the surveys was also conducted using NVivio 8. In this context numbers were assigned to particular categories which emerged from the data allowing the data to be quantified. SPSS V17 was then used to analyse the open-ended questions on the surveys.

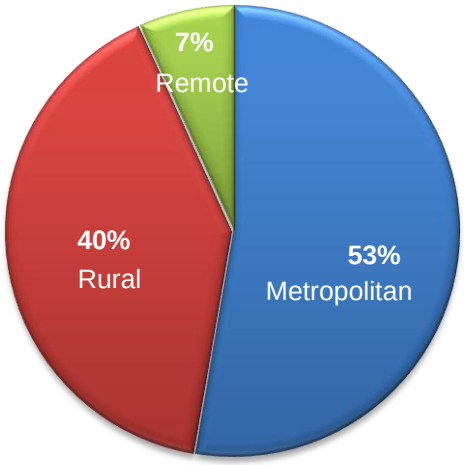
6.0 RESULTS

6.1 Quantitative results

6.1.1 Characteristics survey respondents

The majority of data collected relating to respondent characteristics were collected on the Facility Survey (n=83). The Rural, Remote and Metropolitan Areas (RMMA) classification as defined by the Australian Institute of Health and Welfare was used to classify respondents into metropolitan, rural and remote zones within Western Australia (Australian Institute of Health and Welfare 2004). The metropolitan zone is categorised as capital cities and other metropolitan centres with a population greater than or equal to 100,000. The rural zone comprise urban centre populations of greater than 5,000 and less than 100,000 and the remote zone comprise urban centre populations up to 5,000. Over half the respondents (53%, n=39) were from the Perth metropolitan area, 40% (n=30) were from rural Western Australia and 7% (n=5) were from remote Western Australia. Figure 6 shows the location breakdown of survey respondents.

Figure 6 Breakdown of location of facility survey respondents



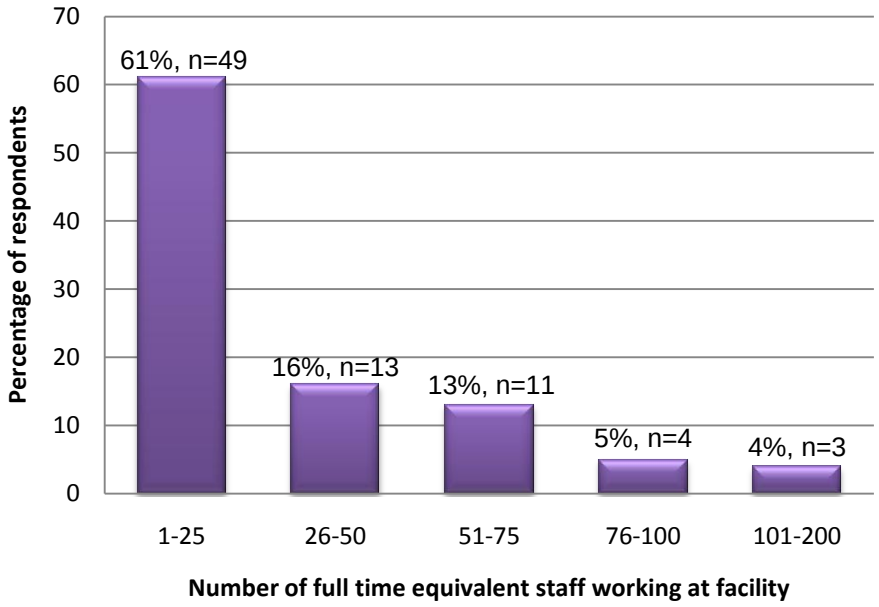
The majority of respondents provided low care residential accommodation (50%, n=41). Approximately one third (34%, n=28) of respondents provided high care accommodation, 32.9% (n=27) provided independent living and/or retirement villages, 9.8% (n=8) provided dementia specific facilities, 7.3% offered community care services and 13.4% indicated other categories describing their facility. Such categories included: ageing-in-place, residential aged care, multipurpose site and hospital with residential care provision. Typically there is an overlap of services provided by organisations within this sector.

The size of respondent facilities varied, with the majority (61%, n=49) having less than 25 full-time equivalent (FTE) staff members. A significantly smaller proportion of facilities employed 76-100 FTE staff (5%, n=4) and 101-200 FTE staff (4%, n=3). Mid-sized organisations employed 25-50 FTE staff

(16%, n=13) and 51-75 FTE staff (14%, n=11). Figure 7 highlights the variation between the sizes of respondent facilities.

Organisational classification data was collected on the CEO Survey (n=36). The majority of the respondents were not for profit run organisations (55.6%, n=20). Thirty three percent (n=12) were for profit and very few were state government and local authorities (5.5%, n=2 and 5.5%, n=2 respectively). Of those that responded, 6% (n=2) indicated that they were faith-based and 14% (n=5) said they were non faith-based. Comparatively, residential care services in Western Australia are provided by: charitable organisations (16.7%), community-based providers (13.5%), local government (3.6%), private operators (28.7%), religious organisations (36.7%), and state government (0.8% (Australian Institute of Health and Welfare 2009b).

Figure 7 Number of full time equivalent staff employed at facility



There appeared to be a stable management workforce. The number of years worked by respondent CEOs in the aged care sector averaged around 13 years with facility managers averaging around 12 years.

6.1.2 Organisational policy

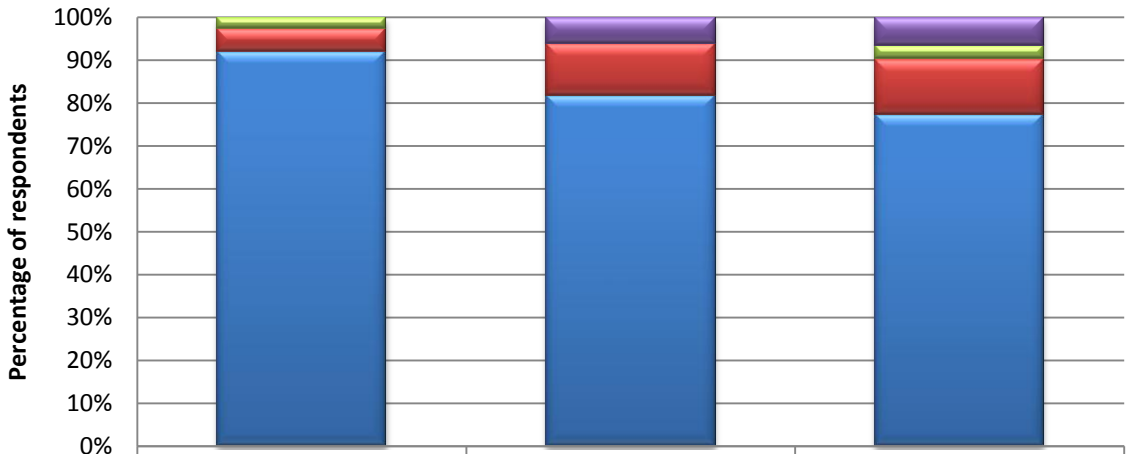
Data collected on overarching organisational policy was done at the CEO level of the organisation. This section of the CEO survey (n=36) aimed to seek information regarding organisational policy specific to older GLBTI people. Figure 8 highlights that the majority of organisations have an existing complaints process that facilitates the reporting of discrimination including that based on gender identity and or sexual orientation for both staff and residents. Over 97% (n=33) of respondents indicated the existence of an established complaints processes at an organisation level. Only one respondent was unsure if such a process existed. Of those who had an established complaints process most (82%, n=27) were aware of the option for staff to report discrimination based on sexual orientation and/or gender identity however 12% (n=4) were unaware. The majority of respondents

were also aware of the option for residents to lodge a complaint regarding discrimination based on gender identity and/or sexual orientation (77.4%, n=24).

When asked to describe the complaints process, most respondents (95%, n=21) indicated that their organisation had a formal internal process, 22.7% (n=5) had a formal external process and 4.5% (n=1) had an informal complaints process. The external processes included lodging the complaints through the Equal Opportunity Commission and complying with accreditation requirements. Formal internal processes were generally through higher management, organisational legal team, disputes committee, residents' advocate and equal opportunity officer.

Over half of the respondents (54%, n=19) indicated there was no specific reference to GLBTI residents and/or staff within their policies. Some (37%, n=13) said there was reference to GLBTI residents and/or staff in their organisational policy and 9% (n=3) were unsure.

Figure 8 Established complaints process at an organisational level (n=36)



	Complaints procedures	Procedure for reporting of discrimination for staff	Procedure for reporting of discrimination for residents
skipped	0%	6.10%	6.50%
unsure	2.80%	0	3.20%
no	5.60%	12.10%	12.90%
Yes	97.70%	81.80%	77.40%

Only 38.8% (n=14) of respondents provided any further comment with reference to GLBTI residents and/or staff in their organisational policy. Of those who provided further comment, the majority (78.6%, n=11) indicated that GLBTI people were included within their general organisational policies, rather than specific reference therefore implying assumed coverage of GLBTI people. Half of the respondents (50%, n=7) indicated that no specific policy for GLBTI staff and/or residents existed. Twenty one percent (n=3) of those who responded suggested that GLBTI staff and/or residents were covered under general non-discriminatory policies and that sexual preference was irrelevant. Only 14% (n=2) of those who responded indicated they had GLBTI specific policies.

Further comments demonstrated that issues relevant to GLBTI staff and/or residents were encompassed in broader antidiscrimination organisational policy rather than GLBTI specific policy.

Additionally 40% (n=6) of those who provided further comment indicated that their organisational policies were about equity regardless of sexuality.

6.1.3 Experiences and attitudes

Data pertaining to organisational experiences and attitudes were collected at the operational level through the Facility Survey (n=83). The majority of respondents (79%, n=65) said they did not currently have any GLBTI residents accommodated in their facility. Thirteen percent (n=11) were aware they had GLBTI residents and 7% (n=6) were unsure. Of those who were aware of GLBTI residents currently accommodated within their facility, there were five gay males, four lesbians and one trans person. Additionally, three facilities indicated that they had previously accommodated GLBTI clients, made up of two gay men, two lesbians and one trans person.

Sixty four percent (n=53) of respondents provided additional information with regards to their facility's experiences with GLBTI residents and/or families. Of these respondents, 77% (n=41) reported they had no current or past experiences with GLBTI residents and/or families. Furthermore these respondents indicated that in their facility, the provision of care was equitable regardless of sexual orientation and/or gender identity (n=6) and that they did not discuss the issue (n=4). Some respondents had cared for GLBTI residents (n=2) and had tried to meet specific needs (n=2), whereas others believed that the needs of GLBTI residents were no different than other residents (n=2).

Respondents were also asked if their facility regarded GLBTI residents as a group who have specific accommodation needs. The majority (70%, n=56) did not regard GLBTI residents as a specific needs group. Twenty two percent (n=18) were unsure and only 8% (n=6) agreed that GLBTI residents have specific accommodation needs.

Of those who made further comment, 52% (n=28) indicated that their facility treated and respected all residents equally and 28% (n=15) thought the needs of GLBTI residents were the same as other residents. Seventeen percent (n=9) of these respondents indicated that there were no specific accommodation needs as they did not have any GLBTI residents and that issues of spouses, respect and privacy were considered equally for all residents (n=8).

Respondents commented on staff training in relation to GLBTI issues from an organisational perspective rather than as an individual. The majority of respondents (82%, n=68) had not received this type of training. Twelve percent (n=10) indicated that they had received training in GLBTI issues and 6% (n=5) were unsure.

Of those who indicated they had received training relating to GLBTI issues, topic areas of such training included:

- Discrimination/equal employment opportunity (n=4);
- Healthcare ethics (n=1);
- General aged care training (not GLBTI specific) (n=4);
- Sexual needs for older people (n=2); and
- GLBTI workshop for staff (n=1).

Respondents were also asked about the incorporation of state and/or federal legislation relating to GLBTI people, into their facility's policy. Most of the respondents were not aware (70%, n=54) of such legislation being incorporated into their facility's policy, with only 12% (n=9) saying that they were aware and 18% (n=14) being unsure. Respondents who were aware of such legislation were asked to describe the type of state and federal legislation which was incorporated into their facility's policy. The three main legislations mentioned were:

- Discrimination laws (n=6);
- Same-sex reforms (n=3); and
- Aged care legislation (n=3).

A Lickert scale was used to explore facility's attitudes towards GLBTI issues. A general statement was made and respondents were asked to indicate if they strongly disagree, disagree, unsure, agree or strongly agree with the statement. Table 3 lists the statements made to respondents and the response categories.

Table 3 Facility attitudes with regards to GLBTI issues (n=83)

	Strongly Disagree n (%)	Disagree n (%)	Unsure n (%)	Agree n (%)	Strongly Agree n (%)
Your Facility recognises that GLBTI residents have specific needs	**4 (5)**	**18 (23)**	**33 (42)**	**19 (25)**	**4 (5)**
Same-sex partners of a resident have the opportunity to be involved in that person's care	**0 (0)**	**0 (0)**	**13 (10)**	**30 (38)**	**40 (50)**
Your Facility provides a GLBTI-friendly environment	**0 (0)**	**3 (4)**	**24 (30)**	**32 (40)**	**21 (26)**
Non-judgemental language is used and promoted within your Facility's printed policy and procedure documents	**1 (1)**	**1 (1)**	**14 (17)**	**32 (40)**	**33 (41)**
All residents' beliefs and personal diversity (e.g. religious, cultural, sexual) are promoted within your Facility's policies and procedures	**0 (0)**	**2 (3)**	**7 (9)**	**24 (30)**	**46 (58)**
A resident's sexuality is not of concern to your Facility	**2 (3)**	**7 (9)**	**8 (10)**	**29 (36)**	**34 (43)**
Staff treat residents as individuals (not defined by their cultural/political/sexual identity) at your Facility	**0 (0)**	**0 (0)**	**4 (5)**	**21 (26)**	**55 (69)**
Your Facility provides a trusting environment where residents feel safe enough to disclose their sexual orientation	**0 (0)**	**1 (1)**	**14 (17)**	**33 (41)**	**33 (41)**
GLBTI issues are not important to your Facility	**5 (6)**	**29 (37)**	**17 (22)**	**17 (22)**	**10 (13)**
GLBTI residents' needs are openly discussed at your Facility	**2 (3)**	**20 (26)**	**25 (45)**	**14 (18)**	**6 (8)**
Other residents are encouraged to support a GLBTI-friendly environment	**3 (4)**	**12 (16)**	**44 (57)**	**14 (18)**	**4 (5)**

Interestingly from the results shown in Table 3 the majority of respondents agreed or strongly agreed that same-sex partners of residents had the opportunity to be involved in that person's care and the majority of respondents (79%, n=63) agreed or strongly agreed that a resident's sexuality was not a concern. The majority (88%, n=70) indicated that a resident's beliefs and personal diversity were promoted within their facility's policies and procedures and that 82% (n=66) of respondents indicated that they either agreed or strongly agreed that their facility provided a trusting environment where residents would feel safe enough to disclose their sexual orientation.

The question was also asked of respondents if the data and information collection forms used by their facility allowed a person to self-identify as GLBTI. Sixty one percent (n=49) of respondents indicated that this was not an option. Twenty percent (n=16) said they did and 20% (n=16) said they were unsure.

Similarly, a majority of respondents (86%, n=69) did not include the term 'sexual orientation' or similar terminology in their resident admission criteria. Only 2.5% (n=2) said they did and identified terminology used as: transgender and sexual/relationship/intimacy needs. Eleven percent (n=9) were unsure.

Respondents were also asked to identify any forms used by their facility which included images and languages which may presume a person is heterosexual. This question was poorly answered in terms of yes, no, or unsure. However some respondents despite not answering the first part of the question indicated that they thought some of their forms were heterosexually biased. These included:

- Data collection forms (n=16);
- Assessment forms (n=15);
- Admission forms (n=20); and
- Promotional material (n=13).

Respondents were provided with the opportunity to make further comment regarding policy and practices of their facility. Only 16 respondents chose to comment further. Themes emerging from these responses include:

- Residents and staff are treated equally regardless of being GLBTI (n=5);
- No specific GLBTI policy (n=6);
- A welcoming environment is provided (n=2);
- Policies are non-discriminatory (n=2);
- GLBTI are invisible in policy and practices (n=1);
- GLBTI issues will be considered in further planning (n=2); and
- People are treated as individuals (n=1).

6.1.4 Current practices

Data pertaining to organisational practices were collected at the operational level through the Facility Survey (n=83). Respondents were asked about current practices within their facility with regards to GLBTI people. This was to determine what was currently happening on the ground and to help identify any gaps in practices which may exist. Figure 9 provides a summary of the responses to each of the questions in this section of the facility survey.

As highlighted in Figure 9, the majority of respondents (70%, n=57) did not use any means of indicating to members of the GLBTI population that it provided them with an inclusive environment. Of the five percent who said they did, strategies included open communication with residents and relatives and non-discriminatory policy.

A majority of respondents (77%, n=64) did not have a nominated GLBTI support person, either formally or informally. Of the six percent (n=5) who indicated they did, they listed the likely staff member to be: the site manager, social worker, allied health staff, grievance officer, care staff or gay staff.

When asked about partnerships with GLBTI community organisations, 77% (n=64) indicated that they did not have any partnerships. Nearly 23% (n=19) were unsure if their facility currently had partnership with GLB TI community organisations. No respondents said they did.

Respondents were also asked if their facility currently promotes a welcoming and accepting atmosphere for GLBTI people. Over a third (39%, n=32) indicated that they did not promote this, whereas 33% (n=27) were unsure. Of the 28% (n=23) who said their facility did promote a welcoming and accepting atmosphere for GLBTI people, they cited their strategies as: treating everyone equally, the employment of gay and lesbian staff and making everyone feel welcome.

Figure 9 Current facility practices regarding GLBTI residents (n=83)

	Means of indicating inclusive environment	Nominated GLBTI support person	Parnerships with GLBTI community organisations	Practices promoting a welcoming environment
unsure	25.60%	16.90%	22.90%	32.90%
no	69.50%	77.10%	77.10%	39.00%
Yes	4.90%	6.00%	0.00%	28.00%

Further comments on facility practices were provided by 18% (n=15) of the respondents. Some of the key themes emerging from these comments included:

- Practices were appropriate and flexible if change was necessary (n=2);
- Practices facilitated a gay friendly environment (n=2);
- All residents were treated equally – there were no specific needs for GLBTI residents (n=5);
- Some older residents would not be comfortable with GLBTI residents (n=2);
- There were no GLBTI residents (n=2); and
- Practices catered for individual needs (n=2).

6.1.5 Comparisons

Comparisons between facilities' attitudes and practices were made across facility size, geographic location and service type using percentages. Regardless of size, geographic location or service type, little difference was found between facilities in terms of their attitudes and practices towards older GLBTI people. Tables relevant to this section can be found in Appendix L.

Types of services are categorised as high care, low care and retirement villages. Facility size is determined by the number of full time equivalent staff (FTE) employed. Number of beds was not used to determine facility size as numbers were inconsistently reported. Geographic location is referred to as metropolitan, rural and remote areas of WA, Respondents were categorised into these three locations based on their postcodes.

Service type and current practices and attitudes

Little difference existed between providers of high care, low care and retirement accommodation when examining current practices. Very few (n=4) respondents across all types of accommodation used specific means of indicating to members of the GLBTI population that they provided a GLBTI-inclusive environment (Table 5). Of those who did, open communication with residents and staff was commonly cited across all service types as their means of indicating a GLBTI-inclusive environment.

Across all service types very few providers (6%, n=5) had a GLBTI liaison person (Table 6). Of those that did, the majority were from high and low care services. Facility/site manager was commonly cited across all categories as that person. Regardless of service type, no respondents had partnerships with GLBTI community organisations.

Furthermore a small number of respondents (28%, n=23) reported that they promoted a welcoming and accepting environment for GLBTI people (Table 7). The most commonly cited means of providing such, across all service types was: 'all clients are welcome' and 'all are treated equally'.

Once again there was little difference between the service types and policy relating to GLBTI people as highlighted in Table 8. Across all three categories only 12% (n=9) of respondents reported having state and/or federal legislation relating to GLBTI people incorporated into their facility's policy.

There was little variation between service types and attitudes. Few respondents (12%, n=10) from all three categories had staff training in GLBTI issues (Table 9). Across all three categories, some respondents indicated that they had GLBTI residents accommodated within their facility (high care n=4, low care n=4, retirement n=4). Similarly, few facilities across all service categories (high care n=5, low care n=4, retirement n=0) regarded GLBTI residents as a specific needs group (Table 11). Table 12 and Table 13 demonstrate the little variation between services having a definition of next of kin (high care n=13, low care n=16, retirement n=12) and a definition of family or immediate family (high care n=11, low care n=10, retirement n=9).

Facility size and current practices and attitudes

It was found that facility size made very little difference to current practices and attitudes. All of the respondents who stated they used specific means to indicate to members of the GLBTI population that they provided a GLBTI-inclusive environment (n=3) had 51-75 FTE staff (Table 5). Across all other facility sizes none used specific means to indicate a GLBTI-inclusive environment.

Table 6 identified the few facilities which indicated that they had a GLBTI support person (6.25%, n=5), with the majority of these being mid sized facilities (51-75 FTE staff 60%, n=3). Additionally the size of the facility did not impact on the number of partnership with GLBTI community organisations, as no respondents had such partnerships.

Approximately 28% (n=22) of respondents indicated they promoted a welcoming GLBTI environment. Half of the respondents (50%, n=11) were smaller facilities with 1-25 FTE staff compared with 18% (n=4) having 26-50 FTE staff and 23% (n=5) with 51-75 FTE staff (Table 7). Those facilities with greater than 76 FTE staff did not use any specific means of communicating a GLBTI welcoming environment. Less than 8% of respondents (n=6) across all facility sizes considered GLBTI people as a specific needs group as shown in Table 11.

There was little variation between the size of a facility and attitudes. Of the few respondents (11%, n=9) who received staff training in GLBTI issues, the majority, 44% (n=4) were from smaller organisations with 1-25 FTE (Table 9). Across all facility sizes, very few respondents indicated that they had GLBTI residents accommodated within their facility (1-25 FTE 50% n=5; 26-50 FTE 20% n=2) as demonstrated in Table 10. Interestingly of the 13% (n=10) of respondents (Table 12) who had a definition of next of kin, 61% (n=19) were from smaller facilities with 1-25 FTE. This was similar for definition of family or immediate family (Table 13). Of the 31% (n=23) of respondents who had a definition of family or immediate family, 48% (n=11) were from smaller facilities with 1-25 FTE staff.

Once again there was little difference between the size of the facility and policy relating to GLBTI people (Table 8). Twelve percent (n=9) of respondents across all the size categories reported having state and/or federal legislation relating to GLBTI people incorporated into their facility's policy. Of those that responded 56% (n=5) had 1-25 FTE staff. Larger facilities with over 100 FTE staff reported having no such policies.

Geographic location and current practices and attitudes

Small differences were identified between metropolitan areas and rural and remote areas. Of those respondents who indicated they promoted a welcoming GLBTI environment (Table 7), the majority (61%, n=11) were from the metropolitan area. Similarly with those respondents who suggested they used specific means to indicate that they provided a GLBTI-inclusive environment (Table 5), 100% (n=3) were in the metropolitan area. Furthermore 100% (n=4) of those who indicated they had a GLBTI support person were from the metropolitan area (Table 6). Geographic location did not have any bearing on facility partnerships with GLBTI community organisations, as no facilities had such partnerships regardless of location.

There was little variation between attitudes of facilities across all three geographic categories. Across all geographic locations, few facilities (13%, n=9) had accommodated GLBTI residents (Table 10). Of these 67% (n=6) were from the metropolitan area, 33% (n=3) rural and no remote facilities. Similarly, a small number of facilities across all geographic locations (7%, n=5) regarded regard GLBTI residents as a specific needs group (Table 11). Of these 60% (n=3) were metropolitan facilities, 20% (n=1) rural and 20% (n=1) remote. Across the three geographic categories less than 10% (n=7) had received training with regards to GLBTI issues (Table 9). Of those who had received training 43% (n=3) of facilities were located in both the metropolitan and rural areas. Of the 48% (n=33) of respondents who indicated they had a definition of next of kin (Table 12) and a definition of family or immediate family (Table 13), approximately half (46% n=15 and 54% n=13 respectively) were from the metropolitan area.

Once again there was little difference between the geographic location of the facility and policy relating to GLBTI people (Table 8). Approximately 10% (n=7) of respondents across all the geographic locations reported having state and/or federal legislation relating to GLBTI people incorporated into their facility's policy. Of those that responded 43% (n=3) were from the metropolitan area compared to 57% (n=4) from rural and none from remote areas.

6.1.6 Future directions

The facility survey also asked about the challenges perceived by facilities when accommodating GLBTI people. Topic areas for future training were also investigated in addition to the perceived barriers to implementing such training.

The majority of respondents (59%, n=48) did not anticipate any challenges with staff in regards to the residency of GLBTI people within their facility in the future and 27% (n=22) were unsure. Fourteen percent (n=11) indicated that there would be challenges as a result of a lack of knowledge and education of GLBTI issues, as well as challenges to staff attitudes and beliefs.

With regards to anticipated challenges with other residents in accommodating GLBTI people in the future, most respondents perceived no challenges (42%, n=34) and 40% (n=32) were unsure. Only 19% (n=15) perceived challenges with other residents due to their attitudes and beliefs. Other concerns were around privacy issues.

Approximately 80% (n=66) of respondents answered the question relating to what they would like to see as topics covered in future staff training. Table 4 provides an overview of the support shown for the various training topic areas. The most agreed upon topic for future training was the impact of staff beliefs and values on the delivery of care, followed by safeguarding GLBTI individuals from discrimination by other residents.

Table 4 Future training topics and their support from respondents (n=66)

Training topic	Number (%)
Specific needs of GLBTI older people	44 (67)
Managing resident and/or staff disclosure	46 (70)
Legal responsibilities regarding discrimination	38 (58)
Legal responsibilities regarding state and federal same-sex laws	35 (53)
Sexuality and sexual expression	30 (46)
Sexual and gender identities	26 (39)
Safeguarding GLBTI individuals from discrimination by other residents	50 (76)
Impact of staff believes and values on delivery of care	59 (89)

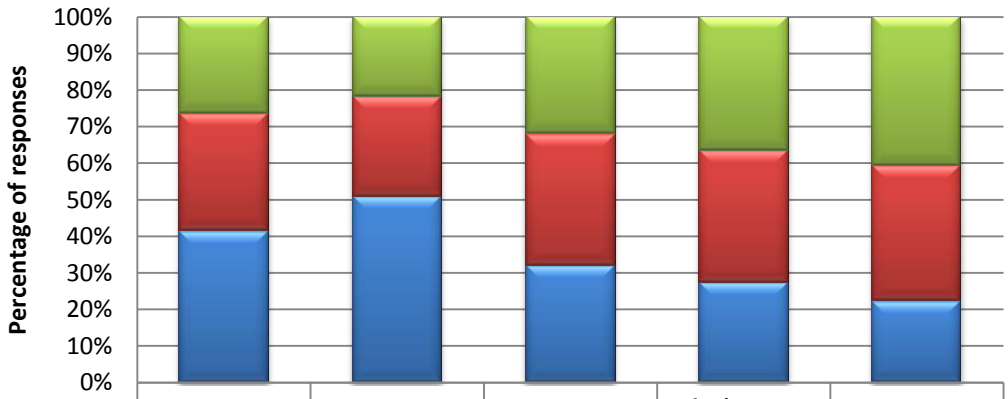
Of the 67% (n=56) who provided information regarding what would assist in implementing training, most cited logistical enablers such as: organised sessions, qualified trainers, accessibility, funding and human resources. Some made reference to making available Information material on the sessions to allow them to make informed decisions about attending.

Just over half of the respondents (54%, n=45) provided information regarding some of the perceived challenges to implementing such staff training as outlined in Table 4. Barriers identified included:

- no or little need for the training (n=5);
- such training was not applicable to their facility (n=15);
- limited funding, time and human resources (n=15);
- staff and residents' attitudes and beliefs (n=10); and
- accessibility (n=3).

Respondents were also asked about what additional services their facility may be interested in utilising. Figure 10 provides a visual and statistical overview of the responses provided. Most facilities would be interested in GLBTI resources which can be displayed and used within their facility. Some listed a GLBTI personal perspective speaker as a useful resource, whereas fewer were interested in assistance with GLBTI policy writing and building relationships with GLBTI community groups. Those who make up the "not applicable" category indicated that given the size of their facility and the potential target group, additional services were not relevant at the present time, others indicated that they may need assistance in the future and one respondent stated that they would have to check with their residents before engaging any of the additional services available.

Figure 10 Services available to assist facilities with GLBTI issues



	GLBTI personal perspective speaker	GLBTI resources	Assistance with GLBTI policy writing	Assistance with building relations with GLBTI community groups	Not applicable
Unsure	26.40%	21.80%	31.90%	36.40%	40.70%
No	32.10%	27.30%	36.20%	36.40%	37%
Yes	41.50%	50.90%	31.90%	27.30%	22.20%

6.2 Qualitative results

6.2.1 Characteristics of industry focus group participants

Of the three managers who participated in the focus group, one was a CEO of a corporate entity which governed five facilities. These facilities provided independent living units and low care residential accommodation. The second participant was the manager of a single entity retirement village. The third participant was the care manager of a corporate entity which governed 20 facilities, providing low care residential accommodation.

6.2.2 Characteristics of GLBTI focus group participants

Three people participated in this focus group and comprised of two lesbians and one gay male.

6.2.3 Focus Group 1 – Industry participants

In the focus group discussion, members talked about experiences with GBLTI clients from both an organisational and personal perspective. It was clear that there had been very few interactions with known GLBTI clients throughout their careers. Only one respondent had some experience with GBLTI staff and residents. The other two did not have any. Of particular note is that the respondents who did not have any known experiences with GLBTI clients or staff had both been in the aged care sector for many years.

> *In all my years of working in health I've never had someone ever say to me, I'm a lesbian female, out of the people that are, within, you know within the patients or the residents or whoever, never in that whole you know [time], in a number of, number of years. So I don't know how staff would respond in that situation* (Respondent low care facility)

> *It never came across my desk as an issue. Lots of sexual issues between staff, between clients, between clients and family and all sorts of things, but never non-heterosexual issues* (Respondent independent living)

Respondents also discussed some of the challenges they perceived for the retirement and residential aged care sector with regards to accommodating GLBTI residents. Key areas emerged from this discussion included: the impact of staff and other residents' own prejudices, discrimination; intimacy and privacy issues; client isolation; and that fact that older GLBTI people were a minority group.

Client isolation was raised as a challenge for the aged care sector as a result of clients having to hide their sexual orientation and/or gender identity. This was a result of older GLBTI people coming into a small community setting (the facility) where they were no longer able to keep their private sphere separated from their social and work spheres. It was thought that they would disclose more of what had been a very private part of their lives.

> *So either they make a decision that they want to let people know about their sexuality or they decide not to let people know because that's the way they've always lived and they become more isolated* (Respondent high/low care facility).

Other residents and staff perceptions as well as discrimination were also seen to be potential challenges for service providers. However respondents indicated that this was an ongoing challenge for providers regardless of the issue.

> *… there is one gentlemen [who] won't allow anybody unless they're a DVA [Department of Veterans Affairs] person to sit at their table and this is, you know that's the full extent of it* (respondent high/low care facility).

> *… you could equally have a problem with a staff member or a resident or somebody else in terms of prejudice or problems so you've got to keep it in perspective because it's likely to be a minority of people and you just have to deal with it as an organisation and as a manager, you just have to work your way round it because my belief is the majority of people would have no, of staff and residents whether it's in a care setting or a retirement village, would have no issues and [they] would just live with it and live around it* (Respondent independent living).

> *… there would be no more discrimination than it would be for any other issue that someone might have a problem with, whether it was religion or cultural background or something* (Respondent independent living).

The respondents also raised the issue that sexuality in general, regardless of sexual orientation or gender identity, was not addressed adequately in residential aged care facilities. The reason respondents provided was that sexuality does not form part of the aged care standards and does not form part of any outcomes or required assessment criteria and consequently is not addressed.

> *It's not on the ACME assessment in terms of doing an assessment on how you get your funding. So it doesn't, it's not captured anywhere ……. So there may well be a lot of people within our facilities who have all sorts of different backgrounds that we just don't know about* (respondent low/high care facility).

The group was asked about the benefits they saw as service providers in knowing if a person was GBLTI. There was agreement it was important to know such information as this would drive the development of the care and lifestyle plans for that client and assist in providing the best possible care. No other benefits were identified by respondents.

One discussion question sought to explore the emerging theme from the industry surveys "we treat everybody the same". Respondents generally agreed that this was due to a very strong anti-discrimination and equal opportunity focus within the sector and that organisational policy incorporates the philosophy that everyone is treated as equally. This philosophy was also evident through sector education and training.

> *…..that particular facility just got on and treated everybody exactly the same in terms of, from, it made no difference whatsoever* (Respondent low/high care facility).

A scenario was provided to further explore the mantra "we treat everybody the same", and highlight some key issues and ways of addressing such issues when caring for older GLBTI people. The scenario was around an older gay man having friends visit him in a residential care facility and bringing him gay magazines/papers to keep him up to date with activities happening in the GLBTI community. Interestingly respondents immediately assumed that such material was pornographic in nature and that the issue was about sexual activity rather than social connectedness.

Additionally the scenario raised the issue of homophobic comments from other residents, and posed the question of how, as a manager, such comments would be handled. All respondents agreed that this would not be an issue, as discrimination of any sort was not tolerated. If it was a staff member who had made the discriminatory comment then they would be disciplined and if it was another resident then the situation would be taken seriously and managed sensitively. The respondents did agree that it is more difficult to manage discrimination by residents. The discussion highlighted that discriminatory comments and attitudes occur at times regardless of what the issues may be and need to be handled appropriately.

> *…. we had a Japanese lady living with us and a gentleman who…. was a prisoner of war and there are very varied views and it'd be fair to say that these two are living in comfortable ambience but it wasn't the case initially* (Respondent low/high care facility).

Also during the discussion the lack of knowledge of recent federal and state legislative changes around sexuality and diverse sexuality issues from survey respondents was raised. Focus group respondents indicated that it may have been the way the question was phrased in terms of specific legislation rather than an overall lack of knowledge of such. However, knowledge of recent legislative changes was still minimal.

The discussion turned to the respondents wanting to know what the older GLBTI population saw as some of the issues and how they could be addressed. Respondents indicated that the aged care sector has many competing priorities, and for the specific needs of older GBLTI to be a main concern, there needs to be an indication of how large such a minority group is in terms of numbers, as the larger the group the greater the priority.

> *… my advice to [GRAI]…, if they've got any evidence of 5-15% [of the population being GLBTI] they should be telling [the aged care industry], they should be headlining any report that goes to an organisation [with such information] because that suddenly become the biggest, the biggest minority group* (Respondent independent living).

Respondents believed that the larger the older GLBTI population, the greater the priority on integrating this issue into aged care training. Once again this came back to competing agendas and the fact that the sector was continuously required to undergo various types of training when it was under resourced in the areas of finance and personnel.

> *I think given the range and the level of training that currently aged care facilities have to do as a requirement I'd be honest and say I think that [GLBTI training] would be quite low down on the list of priorities* (Respondent independent living).

However, there was agreement that if the GLBTI group was a large enough minority group, indicating that there was a need, then providers would be receptive to training around GLBTI issues. For the industry to be receptive, the training would have to be: well resourced, sympathetic to the limited resources available to facilities, readily available and delivered externally.

6.2.4 Focus Group 2 – GLBTI participants

In the focus group discussion, members talked about their personal experiences with providers of retirement and/or residential aged care accommodation. The group's experiences were with providers of residential high care accommodation only. The group perceived providers of residential high care as institutionalised with regimented routines, little room for individuality and little control in decision making.

> *Everyone's treated just the same and they have their own room and they're just thrown into the [mix] as to what care that they get so I don't know, but it's very, it's very matter of factual…..And it's not where you want them to go it's where there's a place for them* (Participant focus group 2).

Participants viewed themselves as self funding their own aged care needs and not as users of aged care accommodation. This applied to community care and developing small communities with friends. There was a belief that if a person had the financial means, then they would be able to 'buy' good care in later life free from discrimination and prejudice.

> *Yeah I think the bottom line's always money. I think that we can have the best care if we've got the money for care, regardless of whether we're gay or straight* (Participant focus group 2).

> *But I imagine if my parents had money enough to actually have care where she [mum] could have stayed in the home I could see a whole different scenario happening with my father and my mother and their relationship and what's actually happening to my father at the moment could be completely different* (Participant focus group 2).

> *We thought if we couldn't find care we're going to have to take care of ourselves. I mean we've got nurses and doctors [as friends] so we're a group of professionals and we thought that we could build a little community ourselves and take care of ourselves* (Participant focus group 2).

The group acknowledged that many GLBTI people do not or will not have the financial means to seek private care in older age and that they would have to rely on the public system. There was a feeling that this would most likely be a grim future.

> *…… I have a son, all of his friends who know that we're gay, out of that pool of 26 year olds, they're going to be our carers and I'd like to think that they'll take good care of us, without prejudice, without anybody actually having to tell them that they need to be nice to us* (Participant focus group 2).

Participants discussed some of the issues they perceived as pertinent for the retirement and residential aged care sector when accommodating GLBTI clients. There was strong agreement that the culturally diverse workforce which exists within the aged care sector could be an issue as staff are likely to have different religious, political and cultural beliefs.

> *Like at the moment because we've got immigration from the sub-continent just pouring through the door their cultural caring for them [residents] is different from what Western or Australian cultural difference is and that's where I think there will be [issues] for us, 'cause I think people are going to come from the Philippines and India and maybe the Arabic countries and they're culturally very different. So I think that's going to impact on gay people or whatever their orientation is and whatever their expectations are because those different sexual orientations are not as accepted as much* (Participant focus group 2).

Respondents were asked about what they thought some of the possible solutions to these identified issues might be. Participants felt that acceptance and integration of openly GLBTI people into retirement and residential aged care accommodation was an evolving process, linked to society's acceptance of GLBTI people in general. They did not expect to see such societal changes happening within their lifetime.

> *How do we effect the change? And I don't know whether we can … but in the end I don't know I suppose ultimately it would lead to something but not in our lifetime, not as we know it* (Participant focus group 2).

> *Younger people in their twenties, by the time they get to our age the process of where we've evolved to will be acceptable but I don't know for us how we're going to get from where we are to being in aged care if that's what's going to happen to us where it becomes acceptable* (Participant focus group 2).

> *I don't believe you will affect society that much that I can slap a big kiss on my partner's lips* (Participant focus group 2).

This was also linked with ageing being a low priority within the GLBTI community itself, particularly among younger members. The GLBTI community was seen as being youth focused, with little intergenerational opportunities.

Participants identified education, accreditation and compliance as means of overcoming some of the issues. They believed that there had to be explicit legislation referring to discriminatory practices based on sexual orientation and/or gender identity, which was linked to accreditation to ensure compliance.

> *I think ... once it's [legislation] in, once it is written I think people are more cautious* (Participant focus group 2).

> *People are not, you know are aware and they may not agree with it, they may think it's a whole lot of crap but because they're going to get hurt by it [lose their accreditation] or could do, then they have to comply, they comply so I think … [it's] … got to be codified and it's got to be spelled out* (Participant focus group 2).

Participants were also provided with a copy of the *draft best practice guidelines – accommodating older GLBTI people*, and asked to comment on their expectations and views of such guidelines. Participants agreed that having such guidelines was a good idea and a necessary part of the process in educating the retirement and aged care sector of the needs of older GLBTI people. However they did express concern about implementing the guidelines and having industry come on board.

> *I think the idea is really great. I think implementing it will be a challenge* (Participant focus group 2).

> *Just simple change in a hospital environment is extremely difficult, this is a huge change. It will take a long time and be extremely difficult* (Participant focus group 2).

> *I think the concept's really good like having posters up and talking about showing posters around places, couples, same sex couples, [but to] display posters and stickers [could be] difficult* (Participant focus group 2).

7.0 DISCUSSION

Findings from this study indicate that the retirement and residential aged care sector in WA is ill prepared to meet the specific needs of older GLBTI people currently in supported accommodation. Furthermore unless change occurs and older GLBTI people are recognised as a minority group with specific needs, the industry will remain ill prepared to meet the needs of GLBTI baby boomers seeking supported accommodation into the future.

There was a general lack of understanding among respondents of the impact of the social and historical context of belonging to a minority sexuality group and the effects of living in a heteronormative environment. This meant that statements such as 'we treat everybody the same' without understanding that while the physical care needs of GLBTI residents will be the same as heterosexual residents, the attitudes of staff can impact negatively on GLBTI clients. For example making derogatory comments about GLBTI people and issues, non-acceptance of partners or close friends as being a resident's family of choice, using language such as asking questions about a 'spouse' or making judgement based on personal attitudes towards GLBTI people such as implying a homosexual lifestyle is immoral, all undermine a sense of personal worth and self-esteem of GLBTI residents.

Many facilities had not considered these unique needs. It was not that they were necessarily antagonistic but that they lacked an understanding of this. Hence many respondents were open to the idea of increasing staff training in these areas.

7.1 Implications for service providers

It is estimated that approximately 8% of the ageing population potentially identify as GLBTI, possibly making this one of the largest minority groups accessing retirement and residential aged care services. The findings from this study have a number of implications for providers of retirement and residential aged care accommodation.

Implications of invisibility and disclosure

Older GLBTI people currently accessing retirement and residential aged care are a hidden population, as demonstrated in this and other studies. Older GLBTI people may not feel comfortable or safe to disclose their sexual orientation and/or gender identity for fear of discrimination, abuse and reduced quality of care. This can have significant health issues and can manifest as stress, anxiety and depression from continually having to maintain a false heterosexual persona. It can also have significant health consequences as important information which impacts on the provision of care may not be disclosed.

As a result of concealment and invisibility, providers tend to be unaware of the existence of older GLBTI residents within their facilities. As such providers are less likely to be able to address the underlying causes of such health issues. They are also less likely to support community connectedness and sexual expression which can impact on overall well being.

The majority of respondents who participated in this study did not have any organisational procedures for handling disclosure of sexual orientation and/or gender identity. Staff must be trained and have the skills to deal with disclosure to ensure that the person disclosing is safe from discrimination by staff and other residents. Such skills will assist in reducing the likelihood of staff unintentionally 'outing' the person who has disclosed, as they are aware of the impact of such. It is the responsibility of the facility to provide a safe living environment for their clients.

Implications of personal attitudes and beliefs in the delivery of care

Heteronormativity and homophobia exist within the broad community and are therefore likely to exist in retirement and residential aged care facilities (Barrett, Harrison, and Kent 2009; Roach 2004). Specific to the aged care industry is its culturally diverse workforce. Some staff may come from countries where discriminatory attitudes and laws against homosexual activity are prevalent. Additionally perceptions, values and attitudes can impact on an individual's level of comfort around issues of sexuality and in particular diverse sexuality groups (Roach 2004). Therefore standards of care can be compromised when staff hold negative personal attitudes towards GLBTI people. It is the responsibility of the care providers to ensure that staff receive adequate training which addresses sexuality in older people including diverse sexuality groups. Such training should also highlight the negative consequences of homophobia and discrimination based on gender identity and/or sexual orientation.

Inclusive communication

"Terminology has implications for the way in which groups view themselves and live their lives" (Smith and Calvert 2001. 12). It is important that staff use appropriate language that is respectful and aligned with how a person identifies themselves. Providers can develop inclusive assessment and data collection forms through the use of appropriate language and terminology, such as using the word 'partner' instead of the words 'husband', 'wife' or 'married'. Such terminology is gender neutral and non-discriminatory and can make GLBTI people feel comfortable and safe to disclose information that may impact on their quality of care.

GLBTI-sensitive practices

Good practice requires a fundamental understanding of diversity as well as knowledge of the impact of an individual's past experiences of homophobia and social exclusion. GLBTI-sensitive practices include appropriate intake and assessment practices, referral sources and access to resources (GLBTI Ministerial Advisory Council [MAC] 2009). Additionally there needs to be an understanding and appreciation of the impact of history and culture (sexual orientation, past experiences, race, gender, etc) on an individual's beliefs and behaviour and their interactions with health professionals.

Consequently, some older GLBTI people have a genuine fear that homophobic attitudes of institutionalised aged care facilities will impact on the quality of care they receive, and that this could result in elder abuse (McNair and Harrison 2002). Older GBLTI people in general do not feel that it is safe to disclose their sexual orientation and/or gender identity to aged care providers as a result of their past experiences of discrimination (Barrett 2008). This stems from a time when disclosure could have resulted in imprisonment, ostracism, job losses and medical interventions. Additionally concerns are raised as a large number of residential facilities are run by religious organisations (McNair and Harrison 2002). The use of GLBTI-sensitive practices enables older GLBTI people to disclose information if they choose, which may impact significantly on having their needs met.

GLBTI-inclusive organisational policies and procedures

Very few if any respondents' organisational policy and procedures made specific reference to GLBTI people. Issues of sexuality were dealt with under general equal opportunity and antidiscrimination policy. Organisational policy sets the benchmark for expected staff behaviours and practices. Through specifically addressing GLBTI issues in organisational policy and procedures, organisations demonstrate their intent in having a GLBTI-inclusive environment and articulate what is expected of staff. It also limits unintentional and indirect marginalisation and discrimination of GLBTI people which can result from specific needs not being consciously considered, and a lack of awareness of relevant GLBTI issues (Irwin 2007; Tolley and Ranzijn 2006).

7.2 Best practice guidelines

The purpose of any best practice guidelines is to encourage organisations to provide the highest standards. One of the aims of the current research was to develop best practice guidelines for management and staff to adopt practices to create an inclusive environment, which is accepting and welcoming of all GLBTI people. They aim to provide an operational context whereby providers of retirement and residential aged care are better able to recognise, understand and meet the specific needs of GLBTI people. A copy of the full guidelines is found in Appendix J.

The development of the best practice guidelines was informed by results from this study and previous research carried out by GRAI, together with recommendations made in the following reports: *Guidelines for care for LGBT patients* (Gay and Lesbian Medical Association 2001), *Community standards of practice for provision of quality health care services for gay, lesbian, bisexual, and transgendered clients* (GLBT Health 1999), *Well proud: A guide to gay, lesbian, bisexual, transgender and intersex inclusive practice for health and human services* (GLBTI Ministerial Advisory Council [MAC] 2009) and *Permission to speak: Determining strategies towards the development of gay, lesbian, bisexual, transgender and intersex friendly aged care agencies in Victoria* (Barrett, Harrison, and Kent 2009).

Examining other recommendations and research findings enabled the identification of appropriate themes from which broad overarching principles were developed. Researching and scrutinising the layout and design of other best practice guidelines aided in the development of the final format. Feedback from the PCG and IAG on the draft guidelines was integrated, producing a final draft. A focus group consisting of members from the GLBTI community was conducted to seek feedback from the target group.

Differences between providers of retirement accommodation and providers of residential high and low care accommodation were considered during the development process. Thought was also given to the need to incorporate the guidelines into existing best practices and for them to be framed in an operational context. Considerations for the design and layout of the guidelines included: practicality, length, ease of use, relevance and functionality. A full outline of the design considerations and development process is outlined in Appendix I.

The guidelines have been produced as a separate, easy to use document which is to be distributed widely within the sector. The guidelines revolve around five identified principles which are supported by an explanatory statement. A ‘how’ section, provides simple low cost concrete examples of strategies for achieving each principle. This is then followed by a brief scenario, providing operational context.

The Best Practice Guidelines are based on five principles:

1. Inclusive and safe environment
2. Open communication
3. GLBTI-sensitive practices
4. Staff education and training
5. GLBTI-inclusive organisational policies and procedures

Refer to Appendix J for the full best practice guidelines – accommodating older GLBTI people.

As a result of this study the notion of older GLBTI people residing in retirement and residential aged care facilities has been highlighted. One facility who participated in the survey advised that as a consequence of the study they will be running a workshop for staff around older GLBTI issues. Furthermore GRAI has been contacted by a survey respondent who has a GLBTI resident. GRAI has consequently responded to this request.

7.3 Future research areas

Further research is required to build on the current body of knowledge around older GLBTI people in an Australian context. The following areas have been identified as requiring further research in order to improve the experience of older GLBTI people in residential aged care facilities. Where possible collaborative approaches enabling comparisons to be made between populations across Australia to provide a national perspective is desirable.

- further develop, implement and evaluate the use of the best practice guidelines developed in this project;
- developing and evaluating a training and education strategy for staff in the aged care sector covering issues of sexuality and gender and sexual diversity in older people;
- research the attitudes, perceptions and practices of the community aged care and ageing-in-place sector in relation to older GLBTI people; including recommendations to ensure GLBTI-inclusive practices in this sector;
- investigate approaches to aged care standards accreditation to include GLBTI inclusiveness criteria including the development of a comprehensive checklist covering areas contained in the best practice guidelines;
- the development of a GLBTI-inclusive assessment tool for providers of retirement and residential aged care which will allow for self monitoring and improvement to become a GLBTI-friendly service;
- examine how retirement and residential aged care providers have integrated the federal government's same-sex legislation into organisational policy and procedures;
- examine the diversity within the older GLBTI population, identifying particular needs of sub-groups;
- explore the implications of HIV and early ageing for providers of residential aged care; and
- research on the varied experiences of ageing as a member of the GLBTI community in Australia.

It is hoped that funding bodies consider these identified areas as worthy of investment.

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9.0 APPENDICIES

Appendix A Timeline – Gay Social History – Australia

1950s

- Homosexuality is illegal for males
- Those engaging in homosexual acts were prosecuted
- Discrimination was systemic in Government institutions
- Openly homosexual men were banned from being employed in Federal Government positions where they could access highly classified information - they were thought to possess a character defect which made them prone to pressure from foreign intelligence services. Therefore making them a national security risk
- Societal attitudes were ones of persecution, condemnation, hatred and discrimination
- Conversion therapy was practiced as a means to make people heterosexual
- Homosexuality was viewed as a "sickness, sin and disgrace" (Kimmel, Rose and David 2006. 1)
- Little motivation from the homosexual subculture for political activism or public debates as the 'gay scene' was concealed from the general population for fear of reprisal
- 'Gay scene' therefore invisible with little motivation (Willett 2000)
- The first attempt (unsuccessful) was made at establishing the first Australian homosexual law reform society
- Perth's earliest record of openly gay scene revolved around the Palace Hotel (1956)

1960s

- Stonewall Bar riots happened in New York - turning point in GLBTI activism - Gay Liberation Front formed in the US which motivated the formation of similar gay activist groups around the world (1969)
- Engaging in homosexual acts in all States in Australia is still a crime
- The ACT Homosexual law reform society successfully established in Canberra (1969)
- Support for homosexual law reform by The Humanist Society NSW (1969)
- Calls for decriminalisation of male homosexual acts are made by the NSW General Assembly of the Presbyterian Church (1967)
- NSW Council for Civil Liberties homosexual subcommittee agrees to support law reform similar to that of the UK, where the limited law reform of the Sexual Offences Act was granted (1967)

1970s

- The first branch of CAMP (Campaign Against Moral Persecution) is formed in Sydney. CAMP was Australia's first openly gay activist group. Branches around Australia soon followed.
- CAMP WA branch first meeting at St George's Cathedral in 1971
- CAMP Inc. - Australia's first homosexual magazine - was published and distributed
- Australia's first gay and lesbian demonstration takes place
- First public forum on gay liberation takes place
- The group Gay Liberation is formed in Sydney - first political activist association - other branches followed
- First National Homosexual conference is held in Melbourne

Appendix A Timeline – Gay Social History – Australia (continued)

1970s continued

- NSW General Assembly of the Presbyterian Church votes for homosexual law reform
- Australia's first commercial gay magazine William and John is published
- First attempt in WA to decriminalise homosexuality – unsuccessful
- Canberra and Goulburn Anglican Synod votes for homosexual law reform
- South Australia becomes the first Australian State to decriminalise homosexuality
- Shaftesbury Hotel in Stirling Street, Perth was popular with members of the gay community
- The Spartans club opened – first safe space for WA gay community (1971) followed by the opening of Connections – Perth's first openly gay bar opened in Northbridge (1975)

1980s

- ALSO Foundation formed in Victoria
- The Gay Rights Lobby is launched in Sydney
- First reports of AIDS cases from the US
- The first case of AIDS reported in Australia
- The WA AIDS Council (WAAC) is established (1985)
- First National AIDS Conference is held
- Australian Federation of AIDS Organisations is formed
- World AIDS Day first celebrated
- NSW is the first state to prohibit discrimination against homosexuality
- WA passes homosexual law reform decriminalising homosexuality (1989)

1990s

- The Australian Medical Association removes homosexuality from its list of illness and disorders
- Tasmania decriminalises homosexual acts, the last Australian State, to do so
- The Rainbow Flag is adopted in Australia (1992) as a gay symbol
- Federal cabinet lifts the ban on gay men and lesbians in the defence forces
- First Australian lesbian couple adopt a child (Adelaide)
- The Australian Centre for Gay and Lesbian Research at University of Sydney is launched
- The first International Lesbian Day is held
- First gay and lesbian exhibition, Pride and Prejudice, is held at the Australian Museum
- First Aboriginal gay and lesbian visual arts exhibition, *Looking Good*, is held
- Federal Industrial Relations Commission extends family leave to same-sex couples under Federal Awards
- First sexual health booklet for lesbians is produced by ACON (Sydney)
- Federal Department of Immigration introduces reforms to the interdependency visa, providing same-sex couples same rights as heterosexual couples

Appendix A Timeline – Gay Social History – Australia (continued)

1990s continued

- WA Equal Opportunity Commissioner releases a report recommending the inclusion of sexuality in the Equal Opportunity Act 1984
- Niel van Zee first openly gay man in WA to run for public office – unsuccessful (1995)
- Brian Grieg & John Hyde first openly gay men in WA to be elected to public office
- Northbridge WA becomes home to the annual PRIDE celebrations (1991)
- PRIDE WA collective formed (1990)
- First PRIDE parade held in WA (1991)
- Giz Watson first open lesbian elected to an Australian parliament (1996)

2000s

- Victoria adopts transgender anti discrimination law
- Victorian Parliament passes statutory amendments, providing same sex-couples the same legal rights as heterosexual couples with regards to: inheritance, stamp duty exemption, property division, workers compensation, State superannuation, recognition as a parent of non biological child, recognition as 'next of kin'
- Single women and lesbians eligible for IVF treatment in Victoria, NSW and QLD
- Amendment of the ACT Government's parental Leave Legislation, allowing same-sex parents the same access to parental leave as heterosexual parents
- The Victorian Relationship Register commences
- Federal Government introduces Same-sex Relationships (Equal Treatment in Commonwealth Laws—Superannuation) Act 2008 and Same-sex Relationships (Equal Treatment in Commonwealth Laws – General Law Reform) Act 2008. The Act recognises both de facto and registered same-sex relationships, ensuring same-sex couples and their dependent children receive the same entitlements as married and heterosexual de facto couples and their dependent children.
- To support the Same-sex Relationships Act 2008, amendments were made to:
  - Aged Care Act 1997
  - National Health Act 1953
  - Health Insurance Act 1973

Appendix B Industry focus group participant's information and consent form

GRAI
GLBTI Retirement Association Incorporated

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FOCUS GROUP PARTICIPANT INFORMATION SHEET

"Accommodation Options for Older Gay, Lesbian, Bisexual, Trans and Intersex (GLBTI) Individuals"
Curtin University of Technology, Bentley

Thank you for participating in the survey for this project and offering to be involved in further discussions. Two focus groups are being held with senior managers from various residential aged care providers, ranging from independent living through to high care services. The aim is to gather more in-depth information on the experiences, issues and challenges facing residential aged care providers relative to this client group.

The focus groups will be digitally recorded and take approximately 60 minutes of your time. All information provided will be treated confidentially and no names will appear on the transcribed interview. Extracts of the interview may be used in the research report, but you will not be identified in any way. Information collected and stored on audio files, written notes or computer files will be carefully secured at all times by the researcher. Data will only be accessed by the researcher and by supervised administrative staff involved in the transcribing of audio recordings. All information will be destroyed after five years.

Information from these focus groups, along with data collected from the industry survey, will inform the development of guidelines towards 'best practice' care for this client group. Consequently, your input is a critical component in ensuring such guidelines are informed, practical and appropriate. A copy of the Final Report, '*Accommodation Options for Older GLBTI Individuals*', will be sent to your organisation at the completion of the study.

Your participation is voluntary and without remuneration. You may withdraw from the focus group at any time without any disadvantage to you or your organisation. If you decide you want to take part in this focus group, please complete and sign the attached consent form. It is not envisaged that sensitive information will be collected during this discussion and there is no known negative consequences for participants.

This study has been approved by the University's Human Research Ethics Committee. Further information can be obtained from:

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WA Centre for Health Promotion Research & Centre for Research on Ageing
Curtin Health Innovation Research Institute | Curtin University of Technology

Focus Group Participants information and consent form V3 12.01.10

Appendix B (cont) Industry focus group participant's information and consent form

CONSENT FORM

I have read the attached *Focus Group Participant Information Sheet* and understand the aims of this focus group. I have also had an opportunity to ask questions, which have been answered satisfactorily.

I understand and am satisfied that this focus group discussion will be recorded by written notes and audio tape and that all the information provided is strictly confidential.

I agree to the information I provide to be used in reports and publications and understand that my anonymity will be maintained.

I appreciate that my participation in this focus group discussion is voluntary and without remuneration; and that I may withdraw at anytime without reason or prejudice.

I am aware that ethics approval from the Curtin University Human Research Ethics Committee has been received for this project.

Signed: _____ Dated: _____

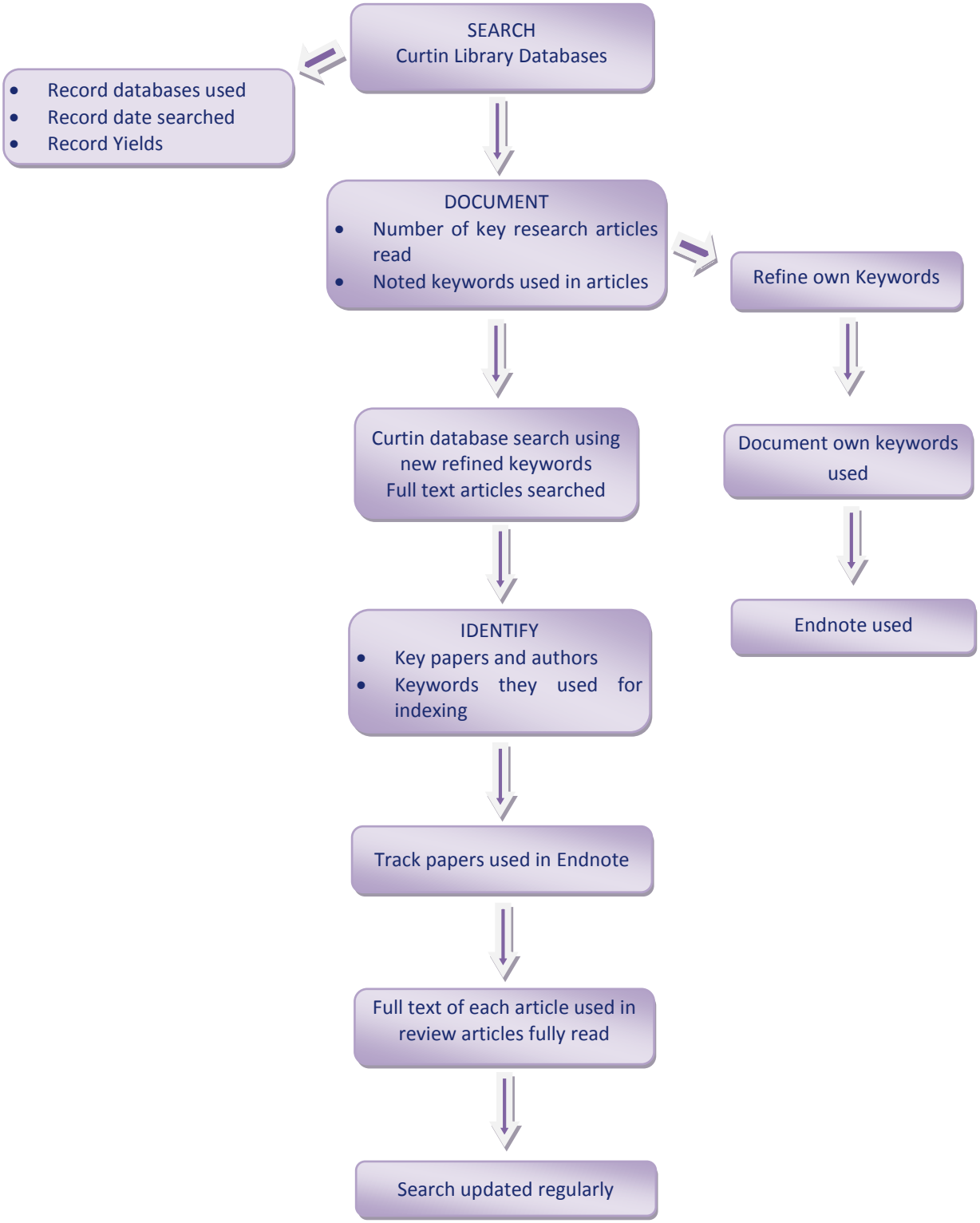
Name: _____

Email: _____

Name of your Organisation: _____

Focus Group Participants information and consent form V3 12.01.10 2

Appendix C Literature Review Research Process Flowchart



Appendix D Modified Dillman Protocol

1. SURVEY DESIGN - CONSIDERATIONS

- Organisational surveys differ from individual surveys
- Defined what constitutes a separate entity for the purposes of the survey ie organisation or facility
- Considered location of entities ie head office address may not be where 'business' is carried out
- Aware of possibility of business trading name being different than registered business name
- Used up to date database as business frequently change their names
- Aware that homogeneity of sample may not exist as organisational size varies as well as levels of care provided
- To overcome this pre telephone contact may be useful to determine diversity within sample
- Address survey to person who is to complete it if possible (increases likelihood of return)
- Considerations in questionnaire design for organisations
  - identify appropriate contact in organisation
  - plan for a mixed mode design (ie qualitative and quantitative data collection)
  - business friendly questionnaire
  - instructions provided in the questionnaire rather than separate booklet
  - industry liaison for content and design of survey (IAG)
  - tailoring of questionnaire to subgroups of population (different levels of care)

2. SURVEY DESIGN PROCESS

- Literature review and theme identification
- Development of questions for each theme
- Survey layout considered
- Survey developed
- Send to project team for feedback
- Incorporate review comments
- Send to Project Control Group for feedback
- Incorporate comments
- Send to Industry Advisory Group for feedback
- Incorporate comments
- Survey pretesting
  - Review by knowledgeable colleagues and analysts (PCG, IAG, research team)
  - Interview to evaluate cognitive and motivational qualities (Aged Care Assoc. Aust representative)
  - Pilot study – SwanCare Group – pilot with their departmental management team in the three areas of accommodation - i.e. community care, independent living and the low and high care centres.
  - Testing for grammar, format, process conducted by IAG and PCG

Appendix D Modified Dillman Protocol (cont)

3. SAMPLING

3.1 Survey goals

- Explore existing organisational and facility attitudes, knowledge and current practices towards older and ageing GLBTI people
- Ascertain current responses from the retirement and aged care residential sector in Western Australia to the needs of older and ageing GLBTI people

3.2 Parameters to be measured

- Attitudes
- Knowledge
- Current practices
- Understanding of needs

3.3 Sample characteristics

- Accommodation providers for older Western Australians
  - Retirement villages
  - Hostels (low care)
  - Nursing Homes (high care)
  - Respite

3.4 Sample size

- Sampling frame database was constructed from the Department of Health and Ageing's listing of aged care service providers in WA
- Centre for Research on Ageing's (CRA's) database listing of Retirement Village providers
- As the total number of the target population is relatively small ie total of 596 facilities in WA (Department of Health and Ageing listing 397 and CRA listing 199 totalling 596) every facility in the sampling frame is to be surveyed
- Therefore the whole target population is the sample
- Frame defects – Department of Health and Ageing's database is approximately 12 months old, CRA's database was last updated 12 months ago
- Predicted Non response/attrition as per Dillman (2007) is 70%

3.5 Criteria

- Inclusion
  - ❖ Included in the sampling frame
  - ❖ Accommodation providers for older Western Australians
- Exclusion
  - Community care – identified from organisational name such as Silverchain

3.6 Generalisability and representativeness of sample

- Generalisability
  - ❖ Generalisability to the Western Australian population is not an issue as the entire target population is the sample
  - ❖ Generalisability to the Australian population is limited as the sample is chosen from Western Australia

Appendix D Modified Dillman Protocol (cont)

- ❖ Efforts were made to procure questionnaires from similar surveys conducted in Victoria and South Australia to guide survey construction, however this was not successful. It would have been useful to use the same measures so that comparisons across the three States could have been made

- Representativeness will be determined once the data has been received and will be calculated on key characteristics such as:
  - ❖ Postcode (Q3)
  - ❖ Facility category of care (Q1)
  - ❖ Classifications (Q2)
  - ❖ Number of staff (Q5)
  - ❖ Single entity or multiple facilities (Q6)

3.7 Sampling Locations

The Rural, Remote and Metropolitan Areas (RRMA) classification from the Australian Institute of Health and Welfare Remote Classification Guide (2004) was used to categorise sample locations.

- State of Western Australia
  - ❖ Perth metropolitan area (Capital cities & other cities with population ≥ 100,000)
  - ❖ Rural WA (population between 10,000 – 99,999)
  - ❖ Remote WA (population less than 10,000)

3.8 Sampling Timing and Frequency

- Survey is to be administered by end of September 2009
- Implementation of survey and data collection will be done one time only

3.9 Procedures for recruitment of sample

- All organisations on the constructed database eligible to receive the survey
- Advertise the forthcoming survey through the IAG peak bodies to ensure organisations are aware of pending survey

3.10 Identifying and contacting participants

- All eligible participants on the constructed database are the target group
- Identify single entity organisations with one facility
  - ❖ CEO and Facility survey to be sent directly to the CEO at the facility address
- Identify large corporate organisations with multiple facilities
  - ❖ Phone CEO's of large corporate organisations with multiple facilities to receive verbal consent for their facilities to participate
  - ❖ CEO to advise how many facility surveys they require
  - ❖ CEO and multiple facility surveys to be sent directly to the CEO for distribution

3.11 Method

- Descriptive cross-sectional design
- Survey
  - ❖ Both qualitative and quantitative data will be collected in the survey
  - ❖ Section A provides background information
  - ❖ Section B provides general information about the person participating
  - ❖ Section C explores Experiences and Attitudes at the operational level (objective 1)

Appendix D Modified Dillman Protocol (cont)

- ❖ Section D explores Organisational Policy (objective 2)
- ❖ Section E explores Practices at the operational level (objective 1)
- ❖ Section F explores Future directions (objective 1)

- Content Validity
  - ❖ Survey reviewed by Project Control Group & Industry Advisory Committee
- Pilot study
  - ❖ Pilot tested on participants with same characteristics and from same sampling frame as main survey participants
  - ❖ These will now be excluded from main survey
  - ❖ Feedback from pilot study will be implemented for main survey

4. IMPLEMENTATION PROCESS (to be done at the CEO level)

- Number surveys
- Print surveys
- Identify independent entities
- Identify corporate entities
- Phone call to CEO's inviting them to participate in the survey
- Letter inviting them
- Packs: CEO pack & Facility
  - ❖ Print cover letter with personalised greeting on letterhead and same ID number as survey
  - ❖ Print labels for postage of surveys
  - ❖ Collate cover letter, survey, mailing envelope, mailing label and replied paid envelope
  - ❖ Collate CEO and Facility packs
  - ❖ Phone call to each CEO seeking participation
  - ❖ Send introductory letter to each CEO
- **Week 1**
  - ❖ Post out survey with replied paid envelope
- **Week 3**
  - ❖ Develop postcard thank you/reminder
  - ❖ Send to all participants
- **Week 5**
  - ❖ Letter and replacement CEO survey
  - ❖ Send to participants who have not responded
- **Week 6**
  - ❖ Telephone follow up
  - ❖ Write script for telephone call
  - ❖ Call non respondents only
  - ❖ Dillman (2007) suggests telephone follow up as an alternative to certified mail. A script is provided to the person conducting the phone call. This provides an opportunity to clarify any questions that may arise.
  - ❖ Also provides opportunity to complete survey on the telephone if necessary
  - ❖ Also provides opportunity to reassure people who do not wish to participate that they will not be contacted again

Appendix D Modified Dillman Protocol (cont)

- **Record keeping**
  - Code accordingly to identify 'return to sender' records from database prior to sending of postcard reminder/thankyou
  - Mark records to indicate completed and returned surveys prior to sending reminder letter and copy of survey
  - Amend mailing list records as per 'return to sender' mail received
  - Mark records to indicate completed and returned surveys prior to week 6 and follow up phone call
  - Mark records to indicate participants who received follow up phone call
  - Keep record of survey response rates

5. DATA COLLECTION PROCESS

- Design data entry workbook
  - Qualitative data analysis to use Nvivo
  - Quantitative data analysis to use SPSS or excel
- Enter responses as surveys are received (this will assist with identifying any problems in the early stages of the implementation process)
  - pilot data used to construct preliminary coding
  - Identification of themes
  - Description of relationship between qualitative and quantitative data collected
  - Description of how both sets of data will be integrated and interpreted
  - Description of the contribution of each method to the research
- Data interpretation
- Weighting
  - Description of how the sample design and final estimation weights were calculated
  - Description of how non response weight adjustments were performed
- Create survey results document
- Create survey summary (US Department of Health & Human Services n.d.)

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ID NUMBER:

Accommodation Options for Older Gay, Lesbian, Bisexual, Trans and Intersex (GLBTI) Individuals

EXECUTIVE SURVEY

Knowledge, attitudes and current practices of accommodation providers, relative to needs of older GLBTI individuals

WA Centre for Health Promotion Research & Centre for Research on Ageing

Curtin Health Innovation Research Institute | Curtin University of Technology

Appendix E Executive Survey (cont)

ID NUMBER:

COMPLETING THIS SURVEY

Thank you for completing this survey which will take between 5 and 10 minutes. Your responses will help to increase our knowledge about attitudes, knowledge, responses and current practices within the retirement and aged care accommodation industry, regarding the older gay, lesbian, bisexual, trans and intersex (GLBTI) population.

Any answers you provide will remain confidential. Please answer every question you can. There are no right or wrong answers. If you are unsure about how to answer a question, tick the response for the closest answer.

This survey is to be completed by the Chief Executive Officer.

INSTRUCTIONS:

- Clearly mark your answers as indicated
- Use the replied paid envelope provided
- Please write legibly
- Feel free to offer additional comments at any stage

Thank you for your assistance.

If you need help with completing this survey, please contact
Rita Freijah, Research Officer, Curtin University
Telephone: 08 9266 1832
Email: r.freijah@curtin.edu.au

This study has been approved by the Curtin University Human Research Ethics Committee. If needed, verification of approval can be obtained either by writing to the Curtin University Human Research Ethics Committee, c/- Office of Research and Development, Curtin University of Technology, GPO Box U1987, Perth, 6845 or by telephoning 08 9266 2784. Ethics approval number: SPH - 0044 – 2008.

2

Appendix E Executive Survey (cont)

ID NUMBER:

IMPORTANT INFORMATION

OBJECTIVES

This survey aims to:

1. Explore existing organisational and facility attitudes, knowledge and current practices towards older and ageing GLBTI people.
2. Ascertain current responses from the retirement and aged care residential sector in Western Australia to the needs of older and ageing GLBTI people.

TERMINOLOGY

Aged Care Accommodation:	For the purposes of this survey Aged Care Accommodation refers to accommodation for older people spanning the spectrum from independent retirement villages through to high care nursing homes.
Bisexual:	A person who is sexually and emotionally attracted to both males and females.
Code of Conduct:	Written organisational guide to ethical behaviour and organisational culture.
Facility:	Refers to the workplace at the operational level – that is the work setting in which actual services are provided.
Gay:	A male whose primary sexual and emotional attraction is towards males. Also can be used as a general term for homosexual of either gender.
Gender identity:	A person's sense of being male, female, somewhere in between or neither.
GLBTI:	Gay, Lesbian, Bisexual, Trans and Intersex
Guidelines/policy:	Organisational policy, procedures and guidelines which are explicitly enforced by the organisation.
Intersex:	A person born with sex chromosomes, external genitalia or an internal reproductive system that is not exclusively male or female.
Lesbian:	A female whose primary sexual and emotional attraction is towards females.
Organisation:	The overarching governing body of your Facility.
Sexual orientation:	Enduring emotional, romantic, sexual and relational attraction to another person; may be a same-sex orientation, opposite sex orientation or a bisexual orientation.
Sexuality:	Sexuality is about sexual feelings (who we are emotionally and sexually attracted to), sexual behavior (how we express our sexual feelings) and sexual identity (who we say we are to ourselves and others based on our internal beliefs).
Trans:	A person whose identity is at odds with their biological sex. A person who does not identify with the gender assigned to them at birth.

3

Appendix E Executive Survey (cont)

ID NUMBER:

CONSENT FORM

I agree to this Organisation and its Facilities participating in the "Accommodation Options for Older GLBTIs" (AOFOG) survey. I understand that this survey forms part of a wider research project (being conducted by Curtin University) into retirement and aged care issues for individuals in Western Australia who identify as GLBTI.

I have read and understood the enclosed *Information Letter*. By completing this consent form I understand that:

- Completing this survey is voluntary
- Any survey answers I provide, and my personal information, will remain confidential to the researchers
- Results from this survey may be published, but my anonymity will be maintained
- Anonymity of this Organisation, the individuals completing the surveys and Facilities involved will be maintained; and
- Ethics approval from the Curtin University Human Research Ethics Committee has been received for this project

I provide consent at the executive level for this Organisation and its Facilities to be involved in the survey.

Signed: _____ Dated: _____

Name of your Organisation: _____

All your answers to this survey, and any responses made by each Facility Manager to the 'Facility Survey' will remain confidential. However as part of the wider study into GLBTI retirement and aged care issues, researchers may need to contact some one to clarify survey responses, or to discuss key issues further. If you are happy to be contacted in the future, please provide your details below:

Name: _____

Contact phone number: _____

Contact e-mail: _____

4

Appendix E Executive Survey (cont)

ID NUMBER:

A) BACKGROUND INFORMATION

This section will provide some background information on your Organisation in terms of staffing, capacity and services provided.

1. Please indicate which classification(s) best describe your Organisation.
   (Tick all that apply)
   a) Not for profit ☐ c) State Government ☐ e) Faith based ☐
   b) For profit ☐ d) Local Authority ☐ f) Non faith based ☐

2. What is the length of time you have worked in the Aged Care Industry?

   Years _____

B) ORGANISATIONAL POLICY

This section will provide information regarding organisational policy relative to gay, lesbian, bisexual, trans and intersex (GLBTI) residents.
Please tick either Y=yes; N=no or U=unsure for each question

3. Does your organisation have established procedures to acknowledge and process complaints at an organisational level? Y ☐ N ☐ U ☐

   → If NO, go to Question 5

4. If "yes", are you aware of options for reporting experiences of discrimination based on sexual orientation and gender identity for: Y N U
   a) staff ☐ ☐ ☐
   b) residents ☐ ☐ ☐

   If "yes", please provide a brief description of the process

   _____

   _____

5. Are you aware of Policies your organisation has which include reference to GLBTI residents and/or staff? Y ☐ N ☐ U ☐

   If "yes", please specify _____

   _____

   _____

6. Please provide additional comment about any aspect of Policy and Practice at your organisation.

   _____

   _____

   _____

   _____

5

Appendix E Executive Survey (cont)

ID NUMBER:

Thank you for taking the time to complete this survey.

Your knowledge and experiences are greatly valued.

Please remember to sign the consent form, and return it with the survey booklet back to us no later than ***Wednesday 28 October 2009****, using the reply paid envelope provided.*

Further information on GLBTI ageing can also be found at:

GLBTI Retirement Association (GRAI)
www.grai.org.au

GLCS (Gay and Lesbian Community Services)
http://www.glcs.org.au/resources.html

WA AIDS Council (08) 9482 0000
http://www.waaids.com/

ACON (AIDS Council of NSW): Ageing Strategy 2006-2009
http://www.acon.org.au/about-acon/Strategies/ageing

Matrix Guild Vic Inc. *My People Report* and *Permission to Speak Report*
http://www.matrixguildvic.org.au/project.html

Australian Government's Same-Sex Law Reforms
http://www.ag.gov.au/samesexreform

GLBTI Health Alliance
http://www.lgbthealth.org.au/

Should you have any questions about this survey please contact
Rita Freijah, Curtin University
Telephone: 08 9266 1832
Email r.freijah@curtin.edu.au

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Appendix F Facility Survey

GRAI
GLBTI Retirement Association Incorporated

lotterywest supported

ID NUMBER

Accommodation Options for Older Gay, Lesbian, Bisexual, Trans and Intersex (GLBTI) Individuals

FACILITY SURVEY

Knowledge, attitudes and current practices of accommodation providers, relative to needs of older GLBTI individuals

WA Centre for Health Promotion Research & Centre for Research on Ageing
Curtin Health Innovation Research Institute | Curtin University of Technology

Appendix F Facility Survey (cont)

ID NUMBER:

COMPLETING THIS SURVEY

Thank you for completing this survey which will take between 15 and 20 minutes. Your responses will help to increase our knowledge about attitudes, knowledge, responses and current practices within the retirement and aged care accommodation industry, regarding the older gay, lesbian, bisexual, trans and intersex (GLBTI) population.

Any answers you provide will remain confidential. Please answer every question you can. There are no right or wrong answers. If you are unsure about how to answer a question, tick the response for the closest answer.

This survey is to be completed by upper or middle management staff. This includes: Manager of Care, Health Information Manager, Facility Manager, Administration Manager, Senior staff, Administrator, Director of Nursing, Nurse Manager, Activity Director, Physical Therapy Director, Volunteer Director or other Facility Managers.

INSTRUCTIONS:

- Clearly mark your answers as indicated
- Use the replied paid envelope provided
- Please write legibly
- Feel free to offer additional comments at any stage

Thank you for your assistance.

All your answers to this survey will remain confidential. However as part of the wider study into GLBTI retirement and aged care issues, researchers may need to contact some participants to clarify survey responses, or to discuss key issues further. If you are happy to be contacted in the future, please provide your details below:

Name: _____

Contact phone number: _____ Contact e-mail: _____

If you need help with completing this survey, please contact
Rita Freijah, Research Officer, Curtin University
Telephone: 08 9266 1832
Email: r.freijah@curtin.edu.au

This study has been approved by the Curtin University Human Research Ethics Committee. If needed, verification of approval can be obtained either by writing to the Curtin University Human Research Ethics Committee, c/- Office of Research and Development, Curtin University of Technology, GPO Box U1987, Perth, 6845 or by telephoning 08 9266 2784. Ethics approval number: SPH - 0044 – 2008.

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Appendix F Facility Survey (cont)

ID NUMBER:

IMPORTANT INFORMATION

OBJECTIVES

This survey aims to:

1. Explore existing organisational and facility attitudes, knowledge and current practices towards older and ageing GLBTI people.
2. Ascertain current responses from the retirement and aged care residential sector in Western Australia to the needs of older and ageing GLBTI people.

TERMINOLOGY

Aged Care Accommodation:	For the purposes of this survey Aged Care Accommodation refers to accommodation for older people spanning the spectrum from independent retirement villages through to high care nursing homes.
Bisexual:	A person who is sexually and emotionally attracted to both males and females.
Code of Conduct:	Written organisational guide to ethical behaviour and organisational culture.
Facility:	Refers to the workplace at the operational level – that is the work setting in which actual services are provided.
Gay:	A male whose primary sexual and emotional attraction is towards males. Also can be used as a general term for homosexual of either gender.
Gender identity:	A person's sense of being male, female, somewhere in between or neither.
GLBTI:	Gay, Lesbian, Bisexual, Trans and Intersex
Guidelines/policy:	Organisational policy, procedures and guidelines which are explicitly enforced by the organisation.
Intersex:	A person born with sex chromosomes, external genitalia or an internal reproductive system that is not exclusively male or female.
Lesbian:	A female whose primary sexual and emotional attraction is towards females.
Organisation:	The overarching governing body of your Facility.
Sexual orientation:	Enduring emotional, romantic, sexual and relational attraction to another person; may be a same-sex orientation, opposite sex orientation or a bisexual orientation.
Sexuality:	Sexuality is about sexual feelings (who we are emotionally and sexually attracted to), sexual behavior (how we express our sexual feelings) and sexual identity (who we say we are to ourselves and others based on our internal beliefs).
Trans:	A person whose identity is at odds with their biological sex. A person who does not identify with the gender assigned to them at birth.

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Appendix F Facility Survey (cont)

ID NUMBER:

FACILITY SURVEY

"Facility" refers to the workplace at the operational level – that is the work setting in which actual services are provided.

A) BACKGROUND INFORMATION

This section will provide some background information on your Facility in terms of staffing, capacity and services provided.

1. **Your Facility's name.** _____

2. **Please indicate which category(s) best describe your Facility.**
   (Tick all that apply)

		No. of beds
a) Nursing home (high care)	☐	_____
b) Hostel (low care)	☐	_____
c) Community Care	☐	_____
d) Retirement Village/Independent living	☐	_____
e) Dementia specific	☐	_____
f) Other	☐	_____

Please specify _____

3. **Postcode of your Facility** ☐☐☐☐

4. **How many full time *equivalent* staff work at your Facility?**
   (Tick one box only)

Full time *equivalent* staff	
a) 1 – 25	☐
b) 26 - 50	☐
c) 51 - 75	☐
d) 76 - 100	☐
e) 101 - 200	☐
f) 201 - 500	☐
g) >500	☐

B) DETAILS OF PERSON COMPLETING THE SURVEY

This section provides some information about you, the survey respondent.

5. **What is your job title?**

_____

6. **What is the length of time you have worked in the Aged Care Industry?**

Years _____

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Appendix F Facility Survey (cont)

ID NUMBER:

C) FACILITY EXPERIENCES AND ATTITUDES

This section asks for information regarding experiences with GLBTI residents and explores Facility perspectives regarding the GLBTI population.

Please tick either Y=yes, N=no or U=unsure for each question

7. Are you aware of any GLBTI residents accommodated within your Facility? Y ☐ N ☐ U ☐

If "yes" tick the appropriate box(es)

	Current Residents	Previous Residents
a) Gay	☐	☐
b) Lesbian	☐	☐
c) Bisexual	☐	☐
d) Trans	☐	☐
e) Intersex	☐	☐

8. Tell us about your Facility's experiences with GLBTI residents and/or families

_____

_____

_____

9. Does your Facility regard GLBTI residents as a group which have specific accommodation needs? Y ☐ N ☐ U ☐

Why or why not?

_____

_____

10. Has your Facility provided you or any other member of staff with any type of training with regard to GLBTI issues? Y ☐ N ☐ U ☐

If "yes" please provide details below (i.e. the type of training and types of topics discussed)

_____

_____

11. Does your Facility have a definition for 'next of kin'? Y ☐ N ☐ U ☐

If "yes" please provide details of the definition(s) below

_____

_____

12. Does your Facility have a definition of 'family' or 'immediate family'? Y ☐ N ☐ U ☐

If "yes" please provide details of the definition(s) below

_____

_____

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Appendix F Facility Survey (cont)

ID NUMBER:

13. Are you aware of any aspects of State and/or Federal legislation relating to GLBTI people which are incorporated into your Facility's policy? Y ☐ N ☐ U ☐

If "yes" please describe:

a) State _____

_____

b) Federal _____

_____

14. Please circle the most appropriate answer from the perspective of your Facility
(1=strongly disagree, 2=disagree, 3=unsure, 4=agree, 5=strongly agree)

Please circle one number on each line

		Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
a)	Your Facility recognises that GLBTI residents have specific needs	1	2	3	4	5
b)	Same-sex partners of a resident have the opportunity to be involved in that person's care	1	2	3	4	5
c)	Your Facility provides a GLBTI friendly environment	1	2	3	4	5
d)	Non-judgemental language is used and promoted within your Facility's printed Policy and Procedure documents	1	2	3	4	5
e)	All residents' beliefs and personal diversity (e.g. religious, cultural, sexual) are promoted within your Facility's Policies and Procedures	1	2	3	4	5
f)	A resident's sexuality is not of concern to your Facility	1	2	3	4	5
g)	Staff treat residents as individuals (not defined by their cultural/political/sexual identity) at your Facility	1	2	3	4	5
h)	Your Facility provides a trusting environment where residents feel safe enough to disclose their sexual orientation	1	2	3	4	5
i)	GLBTI issues are not important to your Facility	1	2	3	4	5
j)	GLBTI residents' needs are openly discussed at your Facility	1	2	3	4	5
k)	Other residents are encouraged to support a GLBTI friendly environment	1	2	3	4	5

15. Do the forms used to collect data and information by your Facility allow a client to self-identify as GLBTI? Y ☐ N ☐ U ☐

16. Do the resident admission criteria for your Facility include the term 'sexual orientation' or similar terminology? Y ☐ N ☐ U ☐

If you use a different term please specify _____

_____

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ID NUMBER:

17. Some forms may only treat a person as heterosexual. Please indicate which, if any, of the following forms used by your Facility include language and/or images that may appear that way. *(Tick all that apply)*

a) Data collection forms ☐
b) Assessment forms ☐
c) Admission forms ☐
d) Promotional material (eg brochures, pamphlets) ☐
e) Not applicable ☐
f) None of the above ☐
g) Other ☐
Please specify _____

18. Please provide additional comments about any aspect of Policy and Practice at your Facility.

_____

_____

D) CURRENT FACILITY PRACTICES

This section will provide information regarding current practices within your Facility with regards to GLBTI residents. *Please tick either Y=yes, N=no or U=unsure for each question*

19. Does your Facility make use of various means to indicate to members of the GLBTI population that it provides an inclusive environment? Y ☐ N ☐ U ☐

If "yes", please describe how this is achieved _____

_____

_____

20. Does your Facility currently have a nominated staff member who acts as a GLBTI support person either formally or informally? (This does not include GLBTI clients or their partner or family). Y ☐ N ☐ U ☐

If "yes" please provide details of how this operates _____

_____

_____

21. Does your Facility currently have any partnerships with GLBTI community organisations? Y ☐ N ☐ U ☐

If "yes", please indicate below

a) GLBTI Retirement Association (GRAI) ☐
b) Gay and Lesbian Community Services ☐
c) WA AIDS Council ☐
d) GLBTI Health Alliance ☐
e) Other. Please specify ☐

_____

_____

_____

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Appendix F Facility Survey (cont)

ID NUMBER:

	Y	N	U
22. Does your Facility have current practices which promote a welcoming and accepting atmosphere for GLBTI people? If "yes" please describe _____	☐	☐	☐
23. Further comments on current Facility practices _____			

E) FUTURE DIRECTIONS

This section will provide information regarding some of the issues and challenges considered by your Facility when accommodating GLBTI residents.

Please tick either Y=yes, N=no or U=unsure for each question

	Y	N	U
24. Does your Facility anticipate any challenges with ***staff*** in regards to the residency of GLBTI people in the future? If "yes", please describe _____	☐	☐	☐
25. Does your Facility anticipate any challenges with ***residents*** in regards to the residency of GLBTI people in the future? If "yes", please describe _____	☐	☐	☐

26. If you had access to training which of the following would you like to see covered in your staff training plan? *(Tick all that apply)*

a) Specific needs of GLBTI older people ☐
b) Managing resident and/or staff disclosure of sexual orientation ☐
c) Legal responsibilities regarding discrimination ☐
d) Legal responsibilities regarding State and Federal same-sex laws ☐
e) Sexuality and sexual expression ☐
f) Sexual and gender identities ☐
g) Safeguarding GLBTI individuals from discrimination by other residents ☐
h) How staff beliefs and values can impact on delivery of care ☐

27. What would assist your Facility in implementing the above training topics?

28. What barriers/challenges might there be in implementing the above training topics?

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Appendix F Facility Survey (cont)

ID NUMBER:

29. Is your Facility interested in any of the following services? *(Please tick all that apply)*

	Y	N	U
a) GLBTI personal perspective speaker	☐	☐	☐
b) GLBTI resources	☐	☐	☐
c) Assistance with GLBTI policy writing	☐	☐	☐
d) Assistance with building relationships with GLBTI community groups	☐	☐	☐
e) Not applicable	☐	☐	☐
f) Other	☐		

Please specify _____

HAVE WE MISSED ANYTHING?

Is there anything further you would like to add, about retirement and aged care accommodation, or GLBTI issues?

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Appendix F Facility Survey (cont)

ID NUMBER:

Thank you for taking the time to complete this survey.
Your knowledge and experiences are greatly valued.

Please return this survey booklet back to us no later than ***Wednesday 28 October 2009****, using the reply paid envelope provided.*

Further information on GLBTI ageing can also be found at:

GLBTI Retirement Association (GRAI)
www.grai.org.au

GLCS (Gay and Lesbian Community Services)
http://www.glcs.org.au/resources.html

WA AIDS Council (08) 9482 0000
http://www.waaids.com/

ACON (AIDS Council of NSW): Ageing Strategy 2006-2009
http://www.acon.org.au/about-acon/Strategies/ageing

Matrix Guild Vic Inc. *My People Report* and *Permission to Speak Report*
http://www.matrixguildvic.org.au/project.html

Australian Government's Same-Sex Law Reforms
http://www.ag.gov.au/samesexreform

GLBTI Health Alliance
http://www.lgbthealth.org.au/

Should you have any questions about this survey please contact
Rita Freijah, Curtin University
Telephone: 08 9266 1832
Email r.freijah@curtin.edu.au

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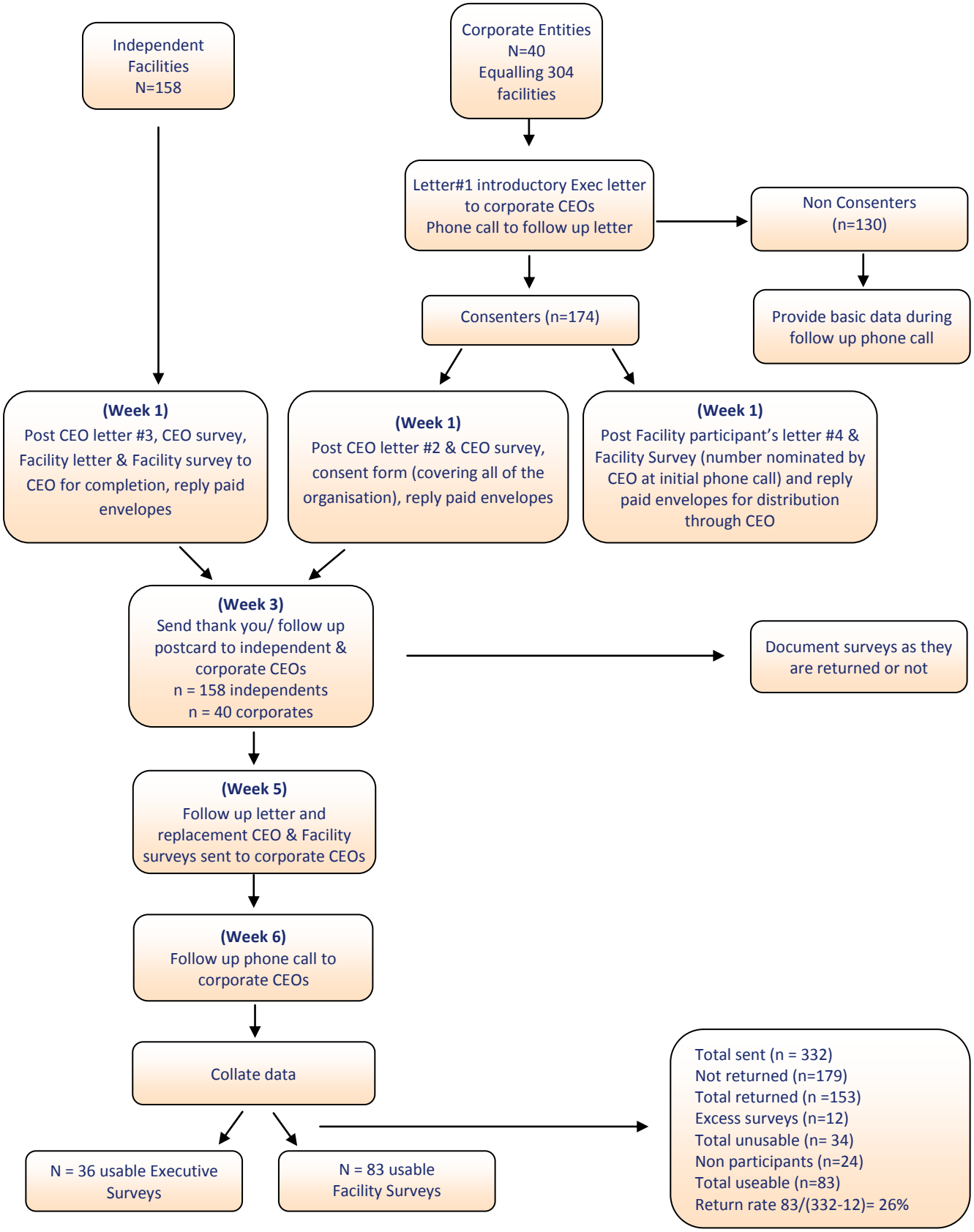
Appendix G Survey Protocol Flow Chart



Appendix H Focus Group Invitation to Participate

GRAI
GLBTI Retirement Association Incorporated

lotterywest

"Retirement accommodation and aged care issues for non-heterosexual populations" Social Research Project

Dear Bob

Curtin University has partnered with the Gay Retirement Association Inc. (GRAI) to conduct research into the needs of older gay, lesbian, bisexual, trans and intersex (GLBTI) people who require supported accommodation as they age. The research is supported by a Lotterywest Social Research Grant.

Thank you for participating in the survey for this project and offering to be involved in further discussions. We are now ready to undertake the next phase of the research where we will be holding several focus groups.

We would like to invite you to participate in a focus group discussion with senior managers from residential aged care services. Your input is a critical component in the success of developing informed, practical guidelines towards 'best practice' care for this client group.

The focus group has been scheduled for 27 January 2010 at 7.30 am. A light breakfast will be provided from 7.00 am. The discussion will last approximately 60 minutes and will focus on some of the issues, challenges and practical solutions to accommodating GLBTI residents.

We hope you are able to attend. Please RSVP no later than **20 January 2010** to Rita Freijah by email: r.freijah@curtin.edu.au or phone: 9266 1832. If you still wish to be involved but are unable to attend at this time please provide details of your availability (dates and times) and we will try and accommodate you.

Yours sincerely

Rita Freijah
Research Officer | School of Public Health | Faculty of Health Sciences
Curtin University of Technology | GPO Box U1987 | Perth | Western Australia 6845
Telephone +61 8 9266 1832 | Facsimile +61 8 9266 2508 | Email R.Freijah@curtin.edu.au

WA Centre for Health Promotion Research & Centre for Research on Ageing
Curtin Health Innovation Research Institute | Curtin University of Technology

Appendix I Best Practice Guidelines – Development Process

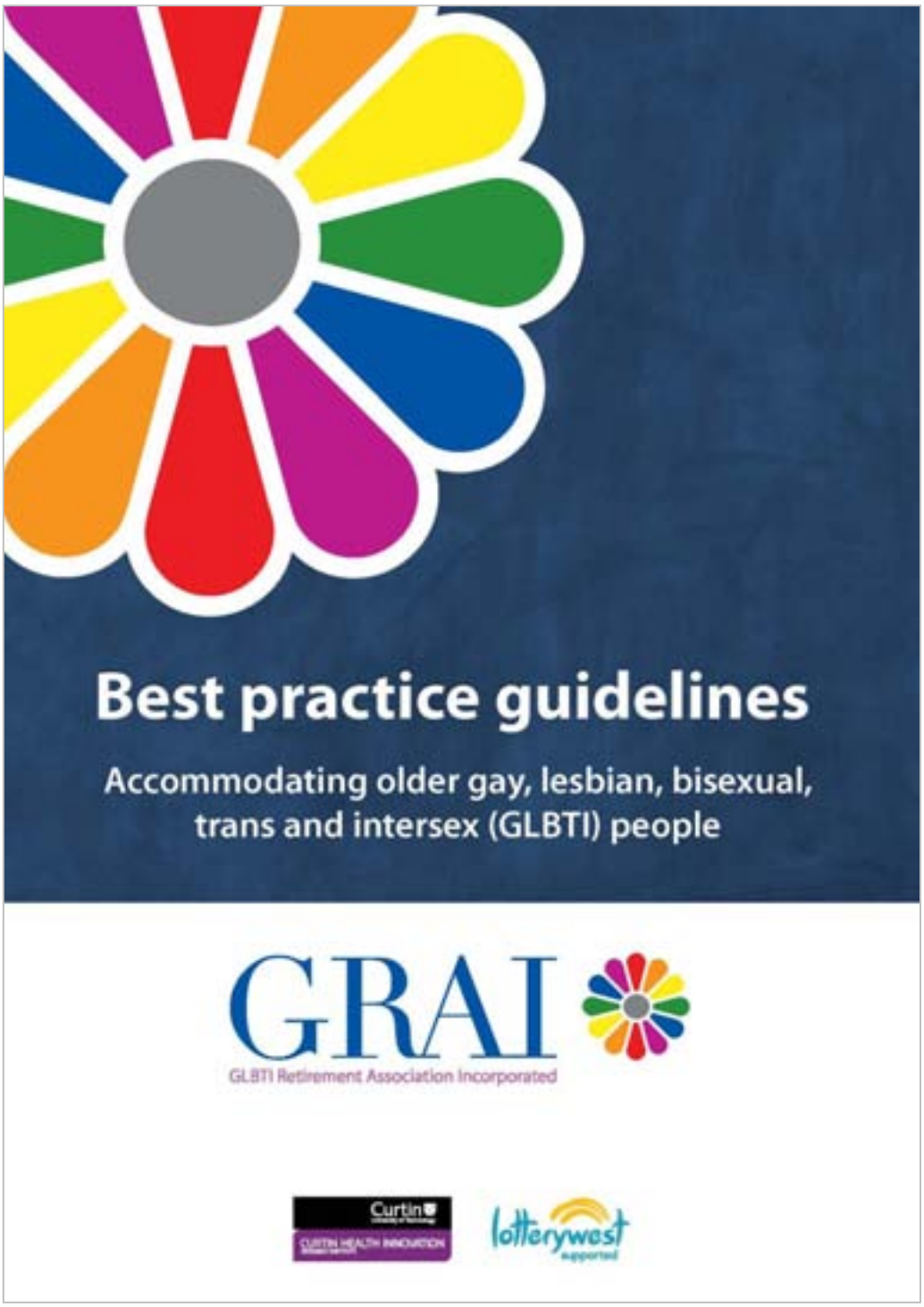
1. GUIDELINES DESIGN - CONSIDERATIONS

a. Context – providers of retirement and aged care accommodation
b. Operational context
c. To be used in addition to current organisational best practice policy
d. Considered the differences between retirement villages and aged care facilities when identifying key themes for guidelines
e. Dissemination of guidelines
f. Considerations in design of guidelines
    i. Practicality of its use
    ii. Short one page document for easy reference
    iii. Prescriptive
    iv. Use of a practical scenario and solutions to demonstrate implementation
    v. User friendly
    vi. East of displaying guidelines in prominent places for all to see
    vii. Industry liaison for content and design of guidelines (IAG)
    viii. Liaison with GLBTI representatives for content and design of guidelines
    ix. Broad overarching principles within the guidelines to encompass providers of different levels of care and services

2. GUIDELINES DESIGN PROCESS

- Literature review and theme identification
- Development of common themes identified
- Layout of guidelines considered
- Guidelines developed
- Send to project team for feedback
- Incorporate review comments
- Send to Project Control Group for feedback
- Incorporate comments
- Send to Industry Advisory Group for feedback
- Incorporate comments
- Focus group test with GLBTI population
- Incorporate comments

Appendix J Best Practice Guidelines



Appendix J Best Practice Guidelines (cont)

Best practice guidelines

Accommodating older gay, lesbian, bisexual, trans and intersex (GLBTI) people

It is estimated that approximately 8% of the Australian population (1.7 million people) identify as gay, lesbian, bisexual, trans and intersex.

In line with Australia's growing ageing population, the number of older GLBTI Australians aged 65 years and over is expected to reach 1/2 a million people by 2051.

Gay, lesbian, bisexual, trans and intersex (GLBTI) people have the right to live in a safe and inclusive environment free from discrimination, oppression and abuse. Understanding cultural and historical backgrounds enables providers to better engage with, recognise and meet the unique needs of minority groups, including GLBTI people.

Purpose

To encourage management and staff to adopt practices to create an inclusive, rather than an exclusive, environment which is accepting and welcoming of all GLBTI people.

Aim

To provide practical strategies to the providers of retirement and residential aged care, so that they are better able to recognise, understand and meet the specific needs of GLBTI people.

Use

To support existing best practice frameworks used by providers of retirement and residential aged care and are intended to highlight the issues specific to older GLBTI people. Practical strategies are provided to assist in a greater understanding, and better management of GLBTI people.

Terminology

The acronym GLBTI is used throughout this document. It encompasses gay, lesbian, bisexual, trans and intersex people. However, it is important to note that diversity exists within the GLBTI population as in any population. *It is recognised that trans and intersex people have additional specific requirements that have not been covered in this document. See the resource section for trans specific information, although it is not ageing specific.*

Principles

Principle 1: Inclusive and safe environment
Principle 2: Open communication
Principle 3: GLBTI-sensitive practices
Principle 4: Staff education and training
Principle 5: GLBTI-inclusive organisational policies and procedures

Appendix J Best Practice Guidelines (cont)

Principle 1

Inclusive and safe environment

Provide an inclusive environment, where GLBTI people feel physically, spiritually and emotionally safe.

An inclusive and safe environment reflects a commitment to the physical, spiritual and emotional wellbeing of GLBTI people.

How

- Consider sexual orientation and gender identity as one of the many cultural characteristics of clients, along with age, gender, disability, language and ethnicity, to ensure appropriate service delivery.
- Demonstrate evidence that your environment is GLTBI inclusive:
  - Display posters, stickers and symbols such as the rainbow flag.
  - Display diverse images on promotional material such as same-sex couples and intergenerational images.
  - Display appropriate GLTBI community magazines and literature within the organisation.
  - Include explicit reference to non-discriminatory policies regarding GLBTI individuals on organisational advertising.
  - Use GLBTI community organisations and GLBTI community papers to advertise your organisation.
- Safeguard GLBTI people from discrimination and prejudice. This includes discriminatory acts by other people, their family and friends, residents and staff.
- Ensure residents are not isolated or discriminated against by other people, their family and friends, and staff in relation to their health condition. This includes mental illness, HIV, other blood borne viruses, etc.
- Recognise that the GLBTI population is diverse and heterogeneous.
- Assist GLBTI people in celebrating GLBTI events such as PRIDE (an annual month of gay events held principally in Perth).

Scenario

Jan (85) is a resident in an independent living unit. She has disclosed to management and some residents that she is a lesbian. She doesn't have a partner but is active in the gay community. Jan has limited mobility and wants to go to an event which celebrates PRIDE. She asks management how they can assist her.

Management discusses with Jan the logistics required to get her to the event i.e. drop off and pick up time, location etc. A decision is made to use the community bus to take her and pick her up. Management also decide to put up a flyer advertising the event on the community notice board, should other people wish to attend.

Appendix J Best Practice Guidelines (cont)

Principle 2

Inclusive communication

Use appropriate language that is respectful and aligned with how a person identifies themself.

Inclusive communication can be achieved through the use of appropriate language. As a consequence, GLBTI people can feel safe and comfortable disclosing information that may impact on their quality of care.

How

- Avoid assumptions – do not assume that everyone is heterosexual.
- Encourage communication with clients through open-ended questions.
- Use questions which are gender-neutral and non-discriminatory such as "Do you have a partner?", rather than "Do you have a husband/wife?"
- Demonstrate acceptance by referring to the person in the manner they wish to be referred to.
- Educate staff on the context of GLBTI issues and its impact.
- Use language which is appropriate and respectful of the client's sexual orientation and/or gender identity – for example, many GLBTI people's families are families of choice, rather than blood relatives.
- Include same-sex partners in care planning and personal activities such as bathing, feeding, etc.
- Differentiate sexual identity from sexual behaviour.
- Be respectful and understanding when a client discloses their gender identity or sexual orientation.
- Speak openly about GLBTI issues where appropriate, as this demonstrates an environment where staff can comfortably and regularly discuss GLBTI issues and sexuality in general.

Scenario

Jim (75) was admitted to a residential aged care facility as Ray, his partner of 30 years, is no longer able to care for him at home. Ray wishes to still be as active as possible in Jim's care.

Jim and Ray made their relationship clear during the admission process and were advised that the organisation had a GLBTI liaison officer. They were also advised that their specific needs would be discussed confidentially at the next care meeting. At the next care meeting a staff member was dismissive of this relationship; this behaviour was noted by their manager. Rather than ignore this, the staff member was asked to meet later that day with their manager who explained and directed the staff member to revise the best practice guidelines of the organisation. Care team members made the effort to engage Ray in care activities and affirmed their long-standing relationship in the same way as they would for a heterosexual couple.

Appendix J Best Practice Guidelines (cont)

Principle 3

GLBTI-sensitive practices

Demonstrate best practice through knowledge and understanding of the impact of history and culture (sexual orientation, past experiences, race, gender, etc) on an individual's beliefs and behaviour, and their interactions with health professionals.

Knowledge of the impact of an individual's past experiences of homophobia and social exclusion is fundamental to the delivery of GLBTI-sensitive practices. GLBTI-sensitive practices include appropriate intake and assessment practices, referral sources and access to resources. They provide an opportunity for GLBTI people to disclose their sexual orientation and/or gender identity if they so choose.

How

3.1 Appropriate referral sources

- Develop a referral list of appropriate GLBTI-friendly practitioners.
- Develop a process for referring to GLBTI-friendly practitioners.

3.2 Intake and assessment practices

- Assessment and treatment plans will include sexual orientation and/or gender identity.
- Admission forms will provide an opportunity for disclosure of sexual orientation and/or gender identity, e.g. the use of male, female, other.
- Assess same-sex partners, next-of-kin and the notion of family sensitively.
- Consider unique needs of GLBTI people during assessment and care planning.
- Consider mental wellbeing as well as physical wellbeing during assessment.
- Seek permission to record information about sexual orientation and/or gender identity.
- Use language which the individual identifies with during assessment and intake interviews, e.g., a client may be more comfortable with the identity of 'gay' rather than 'homosexual'.

3.3 GLBTI resources

- Develop a resource list of relevant GLBTI organisations, support groups and networks.
- Form partnerships with GLBTI community groups and agencies.

Scenario

Jo and Jane present themselves at an admission session into supported accommodation. Staff are not sure if they are just good friends or more. After establishing some initial rapport the staff member asks if they have a partner. They both look at each other and look a bit worried and then laugh and say they are partners. There is relief all round and the form shows this information clearly for other staff. The management endeavours to get a double room. They also ask whether there are any other gay residents and/or staff.

Principle 4

Staff education and training

Provide education and training for all staff to equip them with the skills and knowledge required to support and work with GLBTI people, so they are better able to understand the specific needs of this group.

How

Education can usefully address the following topics:

- The historical context of GLBTI issues.
- Understanding the consequences of having a minority sexual identity and the experience of resultant discrimination and oppression.
- Understanding the implications of disclosure of sexual orientation, as many older people may not feel comfortable about disclosing this.
- An introduction to GLBTI culture.
- Managing GLBTI individuals and their requirements.
- Using appropriate language.
- Understanding sexual diversity.
- Appreciating health issues which may uniquely affect GLBTI people.
- Communicating effectively with GLBTI people and their family and friends.
- The impact of discriminatory behaviour and personal beliefs on the provision of care.
- Implications and obligations of federal legislation recognising same-sex couples.
- Understanding intersex and trans specific health issues.
- Appropriate referral of GLBTI individuals to GLBTI-friendly practitioners.
- GLBTI personal perspective speaker.

Scenario

A new staff member, Dave, arrives at the facility. During orientation it is reiterated to Dave that the organisation strives to be 'gay-friendly' and that homophobia is not acceptable in any form. This was also made clear throughout the recruitment process. Dave is also told that there are a number of gay residents and that a few times a year as part of professional development there will be sessions on gay issues. Management recommends that Dave attend one of these sessions as it would be a good opportunity as a new staff member. He is also shown a copy of the best practice guidelines which are clearly displayed and told who the GLBTI liaison staff person is – a staff member with a special interest and understanding in the area.

Appendix J Best Practice Guidelines (cont)

Principle 5

GLBTI-inclusive organisational policies and procedures

Embed principles and guidelines into organisational policy and procedures to demonstrate your organisation's intent to have GLBTI-inclusive practices and provide an implementation mechanism.

Organisational policy sets the benchmark for expected staff behaviours and practices. Organisational procedures translate policy into practice.

How

- Adopt these guidelines into the organisation's policy framework.
- Display these guidelines in prominent places for all to see.
- Translate guidelines into appropriate languages in the case of linguistically diverse workforces and display in prominent places.
- Include explicit reference to GLBTI people in organisational policy and procedures.
- Include staff procedures which explicitly set out steps to be taken in the event a client discloses their sexual orientation and/or gender identity to a staff member.
- Communicate non-discriminatory policies explicitly referring to sexual orientation and/or gender identity to all staff.
- Develop a written complaints procedure for staff and residents specifically referring to discrimination on the grounds of sexual orientation and/or gender identity.

Appendix J Best Practice Guidelines (cont)

Acknowledgements

These guidelines were developed as the result of research undertaken by GRAI (GLBTI Retirement Association Inc.), and were informed by a range of other documents listed below. The study would not have been possible without the many retirement and residential aged care providers who were involved in a survey of attitudes and practices; managers and members of the GLBTI community who participated in focus groups and members of an Industry Advisory Group. The research was generously supported by a Lotterywest social research grant.

Useful resources

AIDS Council of NSW Inc (2006)
Ageing Disgracefully ACON Ageing Strategy 2006 – 2009
www.acon.org.au/sites/default/files/ACON-Ageing-Strategy-Nov06.pdf

Gay and Lesbian Community Services (WA)
2 Delhi St, West Perth WA, 6005.
Admin phone/fax: (08) 9486 9855
Counselling line: (08) 9420 7201
Counselling line country areas: 1800 184 527
Email: admin@glcs.org.au
Web: www.glcs.org.au

GRAI (Gay Lesbian Bisexual Trans Intersex Retirement Association Inc.)
PO Box 715, Mt Lawley WA 6929
Email: info@grai.org.au
Web: www.grai.org.au

National LGBT Health Alliance Australia
(alliance of organisations across Australia that provide programs, services and research in the areas of LGBT health)
Web: www.lgbthealth.org.au

Perth Inner City Youth Service. (2007)
Simply Trans: Information on transgenderism and transsexuality for young people, their family, friends and support workers. Perth.
www.glcs.org.au/pdf/Simply_Trans.pdf

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WA Gender Project (for transsexual issues)
PO Box 408, Mt Lawley WA 6929
Email: wagenderproject@yahoo.com.au
Web: www.wagenderproject.org

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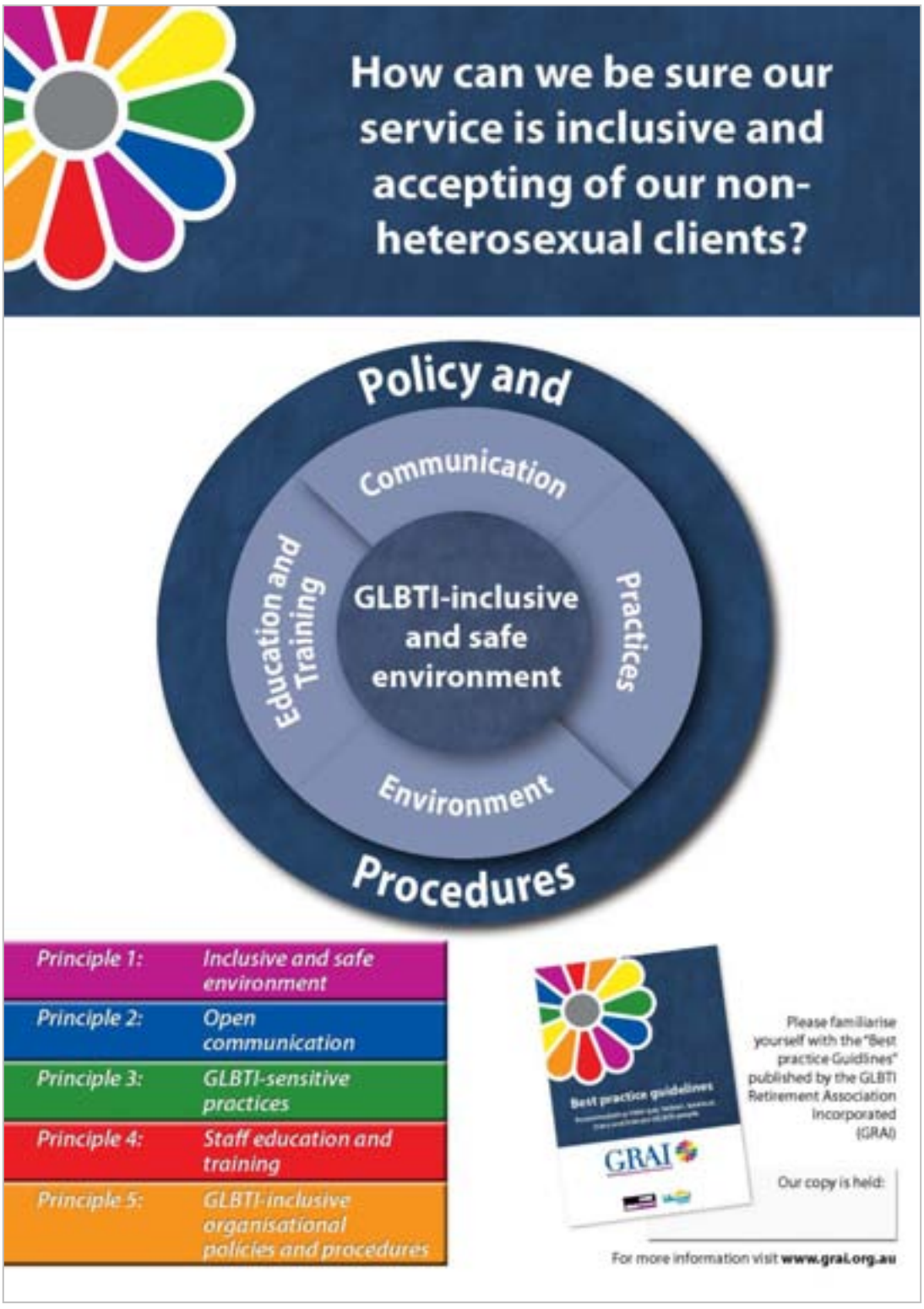
Appendix J Best Practice Guidelines (cont)



Appendix K Invitation to participants – GLBTI focus group

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WA Centre for Health Promotion Research &
Centre for Research on Ageing
Curtin Health Innovation Research Institute | Curtin University of Technology

lotterywest supported

TELL US WHAT YOU THINK...

Join our focus group to comment on GRAI's draft Best Practice Guidelines for Residential Care for older GLBTI.

Wednesday 14 April 2010 in Shenton Park, starting 5.00 pm with refreshments, finishing 6.30 pm.

Contact **Rita Freijah**, Project Officer
r.freijah@curtin.edu.au or 9266 1832 for more details.

Appendix L Tables demonstrating variation of facility attitudes and practices

Table 5 Facility uses means to indicate to GLBTI people that it provides an inclusive environment

		Yes	No	Unsure	Total
Service type					
Nursing home (high care)	n =	3	19	6	28
	%	75.0%	33.3%	28.6%	34.1%
Hostel (low care)	n =	2	30	9	41
	%	50.0%	52.6%	42.9%	50.0%
Community Care	n=	0	4	2	6
	%	.0%	7.0%	9.5%	7.3%
Retirement Village	n=	1	19	7	27
	%	25.0%	33.3%	33.3%	32.9%
Dementia specific facility	n=	0	8	0	8
	%	.0%	14.0%	.0%	9.8%
Other facility	n=	1	10	0	11
	%	25.0%	17.5%	.0%	13.4%
Total	n=	4	57	21	82
Organisation size (FTE staff)					
1-25	n=	0	34	15	49
	%	.0%	60.7%	71.4%	61.3%
26-50	n=	0	13	0	13
	%	.0%	23.2%	.0%	16.3%
51-75	n=	3	5	3	11
	%	100.0%	8.9%	14.3%	13.8%
76-100	n=	0	2	2	4
	%	.0%	3.6%	9.5%	5.0%
101-200	n=	0	2	1	3
	%	.0%	3.6%	4.8%	3.8%
Total	n=	3	56	21	80
Geographic location					
Metropolitan	n=	3	23	13	39
	%	100.0%	47.9%	59.1%	53.4%
Rural	n=	0	20	9	29
	%	.0%	41.7%	40.9%	39.7%
Remote	n=	0	5	0	5
	%	.0%	10.4%	.0%	6.8%
Total	n=	3	48	22	73

Table 6 Facility has a nominated staff member who acts as a GLBTI liaison person

		Yes	No	Unsure	Total
Service type					
Nursing home (high care)	n=	4	22	2	28
	%	80.0%	34.9%	14.3%	34.1%
Hostel (low care)	n=	4	34	3	41
	%	80.0%	54.0%	21.4%	50.0%
Community Care	n=	0	4	2	6
	%	.0%	6.3%	14.3%	7.3%
Retirement Village	n=	2	18	7	27
	%	40.0%	28.6%	50.0%	32.9%
Dementia specific facility	n=	2	6	0	8
	%	40.0%	9.5%	.0%	9.8%
Other facility	n=	0	10	1	11
	%	.0%	15.9%	7.1%	13.4%
Total	n=	5	63	14	82
Organisation size (FTE staff)					
1-25	n=	1	35	13	49
	%	20.0%	57.4%	92.9%	61.3%
26-50	n=	1	12	0	13
	%	20.0%	19.7%	.0%	16.3%
51-75	n=	3	8	0	11
	%	60.0%	13.1%	.0%	13.8%
76-100	n=	0	3	1	4
	%	.0%	4.9%	7.1%	5.0%
101-200	n=	0	3	0	3
	%	.0%	4.9%	.0%	3.8%
Total	n=	5	61	14	80
Geographic location					
Metropolitan	n=	4	25	10	39
	%	100.0%	45.5%	71.4%	53.4%
Rural	n=	0	25	4	29
	%	.0%	45.5%	28.6%	39.7%
Remote	n=	0	5	0	5
	%	.0%	9.1%	.0%	6.8%
Total	n=	4	55	14	73

Table 7 Facility has current practices which promote a welcoming and accepting atmosphere for GLBTI people

		Yes	No	Unsure	Total
Service type					
Nursing home (high care)	n=	10	11	7	28
	%	43.5%	34.4%	26.9%	34.6%
Hostel (low care)	n=	16	13	12	41
	%	69.6%	40.6%	46.2%	50.6%
Community Care	n=	1	1	4	6
	%	4.3%	3.1%	15.4%	7.4%
Retirement Village	n=	6	11	9	26
	%	26.1%	34.4%	34.6%	32.1%
Dementia specific facility	n=	4	4	0	8
	%	17.4%	12.5%	.0%	9.9%
Other facility	n=	4	4	3	11
	%	17.4%	12.5%	11.5%	13.6%
Total	n=	23	32	26	81
Organisation size (FTE staff)					
1-25	n=	11	19	18	48
	%	50.0%	61.3%	69.2%	60.8%
26-50	n=	4	8	1	13
	%	18.2%	25.8%	3.8%	16.5%
51-75	n=	5	1	5	11
	%	22.7%	3.2%	19.2%	13.9%
76-100	n=	2	0	2	4
	%	9.1%	.0%	7.7%	5.1%
101-200	n=	0	3	0	3
	%	.0%	9.7%	.0%	3.8%
Total	n=	22	31	26	79
Geographic location					
Metropolitan	n=	11	14	14	39
	%	61.1%	50.0%	53.8%	54.2%
Rural	n=	7	11	10	28
	%	38.9%	39.3%	38.5%	38.9%
Remote	n=	0	3	2	5
	%	.0%	10.7%	7.7%	6.9%
Total	n=	18	28	26	72

Table 8 Aware of aspects of GLBTI legislation incorporated into facility policy

		Yes	No	Unsure	Total
Service type					
Nursing home (high care)	n=	4	16	4	24
	%	44.4%	30.2%	28.6%	31.6%
Hostel (low care)	n=	4	28	6	38
	%	44.4%	52.8%	42.9%	50.0%
Community Care	n=	0	4	2	6
	%	.0%	7.5%	14.3%	7.9%
Retirement Village	n=	4	17	4	25
	%	44.4%	32.1%	28.6%	32.9%
Dementia specific facility	n=	1	6	0	7
	%	11.1%	11.3%	.0%	9.2%
Other facility	n=	2	7	2	11
	%	22.2%	13.2%	14.3%	14.5%
Total	n=	9	53	14	76
Organisation size (FTE staff)					
1-25	n=	5	32	10	47
	%	55.6%	61.5%	76.9%	63.5%
26-50	n=	2	10	0	12
	%	22.2%	19.2%	.0%	16.2%
51-75	n=	1	7	1	9
	%	11.1%	13.5%	7.7%	12.2%
76-100	n=	1	1	2	4
	%	11.1%	1.9%	15.4%	5.4%
101-200	n=	0	2	0	2
	%	.0%	3.8%	.0%	2.7%
Total	n=	9	52	13	74
Geographic location					
Metropolitan	n=	3	27	5	35
	%	42.9%	55.1%	41.7%	51.5%
Rural	n=	4	18	7	29
	%	57.1%	36.7%	58.3%	42.6%
Remote	n=	0	4	0	4
	%	.0%	8.2%	.0%	5.9%
Total	n=	7	49	12	68

Table 9 Staff receive training in GLBTI issues

		Yes	No	Unsure	Total
Service type					
Nursing home (high care)	n=	5	22	1	28
	%	50.0%	32.8%	20.0%	34.1%
Hostel (low care)	n=	6	34	1	41
	%	60.0%	50.7%	20.0%	50.0%
Community Care	n=	1	5	0	6
	%	10.0%	7.5%	.0%	7.3%
Retirement Village	n=	4	19	4	27
	%	40.0%	28.4%	80.0%	32.9%
Dementia specific facility	n=	1	7	0	8
	%	10.0%	10.4%	.0%	9.8%
Other facility	n=	1	10	0	11
	%	10.0%	14.9%	.0%	13.4%
Total	n=	10	67	5	82
Organisation size (FTE staff)					
1-25	n=	4	41	4	49
	%	44.4%	62.1%	80.0%	61.3%
26-50	n=	2	11	0	13
	%	22.2%	16.7%	.0%	16.3%
51-75	n=	3	8	0	11
	%	33.3%	12.1%	.0%	13.8%
76-100	n=	0	3	1	4
	%	.0%	4.5%	20.0%	5.0%
101-200	n=	0	3	0	3
	%	.0%	4.5%	.0%	3.8%
Total	n=	9	66	5	80
Geographic location					
Metropolitan	n=	3	33	3	39
	%	42.9%	54.1%	60.0%	53.4%
Rural	n=	3	24	2	29
	%	42.9%	39.3%	40.0%	39.7%
Remote	n=	1	4	0	5
	%	14.3%	6.6%	.0%	6.8%
Total	n=	7	61	5	73

Table 10 GLBTI residents within facility

		Yes	No	Unsure	Total
Service type					
Nursing home (high care)	n=	4	20	3	27
	%	36.4%	31.3%	50.0%	33.3%
Hostel (low care)	n=	4	34	3	41
	%	36.4%	53.1%	50.0%	50.6%
Community Care	n=	1	5	0	6
	%	9.1%	7.8%	.0%	7.4%
Retirement Village	n=	4	22	1	27
	%	36.4%	34.4%	16.7%	33.3%
Dementia specific facility	n=	0	7	1	8
	%	.0%	10.9%	16.7%	9.9%
Other facility	n=	1	10	0	11
	%	9.1%	15.6%	.0%	13.6%
Total	n=	11	64	6	81
Organisation size (FTE staff)					
1-25	n=	5	42	2	49
	%	50.0%	66.7%	33.3%	62.0%
26-50	n=	2	9	2	13
	%	20.0%	14.3%	33.3%	16.5%
51-75	n=	1	8	1	10
	%	10.0%	12.7%	16.7%	12.7%
76-100	n=	1	2	1	4
	%	10.0%	3.2%	16.7%	5.1%
101-200	n=	1	2	0	3
	%	10.0%	3.2%	.0%	3.8%
Total	n=	10	63	6	79
Geographic location					
Metropolitan	n=	6	27	5	38
	%	66.7%	47.4%	83.3%	52.8%
Rural	n=	3	25	1	29
	%	33.3%	43.9%	16.7%	40.3%
Remote	n=	0	5	0	5
	%	.0%	8.8%	.0%	6.9%
Total	n=	9	57	6	72

Table 11 Facility regards GLBTI residents as having specific accommodation needs

		Yes	No	Unsure	Total
Service type					
Nursing home (high care)	n=	5	18	5	28
	%	83.3%	32.7%	27.8%	35.4%
Hostel (low care)	n=	4	30	7	41
	%	66.7%	54.5%	38.9%	51.9%
Community Care	n=	0	5	0	5
	%	.0%	9.1%	.0%	6.3%
Retirement Village	n=	0	18	7	25
	%	.0%	32.7%	38.9%	31.6%
Dementia specific facility	n=	2	6	0	8
		33.3%	10.9%	.0%	10.1%
Other facility	n=	1	7	3	11
	%	16.7%	12.7%	16.7%	13.9%
Total	n=	6	55	18	79
Organisation size (FTE staff)					
1-25	n=	1	32	13	46
	%	16.7%	60.4%	72.2%	59.7%
26-50	n=	2	9	2	13
	%	33.3%	17.0%	11.1%	16.9%
51-75	n=	1	9	1	11
	%	16.7%	17.0%	5.6%	14.3%
76-100	n=	1	1	2	4
	%	16.7%	1.9%	11.1%	5.2%
101-200	n=	1	2	0	3
	%	16.7%	3.8%	.0%	3.9%
Total	n=	6	53	18	77
Geographic location					
Metropolitan	n=	3	26	7	36
	%	60.0%	53.1%	43.8%	51.4%
Rural	n=	1	19	9	29
	%	20.0%	38.8%	56.3%	41.4%
Remote	n=	1	4	0	5
	%	20.0%	8.2%	.0%	7.1%
Total	n=	5	49	16	70

Table 12 Facility has definition of next of kin

		Yes	No	Unsure	Total
Service type					
Nursing home (high care)	n=	13	11	2	26
	%	40.6%	28.9%	28.6%	33.8%
Hostel (low care)	n=	16	20	3	39
	%	50.0%	52.6%	42.9%	50.6%
Community Care	n=	3	2	1	6
	%	9.4%	5.3%	14.3%	7.8%
Retirement Village	n=	12	11	1	24
	%	37.5%	28.9%	14.3%	31.2%
Dementia specific facility	n=	2	6	0	8
	%	6.3%	15.8%	.0%	10.4%
Other facility	n=	4	4	3	11
	%	12.5%	10.5%	42.9%	14.3%
Total	n=	32	38	7	77
Organisation size (FTE staff)					
1-25	n=	19	22	4	45
	%	61.3%	59.5%	57.1%	60.0%
26-50	n=	3	8	2	13
	%	9.7%	21.6%	28.6%	17.3%
51-75	n=	6	3	1	10
	%	19.4%	8.1%	14.3%	13.3%
76-100	n=	1	3	0	4
	%	3.2%	8.1%	.0%	5.3%
101-200	n=	2	1	0	3
	%	6.5%	2.7%	.0%	4.0%
Total	n=	31	37	7	75
Geographic location					
Metropolitan	n=	15	20	1	36
	%	45.5%	69.0%	14.3%	52.2%
Rural	n=	15	9	4	28
	%	45.5%	31.0%	57.1%	40.6%
Remote	n=	3	0	2	5
	%	9.1%	.0%	28.6%	7.2%
Total	n=	33	29	7	69

Table 13 Facility has definition of family or immediate family

		Yes	No	Unsure	Total
Service type					
Nursing home (high care)	n=	11	14	1	26
	%	47.8%	30.4%	14.3%	34.2%
Hostel (low care)	n=	10	26	3	39
	%	43.5%	56.5%	42.9%	51.3%
Community Care	n=	2	3	0	5
	%	8.7%	6.5%	.0%	6.6%
Retirement Village	n=	9	13	1	23
	%	39.1%	28.3%	14.3%	30.3%
Dementia specific facility	n=	2	6	0	8
	%	8.7%	13.0%	.0%	10.5%
Other facility	n=	2	6	3	11
	%	8.7%	13.0%	42.9%	14.5%
Total	n=	23	46	7	76
Organisation size (FTE staff)					
1-25	n=	11	28	4	43
	%	47.8%	63.6%	57.1%	58.1%
26-50	n=	2	9	2	13
	%	8.7%	20.5%	28.6%	17.6%
51-75	n=	7	3	1	11
	%	30.4%	6.8%	14.3%	14.9%
76-100	n=	1	3	0	4
	%	4.3%	6.8%	.0%	5.4%
101-200	n=	2	1	0	3
	%	8.7%	2.3%	.0%	4.1%
Total	n=	23	44	7	74
Geographic location					
Metropolitan	n=	13	21	2	36
	%	54.2%	56.8%	28.6%	52.9%
Rural	n=	10	14	3	27
	%	41.7%	37.8%	42.9%	39.7%
Remote	n=	1	2	2	5
	%	4.2%	5.4%	28.6%	7.4%
Total	n=	24	37	7	68

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