in focus
fact sheet

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Leading knowledge exchange on home and community care

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Diversity: Sexual Orientation in Home and Community Care

This *In Focus* looks at the challenges of providing home and community care for **L**esbian, **G**ay, **B**isexual and **T**ranssexual/ transgendered people and communities, their friends, families and caregivers. It uses the abbreviation "LGBT" to refer to diverse groups who share experiences of discrimination based on sexual orientation.

What do we mean by sex, gender and sexual orientation?

- Sex refers to a person's physical characteristics. An inter-sexed person has both male and female physical characteristics.
- Gender is learned behaviour that a culture considers to be 'masculine' or 'feminine' (e.g., appropriate clothing, social behaviour and occupational roles). Gender expectations can differ from culture to culture and from generation to generation.
- Gender identity refers to an individual's internal, psychological sense of self as male or female. While most people's sense of their own gender corresponds to their biological sex, some people who are biologically women identify as a male and some men identify as a female.
- Sexual orientation is different from gender identity and sex. It's about who you are sexually/erotically attracted to and want to form intimate relationships with. Such relationships may be with people of the same sex (i.e. lesbian, gay), the opposite sex (i.e. heterosexual), or either sex (i.e. bisexual).

A brief glossary of additional terms has been included at the end of this *In Focus*.

Why focus on sexual orientation in home and community care?

Equity and human rights. Over the past twenty years, significant legal changes in the Canadian Charter of Rights and Freedoms and provincial human rights legislation now recognize that people can experience discrimination because of their sexual orientation (Egan v. Canada, 1995; Vriend v. Alberta, 1998). Yet, there is still little understanding that LGBT people can face barriers to accessing services, including home and community care, similar to those experienced by people of different races, religions and abilities (Clermont & Sioui-Durand, 1997; Heaphy, et. al., 2004).

Sexual orientation and health status. Growing international research suggests that sexual minority status can hinder access to health and social care and affect health status. Because prevailing negative social attitudes and experiences of homophobia discourage self-disclosure (Stonewall Scotland & NHS Scotland, 2006; Brotman et. al., 2003; Brotman et. al., 2006), LGBT people are more likely to seek help only after problems arise and when illnesses are at a more advanced stage and potentially more difficult to treat. For these reasons, available international health data indicate that after excluding HIV/AIDS related illnesses, lesbian, gay and bisexual demonstrate poorer health than heterosexual and non-trans people.

For example, LGBT populations have:

- higher rates of cervical (Matthews et. al., 2004), breast (Dibble, Roberts, & Nussey, 2004), and anal cancer (Frisch et. al., 2003);
- higher rates of eating disorders (Feldman et. al., 2007);

- higher rates of depression and other mental health issues (Cochrane, 2001; Wang et. al., 2007);
- higher incidences of smoking (Ryan et. al., 2001) and alcoholism (Stall et. al., 2001) related health conditions.

Access to home and community care. LGBT people experience physical and mental decline as part of the aging process and require community support services to maintain their independence. There is mounting evidence that home and community care can support people's independence and well-being, and delay institutionalization despite risk factors such as advanced age, low income and living alone. Such risk factors are exacerbated for LGBT older people.

- LGBT older people may not have life partners or children to call upon, or may be ostracized or closeted from their biological families. A lack of traditional support networks may not be replaced by the strength of other close friendships or the informal support networks found within LGBT communities.

- LGBT older people may wish to avoid community care providers because of previous homophobic experiences. A 1994 study in the United States found that 72% of gay and lesbian respondents were reluctant to use mainstream community services for this reason (Cantor, 2004).

- A series of 13 LGBT seniors' studies in the U.S. (deVries, 2005) found that LGBT seniors were more likely to experience financial difficulties, lacked caregiver support, accessed fewer social services and had higher levels of chronic conditions than their heterosexual peers.

- LGBT older people who are also racial, ethnic, religious minorities and/or live in small urban or rural communities are especially vulnerable to isolation.

These factors combine to heighten the risks for isolation, depression and premature institutionalization.

Challenges to providing home and community care to LGBT populations

Statistics on LGBT populations. There are few statistics on LGBT people in Canada making it difficult to identify barriers to care and the extent to which LGBT appropriate care is needed.

- In 2001, Statistics Canada first included a question on same sex couples: 34,200 self identified as same-sex common law couples or 0.5% of all couples. In 2006, the figure rose to 45,345 or 0.6% of all couples.

- According to the Canadian Community Health Survey in 2003, 316,800 individuals (1.7 % of the Canadian population) between the ages of 18 and 59 self-identified as "homosexual" or "bisexual." These figures likely under-estimate the actual numbers of LGBT individuals given prevailing homophobic social attitudes in Canada and elsewhere. For example, a study conducted by Stein and Bonuk (2001) in the United States reported that only 1 in 4 LGBT individuals disclosed their sexual orientation to healthcare providers.

- The older LGBT population remains largely invisible. Many have practiced a lifelong survival strategy of "passing" as a heterosexual for a number of reasons. Those who became seniors before formal human rights were achieved are reluctant to self-identify for fear of jeopardizing current and/or future services if they "come-out" (Brotman et. al., 2003; Brotman et. al., 2006; Orel, 2004).

- Many older LGBT people anticipate the stress of having to "come out" repeatedly to correct service providers' assumptions (e.g., about "wives," "husbands" and next-of-kin which often exclude non-biological partners, friends and "families of choice"). Hospital staff, social workers, home and community care providers may not have knowledge and training regarding issues facing LGBT populations (Mulé, 1999). This can be particularly distressing when one is vulnerable and needing care (Stonewall Scotland & NHS Scotland, 2003).

As a result, there are no solid figures on the actual numbers of LGBT seniors in Canada making research on LGBT home and community care particularly challenging.

Diversity within LGBT populations. Just as ethnoracial communities are internally diverse, LGBT communities are similarly diverse. Presently there is limited research exploring how race, religion, ethnicity interact with sexual orientation to complicate the provision of home and community care to LGBT individuals.

- For example, one study suggests, lesbians of colour do not receive the same levels of social supports in lesbian communities as do white lesbians (Sinding et. al., 2006).

- Uphold and Mkanta (2004) report that in the US, racialized LGBT individuals (as compared to whites) with HIV/AIDS are less likely to be integrated into HIV-related community support networks and are hence:
  - less likely to disclose their HIV status;
  - more likely to be hospitalized and to stay in hospital longer;
  - more likely to visit emergency departments; and,
  - less likely to use outpatient patient health services and home care.

NOTE: HIV/AIDS is not exclusive to the LGBT population. In the first half of 2006, 33% of all new HIV cases in Canada resulted from heterosexual sex and 10.3% from intravenous drug use (Public Health Agency of Canada, 2006).

Varying community capacity. Community capacity is intricately linked to health and well-being (Putnam, 2000). In previous research, we found that ethnoracial communities can vary in their capacity to support their members (Lum & Springer, 2004). Similarly, LGBT communities may also vary in their community capacity with care consequences for LGBT individuals.

- For example, a recent McGill University study of LGTB seniors living in Halifax, Montreal and Vancouver highlighted differences in the availability of appropriate community support services across geographical locations (Brotman, et. al., 2003).

- Some LGBT communities have limited resources and often cannot meet their members' needs. Citing several international studies, Sinding et. al., (2006) noted that lesbian 'communities' were not homogeneous, but consisted of many independent smaller groups. These groups could only meet members' needs for short periods of time, which meant that lesbians (particularly older lesbians) often remained socially isolated.

- Urban LGBT dwellers were more likely to have access to gay friendly support systems than their rural counterparts.

- The first wave of AIDS-related deaths in the early 1980s devastated a generation of gay men who are now 50-70 years old. Some of these survivors have lost their entire social support network and experience higher levels of isolation than other bereaved groups (Cox, 2006).

- Ageism within LGBT communities contributes to the majority of seniors feeling less welcome and more disconnected from their local communities as they age (Heaphy et. al., 2004; Zians, 2003).

What is LGBT appropriate care?

LGBT appropriate care is care that positively reinforces LGTB identities, rather than forcing LGBT individuals back into the closet (Brotman et. al., 2003).

How do organizations provide LGBT appropriate care?

The National Health Service in Scotland has developed a simple framework toward achieving effective, culturally competent LGBT care.

See. The physical environment, including images and signage, welcomes LGBT populations (e.g., rainbow flags, pink triangles, images of same-sex couples). Agency literature and available public

materials clearly indicate non-discrimination policies and practices.

Hear. Language, written forms and assessments do not assume heterosexuality as the norm (e.g., partner instead of “husband” or “wife”; significant relationships rather than “next of kin”; broad definitions of "family" that include families of choice along with biological relatives, adoptive families, as well as diverse intimate living arrangements that extend beyond traditional marriage or common-law unions).

Feel. LGBT clients and their families need affirmation that their identity is acknowledged and respected; that they have rights and are safe (Stonewall Scotland & NHS Scotland, 2006). This holds particularly true for older LGBT adults receiving care and supports in-home, or in residential or supportive living arrangements. Older LGBT adults today came of age when socially and legally sanctioned discrimination required them to be discreet about their sexual orientation or gender identity. Being “out” could have led to violence, incarceration or forced medical treatment. Home and community care providers need to respect this history and be aware that seniors may express their sexual orientation or gender identity differently than those who are younger.

Privacy. Making public one’s sexual orientation or “coming out” is a gradual, ongoing and highly personal process. People may be fully out, not “out” to everybody or in all aspects their lives, or may never ‘’come out’’ to anyone other than themselves. Thus, service providers need to respect that the designation of sexual orientation and gender identity on any public forms or records should remain the client's choice.

Training. In addition, the development and implementation of comprehensive, culturally appropriate, health promotion policies and health care services for LGBT people need to include training for staff members and care providers to understand LGBT issues. Case management, intake procedures and treatment plans have to take into account sexual orientation where appropriate.

When does LGBT appropriate care matter?

Research on home and community care suggests that providing help with instrumental activities of daily living such as meal preparation, vacuuming, laundry or transportation goes beyond helping a person get the work done (Lum, Ruff & Williams, 2005). Assistance in any activity becomes opportunities for: 1) social interaction, critical for reducing isolation and promoting social connectedness and mental well-being; 2) assessment, critical to monitor changing level of care needs. Someone who is judgmental and discriminatory can provide adequate vacuuming or laundry assistance but will be not be able to promote the independence, well-being and healthy aging of the whole LGBT person.

LGBT populations may not necessarily express a need for specialized services but rather LGBT friendly services that recognize and affirm their identities.

Examples of best practices

Examples of three different communities for LGBT elders, located in San Francisco, Santa Fe, and Vancouver B.C. can be found at the following link: http://www.openhouse-sf.org (San Francisco). http://www.plumlivingproperties.com is a community being planned by rainbow vision in Vancouver BC. Rainbow vision has two properties already operating in the US—one in Santa Fe, New Mexico, and one in Palm Springs, California (http://www.rainbowvisionprop.com).

Toronto Homes for the Aged currently has three long-term care sites that have partnered with local agencies and community centres with expertise in the LGBT population: Fudger House, Kipling Acres, True Davidson Acres (http://www.toronto.ca/homesfortheaged/pdf/hfa_operationschart.pdf). These partnerships provide staff training in culturally appropriate care. Seniors who are interested in the LGBT program connect to the Homes for the Aged through community partners as the regular Homes for the Aged intake process does not allow for the identification of

needs based on sexual orientation. As well, these homes provide clusters of rooms specifically for LGBT seniors. LGBT volunteers are actively recruited from the local area to serve on the care team, helping to provide an accepting environment and supportive social networks (Bennett, 2006).

How can I learn more?

Egale Canada is a national advocacy organization for LGBT people and their families.
http://www.egale.ca/

The Centre in Vancouver has published an education and training manual for LGBT issues intended for use by health and social services personnel.
http://www.lgtbcentrevancouver.com/pdf_s/theManual_vFinal.pdf

Centre for Addictions and Mental Health in Toronto has produced a guide to help service providers create an environment where their clients feel comfortable talking about their sexual orientation and gender identity, especially in relationship to mental health issues.
http://www.camh.net/Publications/Resources_for_Professionals/ARQ2/arq2.pdf

Gay, Lesbian, Bisexual and Transgender Health Access Project in Massachusetts has created a set of community standards of practice for improving care to LGBT clients.
http://www.glbthealth.org/CommunityStandardsofPractice.htm

The National Health Services Scotland and Stonewall Scotland, a LGBT advocacy organization, have co-produced a report aimed to help public services change their policy and practice toward LGBT service users through sharing knowledge and best practices across sector.
http://www.lgbthealthscotland.org.uk/documents/Good_LGBT_Practice_NHS.pdf

The Public Health Alliance for LGBTTTIQQ Equity workgroup of the Ontario Public Health Association has created a manual for developing LGBT cultural competency in agencies and health organizations.
http://www.opha.on.ca/resources/SexualHealthPaper-Jun06.pdf

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Definitions

A person's sexual orientation may be either a transitional step in the process of self-discovery or a stable, long-term identity. This glossary contains additional terms that may be helpful for understanding the complexities of sexual orientation, sex and gender in the non-heterosexual population.

LGTB. It is the abbreviated term used to refer to lesbian, gay, trans and bisexual people. It is also interchangeable with **GLBT** or **LGBT**. **LGBTTTI** is also seen, which includes people who are transsexual, two-spirited and intersexed. The term queer is also used by some people as an inclusive term under which these many identities fall.

Lesbian. Refers to a woman who forms sexual and romantic relationships with other women. Less commonly, some women may prefer the term 'gay woman'.

Gay. Refers to a person who forms sexual and affectionate relationships with those of the same gender; often used to refer to men only.

Bisexual. Refers to a person who is attracted to, and may form sexual and romantic relationships with both women and men.

Transgender/Trans. Trans is a broad term used to describe the continuum of people whose gender (i.e. masculine/ feminine), does not correspond with their sex (i.e. male/female).

Transsexual. Refers to individuals whose gender identities do not correspond to their physical body. Most transsexuals experience this as stressful and anxiety provoking. Most want to be seen as the gender that is in harmony with their identity, and will often seek to modify their body through hormones and/or surgical procedures. The period during which transsexual and trans persons begin changing their appearances and bodies to match their internal gender identity is called transition and the person is considered to be transitioning. Transition may involve a change in physical appearance (hairstyle, clothing), behaviour (mannerisms, voice) and identification (name, pronoun). It is often accompanied by the use of hormones to change secondary sex characteristics (e.g. breasts, facial hair)

Two-spirit[ed]. Used by some North American Aboriginal societies to describe what western societies call gay, lesbian, bisexual and transgendered. Many Aboriginal communities had two-spirit people who were visionaries, were considered to be blessed, and were regarded as spiritual advisors. Often, two-spirit people were the mediators of the community/band because it was believed they understood both sides of disagreements between women and men

Intersex. Intersex people may have external genitalia which do not closely resemble typical male or female genitalia, or the appearance of both male and female genitalia. Intersex people have generally rejected the term 'hermaphrodite' as out-dated. An intersex person may or may not identify as part of the transgender community.

Queer Identified. The word "queer" has traditionally been a derogatory and offensive term for LGBTTTIQ people. Many LGBTTTIQ people have reclaimed this term and use it proudly to describe their identity.

Coming Out. Refers to the process by which LGBTTTIQ people acknowledge and disclose their sexual orientation or gender identity to themselves and others. "Coming out" is often an ongoing process. People who are "in the closet," that is, hide their sexual orientation or gender identity, may "come out" in some situations (e.g., with others in the community), and not in other situations (e.g., at their place of employment).

Family of Choice. Refers to a wide circle of friends, partners, companions and ex-partners who are a source of support, validation and sense of belonging.

Family of Origin. Refers to the biological family or the family that was significant in a person's childhood.

Heterosexism. The assumption expressed overtly and/or covertly that all people are, or should, be heterosexual. Heterosexism excludes the needs, concerns, and life experiences of LGBTTIQ people while giving advantages to heterosexual people. It can be a subtle form of oppression that reinforces a history of silence and invisibility for LGBTTTIQ people.

Adapted from: The Centre. (2006). *LGTB health matters: An education & training resource for health and social service sectors*. Retrieved from http://www.seniorpridenetwork.com/pics/downloads/LGTB%20Health%20Matters.pdf and Rainbow Health Ontario. (2011). *Glossary*. Retrieved June 2011, from http://www.rainbowhealthontario.ca/glossary.cfm

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