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# **The Health and Social Service Needs of Gay and Lesbian Seniors and Their Families in Canada**

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Shari Brotman  
Bill Ryan  
Elizabeth Meyer

with:  
Line Chamberland  
Robert Cormier  
Danielle Julien  
Allan Peterkin  
Brenda Richard



**McGill**

McGill School of Social Work

March 2006

EXECUTIVE SUMMARY

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[www.mcgill.ca/interaction/aging](http://www.mcgill.ca/interaction/aging)  
March 2006

Centre de santé et de services sociaux  
Cavendish



Canadian Institutes of Health Research,  
Social Science and Humanities Research Council of Canada  
CSSS Cavendish/University Affiliated Research Centre in Social Gerontology

## **Acknowledgements**

The success of this project was dependent on the support and ongoing collaboration with the following community partners and project staff:

### **Vancouver**

The Generations Project, The Centre  
Vancouver Coastal Health Authority

### **Montreal**

Action Séro-Zéro  
Réseau des lesbiennes du Québec – Quebec Lesbian Network  
CSSS Cavendish & The Caregiver Support Centre

### **Halifax**

Nova Scotia Rainbow Action Project  
Senior Citizens Secretariat  
Family Caregivers Association of Nova Scotia

### **Canada**

Canadian Caregiver Coalition

### **Project Staff**

Liz Airton	Jean-Francois Garneau	Cathy McGraw
Robert James Allan	Stanislas Kupferschmidt	Liz Meyer
Luc Bergeron	Madeleine Gomes Synnott	Heather Mullin
Ginette Brideau	Mona Hammond	Marlene Pyykko
Shayna Buhler	Allan Klusacek	Brenda Richard
Kristen Catton	Normand Larocque	Genevieve Watier
Weifun Chang	Denis Leblanc	Katie MacLean
Iryna Dulka	Glen Marcotte	Audray Lemay
Dominique du Ruisseau	Jimena Marquez	

We also wish to thank all of the service providers, seniors, and the unpaid caregivers who volunteered their time and shared their experiences with us so that we all may learn and work to improve the face of health care and social services in Canada.

## Support for Professional Development

As a result of this research we have located and developed several training resources that are available to groups interested in pursuing professional development in this area. We have trained facilitators located in Montreal, Vancouver, and Halifax who would be more than happy to provide your organization with a workshop related to the issues of working with gay and lesbian seniors. If you are interested in ordering any of the materials listed below, please contact our Montreal office. Otherwise, you may contact the regional specialists listed below to schedule a workshop in your area.

### Halifax

Brenda Richard,  
Dalhousie School of  
Social Work  
(902) 494-1356  
brenda.richard@dal.ca

### Montreal

Shari Brotman, McGill  
School of Social Work  
(514) 398-7054  
shari.brotman@mcgill.ca

### Vancouver

Chris Morrissey  
LGTB Generations  
Project, The Centre  
(604) 684-8449  
generationsproject@lgt  
bcentrevancouver.com

## Training Materials

- ◆ *The Health & Social Service Needs of Gay and Lesbian Seniors and Their Families* (2006) Executive Summary-  
<http://www.mcgill.ca/interaction/aging>
- ◆ *The Health & Social Service Needs of Gay and Lesbian Seniors and Their Families* (2006) - CD with PowerPoint files & training guide
- ◆ Informational Brochures:
  - *Invisible No Longer: personal care*
  - *Invisible No Longer: lgtb information*
  - created by the LGBT Generations Project at The Centre, Vancouver, BC [www.lgtbcentrevancouver.com](http://www.lgtbcentrevancouver.com)

## Related resources

- ◆ *Understanding & Caring for Lesbian & Gay Older Adults* (2004)
  - CD with PowerPoint files & training guide from the Council for Jewish Elderly & the Center for Applied Gerontology available at:  
[http://www.cje.net/professional/cag\\_education.html](http://www.cje.net/professional/cag_education.html)
- ◆ *If These Walls Could Talk 2*
  - A powerful movie about women from different generations that explores homosexuality from three different perspectives. The first tale, set in 1961 is a moving, harrowing story of a woman who loses her life partner after fifty years. (*available through your local video store*)

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"[Gay and lesbian seniors are] discriminated against just by virtue of the fact that they're unknown. ...the process of not knowing represents a form of discrimination. We don't have the data, why don't we have the data?" Service Provider, Montreal

"I had a doctor I had to go to in a [suburb] and once he found out I was gay, he said, 'O.K. You're fine, I'll sign the paper.' He didn't bother to give me a check-up." Senior, Montreal

## **Introduction**

Who are gay and lesbian seniors in Canada and what are their experiences of accessing health and social services? What are the experiences of caregivers who provide unpaid support to gay and lesbian seniors? How are gay and lesbian seniors perceived by health care and social service providers and are there any institutional supports for gay and lesbian seniors in the health and social service system? To date, it has been difficult to answer these questions because we know so little about gay and lesbian seniors themselves - their histories, realities and experiences of care. The absence of information about the health and health care needs of gay and lesbian seniors and their caregivers stems largely from a lack of exposure to their realities in the health care system. This is so for a variety of reasons including a lack of interest on the part of health and social service institutions to consider their specific needs and a general mistrust of health care professionals and systems on the part of gay and lesbian seniors themselves. Gay and lesbian people of all ages, (but particularly those who are now 60 years of age and older and who lived their young adult lives at a time of great hostility towards gay and lesbian people), have experienced a variety of discriminatory attitudes and practices in the health care system which have contributed to their reluctance to reveal their identities, voice their concerns to health care practitioners and use health care services. What results is a lack of recognition of gay and lesbian seniors and their caregivers and a system that is unprepared to address their unique needs and realities.

To explore these and other issues related to access and equity in health service delivery for gay and lesbian seniors, 90 interviews with gays and lesbian seniors, their caregivers and service delivery providers were conducted in three regions across Canada (Quebec, Nova Scotia, and British Columbia) between February 2003 and January 2006. Questions that were addressed include:

- ◆ What are the experiences of gay and lesbian seniors in accessing health care services in the community?

“Well some people I think you tell, but mostly it’s through the connections that you have, or you refer to your partner...It’s not something that I’ve ever gone around announcing, but I just see it as one part of my life, and its only if its relevant. Like dealing with medical doctors, that’s relevant. So I’ll be clear about it in that case. In other cases it’s left to people to draw their own conclusions.” Senior, Montreal

“Well, when [my partner] was alive he was treated great, by all, all of the doctors that he dealt with. And they knew we were a couple. But we were both treated very great. And we’d just sit and talk with them both together about his medical problems, you know, I was always included in the decisions.” Senior, Montreal

**homophobia** – the fear, hatred, or mistrust of gays and lesbians often expressed in overt displays of discrimination.

**heterosexism** – the privileging of heterosexuality over all other sexual orientations and identities which is often subtle and invisible, but effectively works to create obstacles to achieving full equality for gays and lesbians.

- ◆ What are the experiences and perspectives of caregivers caring for gay and lesbian seniors?
- ◆ How well understood are the needs, realities and experiences of gay and lesbian seniors and their caregivers by health and social service providers? How well prepared is the health care sector to respond to these needs?

### **Study Goals**

In undertaking this research, the research team and its community partners hoped not only to contribute much needed information on the experiences and realities of gay and lesbian seniors across Canada to professionals and institutions but also to begin a process of advocating for changes to the way these experiences and realities are responded to by both mainstream public sector homecare service organizations and gay and lesbian community organizations. To this end, the research process involved the development of relationships and partnerships with multiple health organizations, public health policy bodies, caregiver groups, seniors organizations and gay and lesbian organizations across the country. Through these partnerships, we created possibilities to both encourage dialogue and develop links between activists, health care professionals, researchers and systems. Our partners played a major role in guiding the research and developing change strategies from within their local context. The work is ongoing and will continue well past the end of the research process through the development of training modules, outreach programs, and advocacy.

### **Major Findings**

Many gay and lesbian seniors have experienced homophobia and heterosexism throughout their lifetime and this often limits their ability and willingness to access health services and advocate for their needs in a time of increased dependency on external supports. Although many seniors experience challenges in this area, the added obstacles of being a member of a highly invisible and hidden population adds to the complexity of issues faced by these seniors. Service providers mostly showed a positive intent towards all of

"I went to the same doctor for over 20 years and it was a male doctor and my partner also went to that doctor and that doctor was so utterly clueless. He never asked a question and I never volunteered. And that was one of the reasons that about 18 months ago, both my partner and I switched to a woman doctor and were able to talk openly about who we were and what we were and it's a much more comfortable relationship." Senior, Vancouver

"And [the nurse] said, 'Yes. Was that you?' [the lesbian identified in a newspaper article] I said, 'Yes, it was me.' From then on, I couldn't get anyone to help me out of bed. It was time I learned to get back into bed myself, but it was hard. Because of the pain, you know. But that was the end of that." Senior, Vancouver

"I don't want anybody coming, if they have great prejudice, because that'll be a shock to them and to me. And, it's been very interesting though, because some of the [homecare workers] have had their own religious agendas when they come, and it's been very fascinating you know those agendas are clicked in, and ...I had one lady who was going to save me, from this blasphemous...thing." Senior, Vancouver

their clients, and expressed their desire to treat everyone "the same", but their lack of awareness and willingness to openly address issues of identity and sexuality limited their abilities to provide a strong system of support to gay and lesbian seniors. More detailed explanations of these findings are explored under the following three major themes: identity, discrimination, and service use.

### **Identity**

Stories shared about identity, coming out, being out and negotiating this process were rich and detailed. The prevalent theme throughout all our interviews was "Don't ask-Don't tell". Seniors stated that they would come out to someone if asked but would otherwise not offer up information. Many seniors stated that they simply assumed people knew by their friendship circle, activities or family status. Most expressed that being in a partnership made their identity visible to others. There was an overall passive status toward coming out in face of the health care system. Many seniors spoke of never telling their doctor unless the doctor asked, and that they felt they couldn't or didn't want to say anything on their own.

It was interesting that from the perspective of service providers there was wide variety of responses on how to handle the "don't ask-don't tell" reality. Some, mostly gay and lesbian professionals, talked of the importance of setting the climate and building trust in order to facilitate asking about an older person's sexual orientation. Being out themselves was also perceived as making this process easier. Several heterosexual professionals reinforced the notion of "privacy" as acceptable by stating that they wouldn't ask in order to spare people's feelings, or to make them more comfortable. Those that did state that finding out was important discussed it in terms of "getting to know the person" rather than from a position of understanding the impact of being out on care plans or reducing invisibility. Most service providers told us that knowing would not alter their care planning except perhaps with respect to homemaking services or placement.

"I honestly don't know. I'm the oldest gay person that I know and everyone else is 20 to 15 years younger than I am. I don't know another...another gay person my age that I would have an opportunity to discuss it with." Senior, Halifax

"It would be important, in a sense it could be a stressor because of what they've been through like being disenfranchised, loss or grief, or whatever. And you know, I'd have to say, it has never been important to me. But maybe my awareness needs to be increased." Service Provider, Vancouver

"...there has to be ... more awareness ... I think, in training, medical school, etc." Senior, Halifax

"I think so. For me, ...it's a bit awkward because you're kind of more private, I think, dealing with someone that's gay, I think. For me, anyways, my generation. It might be a little bit different with the younger generation. People are more open about it. Because my dad's kind of private about it. Wouldn't necessarily want anyone coming around that he didn't know because then you sort of, I think, sometimes they judge him. And he didn't really like that, you know." Caregiver, Vancouver

Many seniors expressed that being gay or lesbian was a private matter not to be shared for various reasons; seeing sexual orientation as just a part of one's life, not being relevant to the encounter, to protect the feelings and experiences of loved ones, or to provide safety. Coming out was seen as important for various reasons including improving the relationship with one's health care provider, improving service delivery, or including one's partner in the decision making process. Several politically active people or people involved in the community articulated the necessity of being out for positive self esteem and to demand appropriate and supportive care. This variety of approaches to identity negotiation is important to situate within the historical context in which these individuals lived. Many constructed their identities prior to the era of gay liberation and never embraced the labels "gay" or "lesbian" as a result.

Many seniors spoke of the release of getting older and not caring about who knows now that they are past working age, thus confirming that hiding one's identity to reduce or avoid discrimination in the workplace was a common aspect of people's lived realities. Independence and autonomy were important aspects of older people's identity. This was expressed as a reluctance to rely on others, or seeing oneself as healthy despite obvious and sometimes severe health problems.

### **Discrimination**

The category of discrimination is a broad category which encompasses a wide variety of issues. Our participants' perspectives are quite diverse and affirm that discrimination exists on a continuum from invisibility and ignorance to systemic forms of prejudice, exclusion and hatred. All cohorts discussed the relevance of historical discrimination in the lives of gay and lesbian seniors as they age. There was a distinction made between societal forms of discrimination and discrimination within the health and social service system. It was noted that the terms homophobia and heterosexism were rarely used in participants' discourse although many stories were shared which could be categorized as such.

“Yeah, there are other things that gay or lesbian community organizations could do, short of it being a nursing home, there’s still other things that we could do to be of help to more gay and lesbian folks.” Senior, Halifax

“Sure I think it’s important that they know [I am a lesbian] but anybody that you’re talking to, you want some help from, then they need to know you’re gay or lesbian. ... Otherwise, they kind of assume you are [straight]... health care workers ... need to be trained and, I presume they are trained, to ... take it for granted that lesbians and gays and just part of the groups of people, take it for granted there will be a good number of lesbians and gays.” Senior, Vancouver

“And I think that to have to go to a care facility and to be a lesbian ... could be a really, really difficult situation... there’s a great need to have care facilities ... where they can be with people who understand their lifestyle and who are not shocked or betrayed, and to be staffed by people who are sensitive to the needs of the people, give them as much freedom and pleasure and enjoyment and as decent a life as they can have.” Senior, Vancouver

There were many stories shared by elders about the difficulty of being out as a gay man or lesbian in the years prior to the gay liberation era. People spoke of the reality of losing jobs, lack of family support, threat of violence, arrest and marginalization. In contrast, most elders spoke quite positively about their current lives, indicating that they experienced less frequent discrimination in their lives at the present time, this including their interactions with the health care system. They also acknowledged that although certain legal freedoms have been won, there continues to be a sense of lack of safety in society generally. Within health services, many elders felt that their relationships with care providers were good although some elders did tell stories of discrimination in the context of homecare services. Invisibility and isolation was the most commonly expressed difficulty that elders faced in relation to the health and social service system and in their social worlds general. Caregivers reaffirmed the diversity of experiences and expectations. Several caregivers spoke of the relevance of having a supportive health care provider particularly when that person is providing care in the home and with respect to residential care. One participant spoke specifically of invisibility experienced within caregiver support services and the isolation felt because of a lack of identification of children caring for a gay or lesbian parent. There was also some discussion about the lack of acknowledgement of the caregiver in health settings.

In general all health and social service providers seemed aware of the existence of gay and lesbian seniors, remarking on the historic experience of discrimination that these people must have encountered. Some of them, though, were not able to make the transition from social stigma and discrimination to discrimination in the health and social service system. This was evident in some of the interviews with heterosexual service providers particularly. Service providers who were themselves gay or lesbian had a very rich and deep analysis of discrimination against gay and lesbian seniors and remarked particularly about issues of invisibility and isolation as well as the impact of poverty. These service providers were more likely to describe very difficult and painful stories in a way not exhibited in the seniors’ stories. Although everyone recognized the issues and

"I think you already have to have respect for the people, because the whole locus of control is different in the community than in the hospital. You're entering on a client's turf when you go to their home, and they've got the power to tell you to get lost, if they want to. It's not like in the hospital, that you have them somewhat captive. And so I think just by that very nature of working in the community, if you're working in the community you have to develop that kind of respect or else you won't succeed with clients. And that seems to me more what is successful with any client is respect for the choices they've made that you don't agree with, but they're still going to make those choices and they may make lifestyle choices that you don't agree with or even that are high risk, but still maintaining a relationship in spite of those perhaps differences. So I think that kind of attitude comes from working in the community. And I think that that works with all kinds of people, whether they're gay, lesbian, or elderly, or thieves or drug users or prostitutes." Service Provider, Vancouver

current social climate, most service providers stated that they did not have clients they could identify as gay or lesbian. This exemplifies the real invisibility of gay and lesbian seniors in the health care system. Service providers also stated that they had had no training on the issue. Most gay and lesbian service providers were relying on their own experience and knowledge when they discussed their perception of issues. Gay and lesbian service providers also spoke of their own experiences of discrimination in the workplace and the role they played to agitate and inform other colleagues. Heterosexual service providers would often conflate issues of sexuality generally with their perceptions on the role of discrimination in the lives of gay and lesbian seniors. In other words, they would state that the real problem is that no-one talks about sexuality in eldercare, thereby rendering irrelevant other aspects of gay/lesbian identity and experience. Many service providers stated that the sexual orientation of older clients was irrelevant to their care plans. The exception to this was some recognition of the need to reduce potential stigma in homecare or residential placements. Although service providers seemed to be supportive of all clients regardless of their differences, a few used this discourse of "sameness" to thinly conceal homophobic attitudes. Overall, service providers acknowledged the need to address issues tailored to the experiences of gay and lesbian seniors, yet maintained an attitude that no specific mandate or special training is needed to do so. This contradiction leads to a "status quo" situation in which gay and lesbian seniors' issues and realities are virtually ignored in the health and social service system.

### **Service Use**

Gay and lesbian seniors interviewed for the current study indicated that they have many of the same concerns that their heterosexual peers face in relation to community care services. They expressed a desire to maintain their independence and autonomy, a reluctance to leave their home if and when they need more intensive care and an interest in finding someone to assist with chores around the house in order to respond to activity limitations. Where their talk is unique to the gay and lesbian experience is the emphasis on a desire to live in a retirement home or

"What happens with gay and lesbian people is...it's important when you don't know...It's when you don't know that you are complicit in that oppression and you fail to see who they are and the huge piece of their life."  
Service Provider, Halifax

"If the system is not accustomed to dealing with problems, they themselves are lacking experience to ask the right questions or to respond to the needs."  
Service Provider, Montreal

"[A client's sexual orientation is] important to me, it helps me provide better care"  
Service Provider, Vancouver

community that is specifically designed to address the needs of the gay and lesbian population and a corresponding fear or mistrust of mainstream residential settings. They also expressed a desire to live in a more positive environment that openly affirms their identities as gays and lesbians.

### **Conclusions**

The results of this study have provided a much clearer picture of the lives and experiences of gay and lesbian seniors living near urban centres in Canada. Their voices have made apparent that their health and social service needs are not being adequately met by the formal and community support structures currently in place. The experiences of those living in rural areas have not been included here and this is an important area for further investigation. The legitimate fears that gay and lesbian seniors have about the homophobia and heterosexism they face in seeking health and social services prevent many of them from receiving the care and support that they need. Caregivers reinforce this perspective and also point to the invisibility they experience in both the mainstream health and social service sector as well as within caregiver organizations. Service providers and other health and homecare workers need to be educated to work against these forms of discrimination in order to improve the delivery of services to this population. A list of suggested interventions for agencies and community groups interested in supporting this work is included at the end of this document.

Although there have been recent changes improving the rights and treatment of gays and lesbians in Canada, the historical discrimination and invisibility faced by gay and lesbian seniors have placed them at high risk when they need to access the health and social service system. In order to better meet the needs of this group of aging Canadians, we must take action to change and improve outreach, policy, and practice. Many questions have been answered by this project, but more research is needed. We hope that this project provides a strong foundation to other community projects interested in expanding knowledge about and improved services to gay and lesbian seniors in Canada.

## **WHAT WE LEARNED: AT A GLANCE...**

### **THEME I: IDENTITY**

- The prevalent theme throughout all interviews with all cohorts was “Don’t ask-Don’t tell”: an overall passive status toward coming out in face of the health care system.
- Many service providers used the notion of “respecting privacy” as reason for not discussing issues related to sexual orientation within client care plans.
- Many seniors expressed that being gay or lesbian was a private matter and they would only discuss it if it was relevant to their medical treatment. The exception was individuals who had a history of activism who felt it was essential to come out in order to reduce the invisibility of gays and lesbians.
- Most service providers said that knowing would not alter their care planning for that particular client and asserted the concept of treating all their clients “the same” regardless of their background.

### **THEME II: DISCRIMINATION**

- Incidences of discrimination fell on a continuum from invisibility and ignorance to systemic forms of prejudice, exclusion and hatred.
- All cohorts discussed the relevance and impacts of historical discrimination in the lives of gay and lesbian seniors as they age.
- Some service providers did not connect social stigma and discrimination to discrimination in the health and social service system.
- Most service providers did not have clients they could identify as gay or lesbian.
- Many service providers stated that since no clients are identified, there are no “problems” and therefore no need to alter existing services. “If it ain’t broke, don’t fix it”.
- Most service providers did not have any training on the issues facing gay and lesbian seniors as they age. Moreover, many felt that training was unnecessary.
- Heterosexual service providers would often conflate issues of sexuality generally with analysis of discrimination against gay and lesbian seniors.
- There was some recognition from all cohorts of the need to reduce potential stigma in homecare or residential placements.

### **THEME III: SERVICE USE**

- Adult day care programs helped keep the senior connected to a sense of community and alleviate the pressure on informal caregivers.
- Unpaid support was, with a few exceptions, regularly provided and accessible due to a close network of friends and neighbours.
- Seniors spoke of the importance of having support systems that validated their gay and lesbian experiences.
- Many seniors had a desire to live in a retirement community or have homemaking services that are sensitive to the needs of the gay and lesbian population.
- Seniors had a fear or distrust of the heterosexist institutional setting.

## **COHORT I: SENIORS**

- Historical discrimination was a recurring theme: losing jobs, lack of family support, threat of violence, arrest and marginalization.
- Invisibility and isolation were the most commonly expressed difficulties.
- Issues regarding identity were described as complex and sometimes painful.
- Coming out was generally a positive self-affirming experience which reduced negative feelings when confronted with discrimination. This was connected to the release of getting older and not caring anymore about who knows.
- Most spoke positively about their current lives indicating very little discrimination in their lives at present, including their interactions with the health care system, although this must be read with some caution since seniors do not want to express criticism for fear of reprisals.
- While it was acknowledged that legal freedoms have been won, there continues to be a sense of lack of safety in society generally.
- Many had a close circle of “chosen family” created to fill the support gaps caused by lack of connection to their families of origin due to homophobia.
- Ageism in their lives was a concern and resulted in feeling invisible; being ignored or ostracized by society generally and in the gay and lesbian community.
- Most seniors expressed a need for specialized services for gay and lesbian seniors, particularly with reference to issues such as homecare or residential care services.

## **COHORT II: SERVICE PROVIDERS**

- Most service providers seemed aware of gay and lesbian seniors in a general sense, remarking on the historic experience of discrimination but some were not able to make the connection between social stigma and discrimination to discrimination in the health and social service system.
- Gay or lesbian service providers and those with an anti-discrimination framework had a very rich and deep analysis of discrimination against gay and lesbian seniors and remarked particularly about issues of invisibility and isolation.
- Many service providers stated that the sexual orientation of elder clients was irrelevant to their care plans. The exception to this was some recognition of the need to reduce potential stigma in homecare or residential placements.

## **COHORT III: CARE GIVERS**

- Caregivers addressed the importance of having a supportive health care provider particularly when that person is providing care in the home or residential care.
- Invisibility and isolation within caregiver support services was a concern, particularly with respect to lack of identification of children caring for a gay or lesbian parent.
- Caregivers expressed a general lack of acknowledgement of the caregiver in health settings.

### **REGION I: VANCOUVER**

- There was a wide array of understandings and experiences of working with gay and lesbian seniors by service providers in Vancouver – ranging from the most homophobic in the study to several service providers who were very inclusive of gay and lesbian issues in their practice.
- Seniors and caregivers reported a larger level of gay and lesbian community engagement and involvement.

### **REGION II: MONTREAL**

- Seniors reported a very limited connection to and involvement with gay communities.
- Most seniors and caregivers reported positive experiences with and perceptions of health and social services currently.
- Many seniors talked about moving to Montreal specifically to escape homophobia in other regions of North America.
- Most seniors and their caregivers spoke of an interest in having services tailored to the needs and experiences of gay and lesbian seniors.
- Service providers in Montreal had more education and awareness about gay and lesbian issues than their peers in the other cities.

### **REGION III: HALIFAX**

- There was a much more limited understanding by service providers in Nova Scotia about the needs and experiences of gay and lesbian seniors.
- The impacts of living in small, fairly homogeneous communities with a strong emphasis on family contributed to the invisibility of gays and lesbians in this region.
- Issues that complicated seniors' relationship to service providers and agencies, such as race and poverty, were evident in this region.

## Recommendations

Put “**A. S.T.O.P.P.**” to institutionalized homophobia and heterosexism through:

### Advocacy

- Develop sensitive residential and long term care services
- Create the conditions for sensitive homecare services
- Increase visibility in social agencies and within the health care system

### Social & Political Voice

- Promote advocacy for seniors
- Create empowering conditions for seniors within social organizations
- Create opportunities for like-minded seniors to meet socially
- Celebrate seniors’ diversity in social organizations and agencies

### Training & Education

- Offer gay and lesbian specific curriculum in university settings
- Make available training programs for professionals working in health care systems, social services agencies, and homecare services – *Trainers and curriculum materials are available in Vancouver, Halifax, Toronto and Montreal.*
- Educate social groups and organizations on gay and lesbian seniors’ needs
- Train providers to understand, follow, or challenge current policies and legislation on temporary or alternate decision makers in their regions.

### Outreach

- Develop sensitive outreach programs to seniors and their families with specific emphasis on multiply marginalized populations such as: rural, First Nations, poor, and ethnic and racial minority communities.

### Policy

- Create options inside gay/lesbian and mainstream sectors
- Create opportunities for dialogue between sectors
- Create a “families of choice” policy
  - Decision making and long term planning
  - Caregiving and informal support networks
- Lobby for increased funding for programs
- Incorporate of sexual orientation into “diversity” agenda

### Practice

- Create environments of recognition and support
- Adapt assessments-ask the right questions
- Talk about sexuality
- Include families of choice in decision-making
- Develop best practices
- Recognize complex psychosocial issues
  - Identity: coming-out, self-identification, identification with community
  - Vulnerability: Impact of life-long exposure to stigma
  - Isolation: Managing stigma, exposure to discrimination

## **Further Reading**

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## **Appendix A: Methodology**

We developed a three-year participatory qualitative research program in order to uncover the multiple experiences of care, which emerge in service access and delivery with gay and lesbian seniors and their caregivers. Open-ended qualitative interviews were conducted with 90 participants. Issues of sampling were particularly challenging as they are in most studies on gay and lesbian health generally. The stigmatization experienced by gay men and lesbians seriously limits the possibility of conducting research with samples that are representative of their real diversity because of people's fear of coming out in order to participate, and general invisibility within health services and gay and lesbian communities. This issue is even more resounding when considering gay and lesbian seniors (60+) who are much more invisible in mainstream health and gay and lesbian community settings. This issue of invisibility has resulted in several problematic areas of recruitment. While we are well represented with respect to gender diversity it has been harder to ensure other aspects of internal sociodemographic diversity (such as class, ethnicity and race) and this was only achieved to a minor extent.

On the whole, collaboration with partners from a variety of sectors greatly facilitated participant recruitment. For example, homecare and health care partners supported the recruitment of health care and social service providers and, at times, elderly gay or lesbian clients. Gay and lesbian community organizations supported the recruitment of elders and caregivers as well as gay and lesbian-identified health care and social service providers working in the health care system. Most referrals of seniors came from the gay and lesbian service sector or informal networks of individuals active in their respective cities. Snowball sampling strategies have been used throughout with participants often referring others for participation in the study. Documentation on the study was developed for each city and distributed to local organizations, at meetings, through the mail and in several community newspapers over the course of the study.

Individual interviews were conducted in the interpretive tradition, with open ended questions on the relevant themes. Interview guides were developed for each cohort. We tried to focus on understanding the realities of gay and lesbian seniors, how they perceived themselves, the expressed needs for psychosocial, health and housing services and past/current patterns of service use in the lives of gay and lesbian seniors, (those people with chronic conditions that have resulted in a loss of autonomy such that they are currently using or anticipate using health care services) and their unpaid friend, partner, or family caregivers. For the service providers, the interview guides included questions to explore their work lives, experiences of providing care to gay and lesbian seniors and their families, notions of needs, their understanding of issues facing gay and lesbian seniors and the impact of these understandings on care. In addition, workers' perceptions about the role of the structure of the health care system in determining access and service delivery to these populations are addressed.

## **Appendix B: Points of Interest on our Participants**

<b>Cohort</b>	<b>Montreal</b>		<b>Vancouver</b>		<b>Halifax</b>		<b>TOTALS</b>	
<b>Service Providers</b>	<b>11</b>		<b>10</b>		<b>10</b>		<b>31</b>	
Gender M/F	5	6	1	9	1	9		
<b>Seniors</b>	<b>10</b>		<b>16</b>		<b>12</b>		<b>38</b>	
Gender M/F	7	3	5	11	6	6		
<b>Caregivers</b>	<b>8</b>		<b>11</b>		<b>2</b>		<b>21</b>	
Gender M/F	3	5	5	6	0	2		
<b>TOTAL</b>	<b>29</b>		<b>37</b>		<b>24</b>		<b>90</b>	

### **Seniors**

- The average age of the seniors in our study was 67.
- Our youngest participant was 57.
- Our oldest participant was 86.
- Five participants self-identified with ethno-cultural communities that are often underrepresented in large-scale studies including: Black, Hispanic, Cree, Aboriginal, and Asian Pacific Islander
- About one in five seniors had an annual income below \$15,000.
- Approximately half of the seniors had completed an undergraduate degree.

### **Caregivers**

- Over half of the caregivers in this study identified themselves as the partner of the care receiver.
- One in five caregivers was a child of the care receiver.

### **Health Care and Social Service Providers**

- Average years of experience working with seniors = 19.6 years
- Minimum number of years working with seniors = 2
- Maximum number of years working with seniors = 30+
- Approximately 1/3 of the service providers in this study identified as gay or lesbian.