



Willis, P. B., Raithby, M., Maegusuku-Hewett, T., & Miles, P. (2017). 'Everyday Advocates' for Inclusive Care? Perspectives on Enhancing the Provision of Long-Term Care Services for Older Lesbian, Gay and Bisexual Adults in Wales. *British Journal of Social Work*, 47(2), 409-426. <https://doi.org/10.1093/bjsw/bcv143>

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Link to published version (if available):  
[10.1093/bjsw/bcv143](https://doi.org/10.1093/bjsw/bcv143)

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Title: 'Everyday advocates' for inclusive care: Perspectives on enhancing the provision of long-term care services for older lesbian, gay and bisexual adults in Wales.

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Final version published online: Willis, P., Raithby, M., Maegusuku-Hewett, T. & Miles, P. (2016). 'Everyday Advocates' for Inclusive Care? Perspectives on Enhancing the Provision of Long-Term Care Services for Older Lesbian, Gay and Bisexual Adults in Wales. *British Journal of Social Work*. First published online: January 12, 2016, DOI: 10.1093/bjsw/bcv143

Accepted December 2015.

## **Abstract**

This paper centres on a neglected area of social work with older people—the social inclusion of older lesbian, gay and bisexual (LGB) adults in long-term care environments. The translation of equality law into the delivery of adult care services is a challenging endeavour for organisations, even more so in the morally-contested terrain of sexual wellbeing. In this paper we report findings from a mixed method study into the provision of long-term care for older adults who identify as LGB. Herein we present findings from a survey of care workers and managers (n=121) and from focus groups with equality and LGB stakeholder representatives (n=20) in Wales. Focussing on the current knowledge and understanding of staff, we suggest that affirmative beliefs and practices with sexual minorities are evident amongst care workers and managers, however the inclusion of LGB residents needs to be advanced systemically at structural, cultural and individual levels of provision. There is a need for enhancing awareness of the legacy of enduring discrimination for older LGB people, for cultural acceptance in care environments of older people's sexual desires and relationships, and for a more explicit implementation of equality legislation. Social workers in adult care can advance this agenda.

**Keywords:** Older LGB adults; sexual identity; sexuality; residential care; older people; ageing; adult care; social work.

## **Introduction**

The last fifteen years has brought a major shift in the civil recognition of lesbian, gay and bisexual (LGB) citizens in the United Kingdom (UK). The Equality Act 2010 cemented legal requirements for public and private service providers to provide non-discriminatory services

to LGB citizens, inclusive of social work and older people's services. However, frequently missing from political discourse on equality and sexual orientation is discussion about older people's sexual lives. Many older LGB people have endured legal, medical and social discrimination across their life course, compounding their reluctance to access health and social care services (Barrett *et al.*, 2015). The lives of older adults over 60 years of age have been overshadowed by the criminalisation of sexual relations between men (until decriminalisation in 1967), the pathologisation of same-sex desires as a symptom of mental disorder and, the representation of same-sex relationships in moral discourse as sinful and socially degraded (Concannon, 2009; Fish, 2012). This legacy casts a long shadow that can filter older LGB adults' perceptions of social and political institutions, including social services.

In 2009 Concannon lamented the lack of social work literature pertaining to older people, sexuality and social care. Since this call increasing attention has been devoted to the needs and interests of this cohort (see, for example, Fannin *et al.*, 2008; Price, 2011; Fenge and Jones, 2012). While social workers' attitudes towards older LGB people has not been a subject of social work enquiry, there is research indicating variations in professional attitudes towards LGB lives more broadly. Survey research suggest that homophobic and heterosexist attitudes are not generally characteristic of social work groups but where there are differences women report more favourable attitudes than men (Berkman and Zinberg, 1997; Brownlee *et al.*, 2005). Other significant positive factors include having 'gay-friendly parents' and direct contact with lesbians and gay men (Swank and Raiz, 2010; Papadaki, 2015). High levels of religiosity, or the degree to which social work students and practitioners invest in religious doctrine, is correlated with less supportive attitudes towards lesbian and gay men's lives (Berkman and Zinberg, 1997; Swank and Raiz, 2010; Papadaki, 2015).

In this paper we address the translation of equality policy into provision of long-term care for older adults who identify as LGB. We examine the delivery of services to older adults in residential and nursing environments across Wales and explore the question, *'What is the current knowledge and attitudes of long-term care staff and managers towards older LGB residents?'* To address this, we present qualitative and quantitative findings from a mixed-methods study conducted in Wales between 2011 and 2013. Our discussion contributes to the recent call for the social work profession to strengthen its 'foundations for informed, competent and critical social work practice with older people' (Richards *et al.*, 2013, p. 9). Our objective is to develop a deeper understanding of how social workers providing support to older people of different sexual identities can help enhance care environments and address barriers on the basis of age and sexuality. We believe that the lessons to be learned for social care workers can likewise inform critical social work practice with older adults and sharpen attention towards the sexual wellbeing and rights of older people.

## **Background to the research**

International literature on the views and attitudes of care staff employed in care environments show variations in degrees of support for older people's sexuality and sexual relationships. In the UK managers of care environments have found to be more permissive in attitudes than staff providing direct care while nursing staff were found to be more restrictive in their attitudes than care staff (Bouman, Arcelus and Benbow, 2007). Staff members' responses to the sexuality of older residents can be mediated by their level of personal comfort with older people being sexually active in conjunction with the ethos of the organisation – the more supportive culture, the less discomfort (Mahieu, Elsse and Gastmanns, 2011). Other research has been attuned to differences in attitudes towards older non-heterosexual residents. Villar et

al.'s (2015) interview-based research with staff in care facilities in Spain indicates differences in respectful attitudes towards older LGB residents, with some staff advising older residents to keep LGB identities hidden. Tolley and Ranzijn's (2006) survey of Australian care environments suggested that heteronormative attitudes were prevalent in residential homes. In this context, heteronormativity is defined as the institutional, organisational and interpersonal dynamics by which heterosexuality is continually aligned as a dominant social marker of sexual normalcy (Tolley and Ranzijn, 2006). Arguably, increased direct contact with lesbian and gay residents (Tolley and Ranzijn, 2006), and LGB adults living in the community (Dickey 2013), can help dismantle homophobic attitudes amongst staff. Unsurprisingly it is also recognised that other residents can express homophobic views (Knockel, Quam and Corghan, 2011), heightening the need for care staff and managers to openly express support towards older LGB residents.

A chief concern reported by older LGB adults is the need to feel safe about 'coming out' and identifying as LGB to other residents and staff (Barrett 2008). Other concerns include, fear of prejudicial treatment (Hughes, 2009; Higgins *et al.*, 2011), anticipating rejection and isolation (Stein, Beckerman and Sherman, 2010), and, lack of recognition of LGB individuals' lives across policy and organisational life (Phillips and Marks, 2006). Essentially, older LGB adults have voiced concerns about homophobic treatment in long-term care. Here, homophobia refers to a set of shared and individual beliefs in which intolerance and antagonism is conveyed towards sexual identities and same-sex relationships that stand outside heterosexuality (Green, 2005). Older adults' experiences of prejudicial treatment may be compounded by ageist assumptions that older people are asexual and disinterested in sex in later life—sex is frequently coupled with 'young, beautiful, able-bodied and heterosexual' subjectivities (Bouman and Kleinplatz, 2015, p. 1).

UK research suggests that older LGB adults have little confidence in health and social care providers and have diminished levels of support in comparison to heterosexual peers. Stonewall (2011) indicate that LGB adults over 55 years of age in England and Wales are more likely to be single and live alone and are less likely to have regular contact with biological family. Conversely, three in five respondents (N=1036) indicate they do not hold confidence in social services, including housing, for meeting their needs in later life (Stonewall, 2011). Survey research from the Republic of Ireland presents a similar picture of older LGB adults (55+) living alone without automatic support from partners (Higgins *et al.*, 2011). This is not to argue that LGB adults always experience estranged relationships with biological family. Australian survey findings highlight supportive relationships shared between older LGBTI (including transgender and intersex) Australians and biological kin (Hughes and Kentlyn, 2014). Alternatively, Heaphy and Yip (2003) refer to the importance of 'chosen relationships' in which familial-type bonds are shared between older LGB adults and

friends and partners. Fundamentally, older LGB adults may rely on different configurations of social networks whose members need to be included in decision-making by care staff, and social workers, where appropriate.

### **Policy and theoretical frameworks informing the research**

Our research was situated in Wales as a UK devolved nation. Over the last decade the Welsh Government (2013) has developed its own health and social care agenda for older citizens within a human rights-based framework, which encompasses the recognition of LGB adults as a minority group. This agenda has been recently enhanced through the enactment of new legislation (Social Services and Wellbeing (Wales) Act 2014) and the focus on the promotion of social wellbeing. With regards to improving health and social care services, the National Service Framework for Older People in Wales (Welsh Assembly Government, 2006) stipulates a requirement to 'root out' discrimination from service providers, including on the basis of sexual orientation. This is strengthened by anti-discrimination measures in the Equality Act 2010 (England and Wales) in which age and sexual orientation are protected characteristics (Section 29).

Staff employed to provide care to residents operate within the policy frameworks of the agency and the wider legislative context. Through their daily work, they are the direct channel for translating such policies into the everyday experiences of residents. Lipsky's (1980) work on street-level bureaucracy focuses on the discretionary spaces of public service workers with relatively high levels of professional autonomy who regularly interact with the people they serve. In Lipsky's (1980) formulation, such workers act under competing pressures with limited resources, and therefore simplify the nature of the job and adapt it. This can lead to intended policy aims being re-shaped or distorted in their practical



implementation, as from the public's perspective, these staff effectively make the policy that they are charged with implementing.

This issue of professional discretion has been explored more recently in relation to social work (Evans, 2011; Ash, 2013) but only more tangentially in relation to practices in care homes, for example in social worker decision-making in placement reviews (Scourfield, 2013). However, such analyses have not been undertaken with care home staff, who may be employed by public bodies or private employers. Frontline care staff may be more limited in the autonomy that traditionally defines professionals, but are nevertheless pivotal in exercising their practice judgment through their work, thereby shaping the experiences of older residents, for better or worse.

## **Research methods**

We adopted an across-study mixed-model approach (Johnson and Onwuegbuzie, 2004) in which focus groups, semi-structured interviews and self-administered questionnaires were utilised concurrently across all phases of the research. This approach was best suited for developing a broader overview of the knowledge and attitudes of care staff across the sector (through survey methods) and for generating a deeper understanding of stakeholders' perspectives on an inclusion agenda (through focus groups). Herein we report findings from two data sets—1) a survey of care and nursing staff and 2) focus groups with stakeholders. We have previously reported findings from interviews with older LGB-identifying people (Willis, Maegusuku-Hewett, Raithby and Miles, 2014) about their expectations of long-term care provision. The study received ethical approval from local and national NHS Wales research governance committees and the host university.

*Focus groups with stakeholders*

We facilitated 9 focus groups with practitioner and policy stakeholders (N=62) to generate discussion about good practice and policy for providing inclusive care. Here, we concentrate on 4 focus groups conducted with advocacy and policy stakeholders, including representatives from older people's human rights and equality groups and independent housing organisations. The other 5 groups were with care staff and managers employed in care environments across Wales; we report on these findings elsewhere (Willis et al., 2014). Participation was through selected invitation from a list of stakeholders compiled by the project's advisory group. The advisory group, consisting of older LGB community members and third-sector advocates and campaigners, advised on the development of the research tools and dissemination of findings. . There were a minimum of 4 participants per focus group and a total of 20 participants across groups. Participants ranged in age: 15% between 31-40 years, 40% 41 to 50 years, 10% 51-60 years, 25% 61-70 years, and 2 people (10%) over 70 years of age. There were 9 women and 11 men with two participants indicating a different gender from that assigned at birth. The majority were white with one person indicating mixed heritage background. Over half the participants identified as LGB with 7 members identifying as 'gay' and 5 identifying as 'lesbian' (one person did not respond to this item).

Focus groups were convened across North and South Wales and followed a protocol containing themes prominent in the literature, for example, current understanding of inclusive care; achieving equal treatment in care; and, developing equality policy and guidance. Group discussions were audio recorded and transcribed. Transcripts were analysed thematically in NVivo following a line-by-line coding format, and initial themes were compared and discussed between two coders to consolidate core themes.

*Survey of care and nursing staff and managers*

To gauge the views, attitudes and knowledge levels of care and nursing staff we devised a self-administered questionnaire comprising of two psychometric measures: the Ageing Sexuality Knowledge and Attitude Scale (ASKAS) (White, 1982; Bouman, Arcelus and Benbow, 2007) and the Lesbian Gay Bisexual-Knowledge Scale for Heterosexuals (LGB-KASH) (Worthington, Dillon and Becker-Schutte, 2005). ASKAS assesses individual's knowledge and attitudes towards sexuality in older age; the attitudinal component consists of 26 items with a 5-point Likert scale (1=strongly disagree; 5=strongly agree). The measure reports moderately high internal consistency (Cronbach alpha,  $\alpha=0.70$ ). The LGB-KASH consists of 28 items divided into five subscales to ascertain the attitudes of respondents towards LGB-identifying people. Subscales reflect the dimensions of 'hate', 'LGB knowledge', 'LGB civil rights', 'religious conflict', and 'internalized affirmativeness' using a 6-point Likert Scale (1=Very characteristic of me or my views; 6=Very uncharacteristic of me or my views). Subscales report high internal consistency for Cronbach alpha: Hate ( $\alpha=0.81$ ); Knowledge ( $\alpha=0.81$ ), LGB Civil rights ( $\alpha=0.87$ ), Internalized Affirmativeness ( $\alpha=0.83$ ), Religious Conflict ( $\alpha=0.76$ ) (Worthington, Dillon and Becker-Schutte, 2005). The questionnaire included 12 demographic questions (for example, current age, gender, country of birth, religious background, sexual identity), and 4 open-ended questions to explore staff members' experiences of working with older LGB residents. After piloting the questionnaire in three care homes, it was sent to randomly-selected residential, nursing (private and local authority) and extra care facilities across 4 local authorities in urban and rural locations in North and South Wales. Survey data was analysed using SPSS to produce descriptive scores and frequencies.

## **Findings**

### *Results from the survey*

Thirty two (63%) agencies participated out of 51 invited, resulting in 121 completed questionnaires from 600 distributed (response rate 20%). Survey respondents were predominantly white (87.6%), heterosexual (94.9%), female (91.6%), and of Christian faith (71.2%). 73.5% of respondents were care workers, 11.5% nurses and 13.3% registered managers with 2 respondents (1.8%) identifying as registered providers. Nearly two thirds (63.0%) were employed in private or residential facilities, 15.9% with local authority nursing or residential care, with a small percentage (16.8%) working in extra-care environments; 4.2% indicated 'Other' care homes. In terms of length of time in current role, 42.4% had been employed less than 5 years, 23.7% 5-10 years, 10.2% 10-15 years, and 13.6% 15-20 years with 10.0% indicating over 20 years. With a majority white sample, the views of black and ethnic minority staff were not sufficiently represented. We were constrained by the ethical requirement to rely on gatekeepers within agencies, primarily managers, to request employees to complete the questionnaire, which may also explain a low response rate.

For the ASKAS measure, the highest total score across the 26 items can be 130, and the lowest 26, with scores below 78 reflecting more permissive and supportive attitudes towards older people's sexuality (Bouman, Arcelus and Benbow, 2007). The mean total scores of the ASKAS was 59.84 with a standard deviation of 12.24. The highest score was 95 and the lowest was 35. All managers and registered providers (n=15), 91.5% (n=65) of care assistants and 80% (n=8) of nurses scored less than 78. This suggests our sample held moderately affirmative attitudes towards sexual activity in later life. For example, most respondents disagreed with statements about declining sexuality (n= 83, 69.2%), and lacking

interest in sexual activity (n=94, 78.4%) in later life; the immorality of recreational sexual activity amongst older people (n=90, 74.4%), or the disgrace that older people should feel if they show sexual interest (n=108, 90%). Furthermore the survey revealed only a minority of respondents would discourage sexual activity (n=11, 9.2%) between residents; segregate male and female residents (n=3, 2.5%); or complain to management in order to cease sexual activity (n=21, 18.0%).

Optimistically, the majority of respondents recognised the role of care services in supporting sexual relationships through opportunity for integration amongst residents (n=91, 75.8%), and facilitating privacy so as to allow residents to engage in sexual activity without fear of intrusion or observation (n=78, 65%). Aside these positive findings, the AKSAS measure revealed some gaps in staff and managers' knowledge about sexual functioning in later life with 53.8% (n=63) wanting to 'know more about the changes in sexual functioning in older years'. Equally, 78.3% (n=94) agreed or strongly agreed with the statement that staff of care and nursing homes ought to be trained or educated with regard to sexuality in later life.

For the LGB-KASH, subscale scores are derived from aggregated means—higher individual scores indicate degrees of lack of hateful attitudes, and lower scores indicate greater degrees of knowledge of LGB history, support for civil rights, greater degrees of religious conflict and greater internalized affirmation (Worthington, Dillon and Becker-Schutte, 2005). Table 1 contains a summary of LGB-KASH mean scores and standard deviations for each sub-scale.

[Table 1 here]

While LGB-KASH sub-scores provide a mean indicator of respondents' knowledge and attitudes, the 28 individual measures that make up each sub-scale also provide interesting detail of the variability of respondents' views. The sample mean scores suggest that respondents do not consider overtly homophobic views and hatred to be characteristic of them ( $m= 5.49$ ). For example with the statements, 'it is important for me to avoid LGB individuals' and 'LGB people deserve the hatred they receive', the vast majority of respondents (97.5%,  $n_1= 116$ ,  $n_2= 115$ ) considered these statements as uncharacteristic to very uncharacteristic of their views. Subscale 2 suggests respondents do not feel knowledgeable about LGB history, symbols or community formations ( $m=5.03$ ). This was evident in individual measures that illicit views on the extent of knowledge about the history of, for example, the Stonewall Riots, Parents Families of Lesbians and Gays (PFLAG), and the symbolism of the rainbow flag. Here, 90.7% ( $n= 107$ ), 95.7% ( $n= 5$ ), and 84% ( $n=100$ ) respectively, reported knowledge of these to be uncharacteristic of them. That said, despite a lack of knowledge, respondents appeared supportive of civil rights for LGB people with a mean score of 2.02 on sub-scale 3, one particularly relevant measure being 'I think marriage should be legal for same sex couples' wherein 77.5% (93 out of 120) of respondents agreed with this statement. Responses to questionnaires were gathered in 2012 – the Marriage (Same-sex Couples) Act, as it applies to England and Wales, received Royal Assent July 2013.

Where religious beliefs intersect with attitudes ( $m= 4.53$ ), we found some ambivalence. For example 16.1% ( $n=19$ ) 'have difficulty reconciling [their] religious views with [their] interest in being accepting of LGB people' and just under half (41.2%,  $n=50$ ) 'keep [their] religious views to [their]self in order to accept LGB people'. The mean score for sub-scale 5 ( $m=3.90$ ) suggests less proactive or personal affirmative attitudes. For example, less than half (43.7%,  $n=52$ ) 'would display a symbol of gay pride to show support of the LGB community'.

*Findings from stakeholder groups*

Theme 1: Cultural and interpersonal challenges to delivering inclusive care

Across focus groups there was shared recognition that, a) changes to the culture of care homes needed to happen before older LGB people could feel fully included in these environments, and b) the cornerstone of initiating change started with recognition of the legacy of illegality and stigma attached to minority sexual identities. One individual from an older people's advocacy group remarked, 'There are older people who regardless of what legislative and policy changes are implemented will forever carry round a memory of their sexual orientation being illegal...' (FG3 [Focus Group], M1 [Male]). As an outcome of this legacy, some stakeholders voiced concerns about residents feeling compelled to retreat back into the metaphorical closet by hiding references to LGB identities and life-histories or having one's personal life thrust into the public arena:

'Even if you haven't come out to many people, just the closest people to you, suddenly you know that all these strangers know all about you, even if you've been quite comfortable in your own home, within your own circle of friends and family.

And the culture shock that that brings has got to be quite considerable ...' (FG4, F2)

An additional stressor for older LGB residents is having to repeatedly 'come out' to new audiences: 'And you could go into a home, have sorted everybody out, everyone knows you're gay, and then somebody dies and somebody new moves in, and you've got to do the whole damn thing again.' (FG4, M1). The importance of residents feeling in control of their home environment was cited as essential to creating care settings that were the next best option to living at home. An overarching concern was the failure of staff to recognise the

sexuality of older adults and to not comprehend supporting sexual relationships as part of the delivery of care. One matron of a nursing home commented: 'I've got care staff who say, "He's (male resident) really, you know, he's really sexual, matron!" So I think across the board it's sensuality and sexuality that people are not supposed to have within the care homes.' (FG3, F1).

A fundamental dimension to inclusive care is the attitudes and knowledge of staff and managers. The potential for individual staff to harbour homophobic views was a concern raised across focus groups alongside a lack of knowledge about LGB lives and identities. More specifically, some stakeholders were worried that staff would perceive LGB residents as a unified group with similar life-experiences to the neglect of different patterns of living on the basis of other social identities such as gender and ethnicity. The dual impact of identifying as LGB and living with a disability or belonging to an ethnic minority group were framed as intersecting characteristics that could heighten vulnerability to discrimination or exclusion.

## Theme 2: Reimagining the physical and cultural environment of care settings

According to stakeholders, the onus was on managers to promote an inclusive culture and actively signify this without relying on residents to have to 'come out'. The importance of role modelling through leadership was flagged as crucial for developing a more inclusive work culture (for LGB employees) and home environment. This started with managers being prepared to push forward an equality agenda: '... a service is as good as its local management, because its local management are critical to the culture of that scheme' (FG3, F2). The cultural milieu of a care home is equally determined by the quality of interactions of staff with residents. Stakeholders considered training for all care staff to be an important



strategy to strengthen awareness about LGB lives and sexuality in older age. For training to be effective long-term, managers had to demonstrate positive leadership, back-up the messages conveyed and ensure that training outcomes were adhered to. One stakeholder believed that training alone would not be sufficient to breakdown discriminatory attitudes, emphasising the importance of assessing staff members' values pre- employment: '... I can't think of anything worse than being in a care home full of people who are very nice, very well trained and have hidden their prejudices well' (FG1, F2).

The role of external agencies such as inspectorates and independent advocates were identified as critical friends for tackling homophobia but with limited application. One stakeholder discussed the lack of available advocates while another identified a paucity of evidence captured in Inspectorate reports:

'Advocacy's the same. Even though it's in the national minimum standards, rarely do you ever see it in any of the inspection reports. (...) What sometimes happens is because it's in the National Minimum Standards, they tend to have the leaflets if there's advocacy available. Now, that's not enough. We need proactive access to advocacy...' (FG4, F1)

Stakeholders expected management to implement 'zero tolerance' policy towards homophobia to ensure that all staff were clear on the values stance of the organisation. This needed to happen alongside regular and ongoing supervision. For agency policy to be viewed as meaningful and effective, it needed to evolve from the ground up and be anchored in current practice.

*Theme 3: Staff as 'everyday advocates'*

Stakeholders identified an enhanced role for care and nursing staff as 'everyday advocates' to alleviate the burden of challenging homophobic actions from the shoulders of LGB residents. Everyday advocates were staff and managers who were prepared to 'stick their neck out' and challenge the homophobic commentary of others, including residents. For this to happen, staff needed to be equipped with the confidence and skills to appropriately challenge discriminatory views. There was common agreement that residents should not be sheltered from being challenged if their views imposed on the respect and dignity of others.

A human rights-based approach was emphasised by some stakeholders as instrumental to upholding universal principles of respect, equality and inclusion. Concerns were expressed that managers and staff in socially privileged positions, inclusive of heterosexuality, may be blinkered to recognising homophobic speech and actions or lack confidence to challenge appropriately. There was some recognition that this could be difficult to achieve in small organisations with restricted staffing levels and limited support. Similarly, there was acknowledgement that employees had to feel valued in their occupation if expected to promote the rights of others in their care. This entailed changing wider societal perceptions about the role of care staff and emphasising the attributes they bring to emotionally-challenging labour:

'So part of the thing about caring is actually how do we change the perception of the role, or the marketing of the role of caring, well like you were saying, the fact that you're working here shows how exceptional that you are...Or that it's like a badge of honour that you've made the grade and can work in this care home' (FG3, M2).

Stakeholders recognised the complexity of balancing conservative religious views of staff and residents (in which same-sex relationships may be regarded as immoral and socially degenerate) with the rights of LGB residents to express and discuss their sexual identity and relationships. One stakeholder described this tension as a 'liberal nightmare', framed as an insolvable problem for care staff to have to manage on a day-to-day basis with little practice guidance available.

## **Discussion**

Long-term care environments are not typically communities of choice for older people. For older LGB adults, fears about receiving hostile responses from other residents and staff can be amplified in addition to the cultural adjustment of living in unfamiliar surroundings. Through our research we examined more closely the attitudes and knowledge-base of health and social care workers providing care in long-term environments to older adults whose sexual lives and histories sit outside heterosexual norms. Here, we discuss these results in the context of priorities specified by stakeholders in the above findings.

Stakeholders were concerned that care staff and managers would polarise sexuality and ageing in their provision of care—the societal assumption of asexuality that accompanies older people's lives and confounds recognition of older adults as sexual persons (Bouman and Kleinplatz, 2015). Survey findings suggest care staff do not invest in this assumption—mean scores from the AKSAS measure revealed that most of the respondents held affirmative attitudes overall about sexual activity in older age and do not perceive older adult's sexual expression as immoral or disgraceful. Akin to Bouman, Arcelus and Benbow (2007), we found that respondents conveyed in the main positive and permissive attitudes towards sexual activity in later life. Stakeholders emphasised the importance of a human-rights based

approach to residential care; findings from the ASKSAS measure suggest the majority of staff are equally invested in facilitating privacy for older people's sexual relationships and respecting their choices. What is less apparent is whether the same attitudes transfer to same-sex relationships.

Descriptive findings from the LGB-KASH scale suggest that care and nursing staff and their managers are generally supportive of LGB identities and relationships, however these scores are not age-specific. Despite stakeholders' concern that care staff do not have sufficient knowledge about LGB lives, our findings indicate that staff do not consider overtly homophobic views to be characteristic of them. This may not be surprising given that the most recent National Survey of Sexual Attitudes and Lifestyles reports increasing acceptance in attitudes towards same-sex relationships across the UK (Mercer *et al.*, 2013). Stakeholders place firm expectations on the shoulders of staff and managers to speak out and challenge homophobic expressions in line with the principles of the Equality Act 2010. However, positive scores on the LGB-KASH scale do not necessarily indicate respondents' willingness to act on their beliefs and challenge others. Indeed, respondents indicate more restrained responses to the prospect of overtly displaying support for LGB individuals and civil rights.

While the majority of respondents indicate permissive attitudes towards the sexual lives of older people, the findings indicate gaps in their knowledge of a) changes in sexual functioning in older years and b) important aspects of LGB history. While our respondents may not invest in ageist assumptions that sexual interest diminishes with older age (Bouman and Kleinplatz, 2015), there is a demand for more skills and knowledge to engage with residents in respectful discussion about their sexual histories, health and desires. Presenting first-person narratives of the historically oppressive treatment of LGB (and transgender) people could help promote understanding of these generations, whom in enduring these turbulent histories, may be reluctant to access social care (Barrett *et al.*, 2015). Ambivalent

attitudes towards sexual diversity on the basis of religious faith also needs to be tackled.

Echoing findings from surveys of social work cohorts (Berkman and Zinberg, 1997; Swank and Raiz, 2010; Papadaki, 2015), we found that items capturing the intersection of religious views with support for sexual minority groups produced more conservative, and therefore potentially less supportive, scores. Through training, participating staff can be invited to reflect on their beliefs, and to develop practical strategies for addressing religious-based conflicts that may arise across staff-resident and resident-resident interactions.

It is evident from the findings that participating stakeholders who are in positions to steer policy and practice standards advocate a systemic and cultural approach to promoting affirmative practice as well as to understanding the histories and life-experiences LGB residents. Indeed, the cultural milieu has great importance for shaping care practices within organisations, and impacting on the quality of residents' lives. Managers are key players in providing opportunities for community engagement and meaningful staff-resident relationships, and they have a fundamental role in providing leadership, training and awareness-raising of sexuality in later life. They are more than administrators, but typically, are trained practitioners who straddle both frontline practice and responsibility for implementation of the organisation's aims. In terms of upholding care standards, there are high expectations placed on the shoulders of staff to act as everyday advocates for older LGB residents and to champion their rights. Arguably this is entirely appropriate given that older residents are reliant on staff to provide care, promote their interests and protect them from harm, including discrimination.

There are some parallels here to Lipsky's (1980) theory of street-level bureaucrats. Care workers may not be afforded the same level of autonomy as conferred upon other professions such as social work. Nevertheless, they operate at the forefront of service delivery, interacting with and making micro decisions about the everyday care of service users. Thirty-five years

ago, in the context of North American public services, Lipsky (1980) pointed out that recipients of services often have little choice in the services they receive. They may also face the dilemma of asserting their rights as citizens, and risking antagonism from staff providing the services. This continues to be pertinent in long-term care environments that are not intentional communities, where the attitudes and practices of front-line staff can impact tremendously on older service users requiring person-centered care.

### *Implications for social work practice with older people*

There can be a critical role for social workers in this arena by acting as human rights advocates in promoting the rights and interests of residents whose lives are situated outside heterosexual norms and expectations. At a casework level, social workers have responsibility as assessors of need for the entry to long-term care settings. However, they have limited control over the quality of the care providers who are commissioned and purchased by their local authorities. Nevertheless, social workers can exercise micro-level advocacy directly with care home providers regarding the needs of older LGB residents during their initial review period. Social workers can also have a role in reporting to their local quality assurance and commissioning bodies where they may feel that particular care settings may need further development in their awareness and practice of diversity. In turn, this dialogue can promote the development of services that are receptive to meeting the heterogeneous needs of service users, inclusive of diverse sexual histories and life-experiences, and verifying providers' policies on social inclusion. At a strategic level, social workers can join with their professional bodies in campaigning for inspectorates and care quality agencies to monitor and report on care provision to LGB residents and to lead on raising standards through the delivery of ongoing training and manager support. This should be a shared responsibility between individual practitioners and professional bodies.

To harness the potential for service user involvement, older LGB-identifying citizens living in the community could act as community advocates: social work-supported schemes in which community volunteers visit homes over a period of time, engage with residents and staff in discussions about sexuality and inclusion and undertake LGB-friendly audits of the physical and cultural dimensions of the home. This approach is highly compatible with the emphasis given to co-production between social services and user groups in the new Social Services and Wellbeing (Wales) Act 2014, and is a model that has potential transfer to other national contexts. Social workers in the UK are no strangers to models of service user involvement in research and project evaluation (see, for example, Cossar and Neil, 2013), and parallel models already exist on the meaningful participation of community visitors in enhancing the quality of life of older residents in care homes in Southern England (Tanner and Bethany, 2014). Social workers in adult statutory teams are in a pivotal position to bring together care providers, third sector organisations and community groups in the locality to initiate such initiatives.

Finally, the preparation of future cohorts of social workers through qualifying and post-qualifying education is an area that requires more development and research. Although Quality Assurance Agency (2008) subject benchmarks for social work education in the UK emphasise embedding the principles of countering discrimination in the syllabus, it is not known how far social work qualifying programmes pay specific attention to sexuality in later life and older LGB people in particular.

### *Limitations*

As identified in the findings, the self-administered questionnaire frequently produced missing responses to some items. This is a limitation of utilising this mode of questionnaire to gather responses on a highly sensitive topic, with some items posing frank and explicit questions. In particular, we found even the most peripheral discussion of older people and sexual relationships presented challenges to some respondents. These challenges indicate not only the sensitivity of the topic, but also the time restrictions on care staff within their working shifts for full completion of standardised measures. The research did not encompass the needs and interests of older transgender people as the focus was on sex, sexual identity and long-term care provision. The care needs of transgender adults in later life, and how they negotiate the gendered-assumptions of care staff and residents, has received scant attention in either ageing or social work literature. This warrants separate inquiry.

### **Concluding comments**

Given this period of change in the policy ethos in Wales toward social wellbeing and co-production, the time is ripe to encourage social work practitioners to seize their potential for active engagement with individual long-term care environments and wider strategic forums in order to realise the advocacy roles that are open to them. Across national contexts, social workers engaged in the commissioning of long-term care for older adults need to be aware of the historical legacy of discrimination towards LGB people and how this may impact on older people's reticence to access health and social care provision or residential settings. Social workers need to verify providers' policies on inclusion and equality with evidence from within the cultural milieu and inspection reports. Care managers and frontline care staff alike have pivotal roles as 'everyday advocates', where they can use their professional discretion to



tackle homophobia and ageist assumptions about sexual wellbeing in later life, and promote the rights and citizenship of older LGB residents.

**Statement of funding:** This research was funded by the National Institute for Social Care and Health Research (NISCHR), Welsh Government 2011-2013 (SCRA/10/03).

**Acknowledgements:** Our gratitude to the reviewers for their highly encouraging and constructive comments.

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Table 1

Mean scores and standard deviations for LGB-KASH sub-scales.

<b>Subscales</b>	<b>N</b>	<b>Mean</b>	<b>S.D.</b>
<b>1. LGB Hate</b>	121	5.49	0.78
<b>2. LGB Knowledge</b>	121	5.03	0.90
<b>3. LGB Rights</b>	121	2.02	1.05
<b>4. LGB Religious Conflict</b>	121	4.53	1.13
<b>5. LGB Internalised Affirmativeness</b>	121	3.90	1.17