Uniting

Report

Research and Social Policy

27 April 2020

LGBTI experiences of Aged Care

Analysis of results of online survey

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Executive summary

This report presents the results an online survey Uniting conducted between late 2018 and late 2019, investigating the experience of older Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) people in relation to aged care. It is intended to be a comprehensive reference, and to provide a foundation for developing shorter, more targeted and practical documents. As such, it presents the results for every question, and analyses important associations between questions in depth.

We obtained around 130 respondents, from both within Uniting and the general public. As a group, they were fairly representative of our main population of interest: 92% identified as LGBTI; 31% stated they were clients of aged care services; and 72% indicated separately they were old enough to be potential clients. A substantial minority (22%) were in our secondary target group of people working in the aged care sector. Respondents skewed towards regional NSW compared with the general population. They were also quite a vulnerable group. Around 40%, reported experiencing at least one of a range of vulnerabilities, including health problems, membership of legislatively-recognised equity groups in aged care, or struggles with coping and caring. Vulnerability factors often compounded each other. For example, two thirds of those who reported caring for another person also reported a lack of social support or troubles accessing/paying for services.

Respondents generally reported feeling safe to disclose sexual orientation or gender identity when engaging with aged care and other similar services, and that they had not had difficulties accessing services because of sexual orientation or gender identity. Both factors have improved somewhat since our 2012-13 survey, but there is still room for improvement. Respondents were very negative in their overall assessment of whether aged care services meet the needs of older members of the LGBTI communities.

Respondents identified two groups of factors as important for the wellbeing of older LGBTI people in care: visible signs of welcome and inclusive language (symbolic and discursive inclusion), and social factors (ensuring access for partners and supporting LGBTI couples). They reported that issues of disclosure/ harassment, clinical care and supporting couples/partners were subjectively important to older LGBTI people in care.

There were few clear trends, when responses on issues such as safety, experience of discrimination, or assessment of what matters in aged care were broken down by demographic factors or life circumstances. There is, however, some evidence that issues like quality of care and access to support networks while in care are especially important to those who reported a sexual orientation other than lesbian/gay/homosexual, and those who report greater levels of vulnerability.

With respect to Uniting in particular, respondents who were familiar with our LGBTI engagement work were more likely to agree with the statement that we are LGBTI-inclusive, and also that our services meet the needs of members of the LGBTI communities. Those who expressed this opinion identified particular strengths around visible signs of welcome and inclusive language (symbolic and discursive inclusion), and sensitive handling of disclosures. There is room for improvement in all these measures, particularly around signs and symbols of inclusion and support for couples. Respondents did not seem to be particularly aware of our clinical practice. Too few employees responded to the survey to reach solid conclusions about their views.

Aims

This project was originally undertaken at the request of the then-LGBTI Working Group, and was intended to inform ongoing work around engagement, inclusion and improved service delivery to assist members of the Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) communities.

As a first step towards this goal, in 2018 the Working Group identified the need to understand the needs and aspirations of older LGBTI people, and particularly of LGBTI clients of our home and community, independent living and residential aged care services.

The specific aims of this project were to:

- identify the satisfaction level of our clients with the services we provide as an organisation;
- understand the LGBTI communities (within our organisation) better; and
- identify possible areas for improvement in the services we provide.

This report is intended to meet these goals by:

- analysing the communities' needs, hopes and fears, as identified by a survey and with reference to existing scholarship and policy;
- analysing any differences in these results compared with the results of the last survey we conducted in 2012-13;
- identifying any issues we need to work on to be more inclusive of a larger number of LGBTI people seeking or receiving our services; and
- making recommendations for any changes to Uniting's services, practices or other activities to improve the quality of our service or our engagement generally with the LGBTI community.

Background

The needs of LGBTI people have not been well understood by aged care service providers until fairly recently,[1] and there are still significant gaps in our knowledge. There remains an ongoing need for aged care services to work to be more inclusive of these communities.[2] Uniting has been a prominent contributor to this.[3] This began following the introduction of the *National LGBTI Ageing and Aged Care Strategy*.[4]

LGBTI people have some common perspectives and experiences, including a history of significant discrimination, persecution and abuse in institutional settings.[5] Older members of the LGBTI communities have often hidden their identity, and may experience particularly acute loneliness as those they are 'out' to pass away.[6] Our own staff and

[1] Kimmel (2014) 'Lesbian, gay, bisexual, and transgender aging concerns', *Clinical Gerontologist*, Routledge.
[2] Hughes (2016) 'Loneliness and social support among lesbian, gay, bisexual, transgender and intersex people aged 50 and over', *Ageing and Society*, 36(9), pp. 1961-1981.
[3] Brown*, et al.* (2015) 'LGBTI Ageing and Aged Care', *Australas J Ageing*, 34 Suppl 2, pp. 1-2.
[4] Department of Health and Ageing (2012) *National Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Ageing and Aged Care Strategy*, Canberra, Commonwealth of Australia.
[5] Spencer and Patrick (2010) 'Revisiting traditional survey methodology to recruit and survey lesbian, gay, and bisexual older adults.', in Streiner and Sidani (eds), *When research goes off the rails: Why it happens and what you can do about it*, Guilford Press, pp. 211-218.
[6] Hughes (2016) *op. cit.*

clients have told us handling of dementia, end-of-life care and relationships with birth family are sensitive and important.[7]

LGBTI elders are also a diverse, non-homogenous group,[8] which has implications for service needs and barriers, clinical care, and staff awareness and inclusivity. For example, people who identify as bisexual or queer may feel doubly-excluded, since their identity is not always recognised by other members of the LGBTI communities,[9] and there is some evidence they experience poorer health outcomes.[10] LGBTI people with intellectual disability face challenges in expressing their sexual preferences, and are frequently overlooked by providers (an experience they share with many other people with disability).[11] LGBTI members of CALD communities can face barriers due to "invisibility", taboo or illegal nature of LGBTI identities in some cultures, countries, religions and languages.[12]

Research is an important way of hearing the voices of LGBTI elders, but gathering data is challenging. Recruitment and engagement are difficult, because LGBTI people often are unwilling to disclose their identities, especially in institutional settings where they may not feel safe. This tends to favour participation in research by those who are already "out". Qualitative studies can overcome this to some degree, particularly where researchers are themselves members of the LGBTI communities and may be able to rely on personal networks to recruit people who are not fully "out".[13] Quantitative studies can sometimes rely on collaboration between researchers and the communities to achieve the same thing.[14] However, there is very little quantitative data specifically on the subject of interest for this paper (aged care), particularly data for Australia and the period since the Commonwealth Government introduced its *National LGBTI Ageing and Aged Care Strategy*. The main exception to this is Uniting's own earlier survey, conducted in 2012-13.[15]

Methods

We adopted very similar methods to our previous survey in 2012-13, in an effort to produce comparable results: an online survey in two phases. Both were conducted with the approval of the UTS Human Research Ethics Committee (ETH18-2386).

The first survey was open from September-November 2018, and focussed on clients and staff in our own aged care services. We advertised it through posters in our residential

[7] Personal communication from members of Uniting's (staff) LGBTI Working Group, and (resident/client) LGBTI Reference Group. These comments were made during development and validation of the survey instrument used for this project.
[8] Kimmel (2014) *op. cit.*
[9] McLean (2001) ' Living life in the double closet: Bisexual youth speak out.', *Hecate*, 27(1), pp. 109-115.
[10] Fredriksen-Goldsen and Kim (2017) 'The Science of Conducting Research With LGBT Older Adults- An Introduction to Aging with Pride: National Health, Aging, and Sexuality/Gender Study (NHAS)', *Gerontologist*, 57(suppl 1), pp. S1-S14.
[11] Noonan and Gomez Taylor (2011) 'Who's Missing? Awareness of Lesbian, Gay, Bisexual and Transgender People with Intellectual Disability', *Sexuality and Disability*, 29(2), pp. 175-180.
[12] Crameri*, et al.* (2015) 'It is more than sex and clothes: Culturally safe services for older lesbian, gay, bisexual, transgender and intersex people', *Australasian Journal of Ageing*, 34(2), pp. 21-25.
[13] Lee (2008) 'Finding the Way to the End of the Rainbow: a Researcher's Insight Investigating British Older Gay Men's Lives', *Sociological Research Online*.
[14] Fredriksen-Goldsen*, et al.* (2017) 'Plan of action for real-world translation of LGBTQ health and aging research', *LGBT Health*.
[15] Dicks*, et al.* (2015) *op. cit.*

aged care facilities, on the invoices of home care clients and independent living villages, and in-community care services such as day centres and seniors' gyms, and on our social media and internal communication channels. Although our advertising clearly sought to recruit LGBTI clients, the recruitment mechanisms and survey instrument meant that anyone with relevant experience (including carers, family, staff, etc., whether identifying as LGBTI or not) could participate. We obtained 20 responses, of whom 6 indicated they were members of staff. This was better than 2012-13, when we had no internal respondents, but still only represents a very small proportion of our estimate of the number of members of the LGBTI communities who may be in our residential aged care facilities.[16] More importantly, it is too few for the kind of quantitative analysis we hoped to conduct.

We therefore decided to open the survey to members of the public, as we had for our earlier survey. This was open from July-September 2019. We advertised it on the Uniting website and our social media platforms. We also worked with ACON's Pride in Health + Wellbeing team, Alice's Garage and Silver Rainbow, who advertised the survey on their social media accounts. We chose these three organisations because they are well known in the LGBTI communities and focus on aged care in their work. We obtained a further 112 responses.

We recruited participants for both surveys through anonymous self-selection instead of a random sampling method, even though this would limit our ability to make statistically rigorous inferences about broader populations from our responses. We did this for several reasons. We were interested in reaching members of the LGBTI communities who were not already "out", and could therefore not rely on an existing sample frame. In addition, advice from our in-house LGBTI representative bodies following the 2012-13 survey strongly indicated the need to ensure participation was confidential and anonymous, and understood to be so by potential recruits. This meant we could not rely on recruitment methods which might entail a risk that potential respondents would be outed to third parties in their homes or communities (e.g. being seen to take a flyer or speak to a member of staff). We learned this was particularly important to members of the LGBTI communities when engaging with a faith-based service provider such as Uniting.

Study data were collected and managed using REDCap electronic data capture tools hosted at UTS.[17] Study data were analysed using R,[18] and graphs were prepared using Microsoft Excel.

Descriptive statistics from 2018-19 survey

This section describes the distribution of responses to each question in the 2018-19 survey. Analysis of systematic associations between responses to different questions (e.g.

[16] This is based on the Human Rights Commission's estimate that LGBTI people make up 11% of the population, and our total client base for residential aged care (5,000). This may be an over-estimate, because members of the LGBTI communities have historically been unwilling to seek services from church-based providers due to past discrimination, and because of the impact of the AIDS epidemic of the 1980s and 1990s on life expectancy of gay men.

[17] Harris*, et al.* (2009) 'Research electronic data capture (REDCap) – A metadata-driven methodology and workflow process for providing translational research informatics support', *J Biomed Inform*, 42(2), pp. 377-381; Harris*, et al.* (2019) 'The REDCap consortium: Building an international community of software platform partners', ibid., 95, p. 103208.

[18] R Core Team (2019) *R: A language and environment for statistical computing*, Vienna, Austria, R Foundation for Statistical Computing.

age and feelings of safety disclosing gender identity or sexual orientation) is presented in "Analysis" below.

Demographics

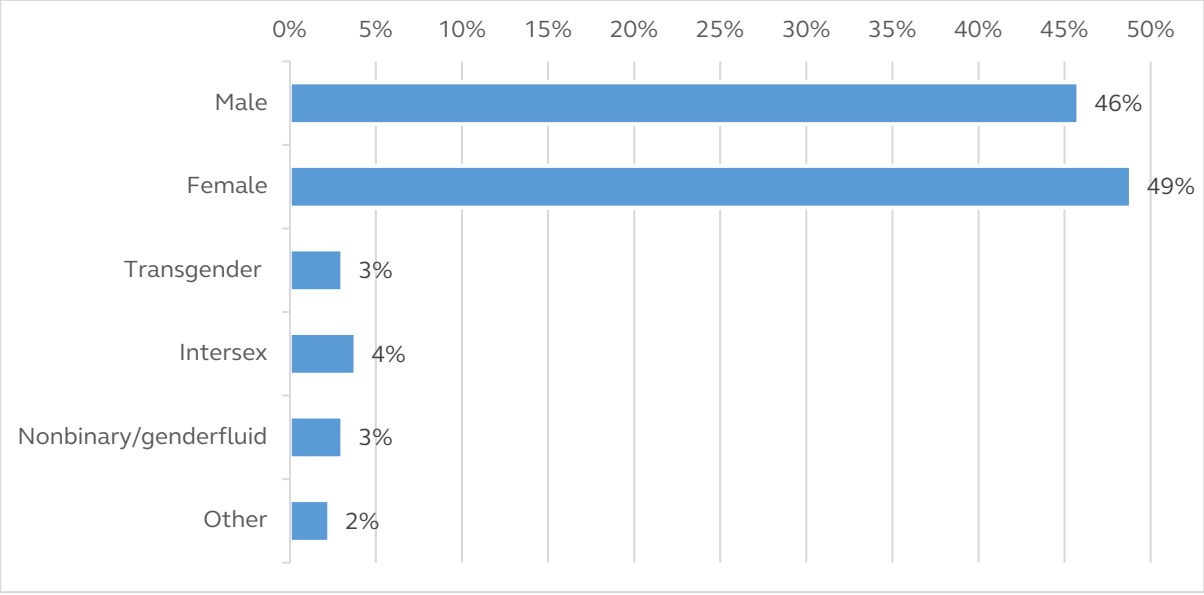
92% of respondents were in our primary target group: LGBTI people who are either clients or potential clients of aged care services. A substantial minority (22%) were in our secondary target group of people working in the sector. These groups are not mutually exclusive. A small number appear to have no direct contact with the aged care system; we assume they heard of the survey through networks in the LGBTI communities. Among the very small proportion who identified as both heterosexual and cisgender, half were employed in the sector and half were Uniting clients/residents.

Gender identity

95% of respondents identified as either male or female, with slightly more identifying as female than as male. Small proportions identified as transgender, intersex, nonbinary/ genderfluid or "other". 6% of respondents selected more than one option (not shown); almost all these respondents identified as transgender or intersex as well as one of the other options.

We acknowledge that the way we report these results is not consistent with best practice in the use of terminology. In particular, "intersex" is not a gender identity but rather a set of physical characteristics, while transgender may be considered a gender experience rather than a gender identity. We originally intended to report these results in a manner consistent with best practice. Unfortunately, we collected this data for some respondents under the label of gender identity due to an administrative error. This may have resulted in a change in the number of people identifying in these two categories.

Figure 1 – How do you describe your gender identity to others, when you choose to reveal it? (n=131)



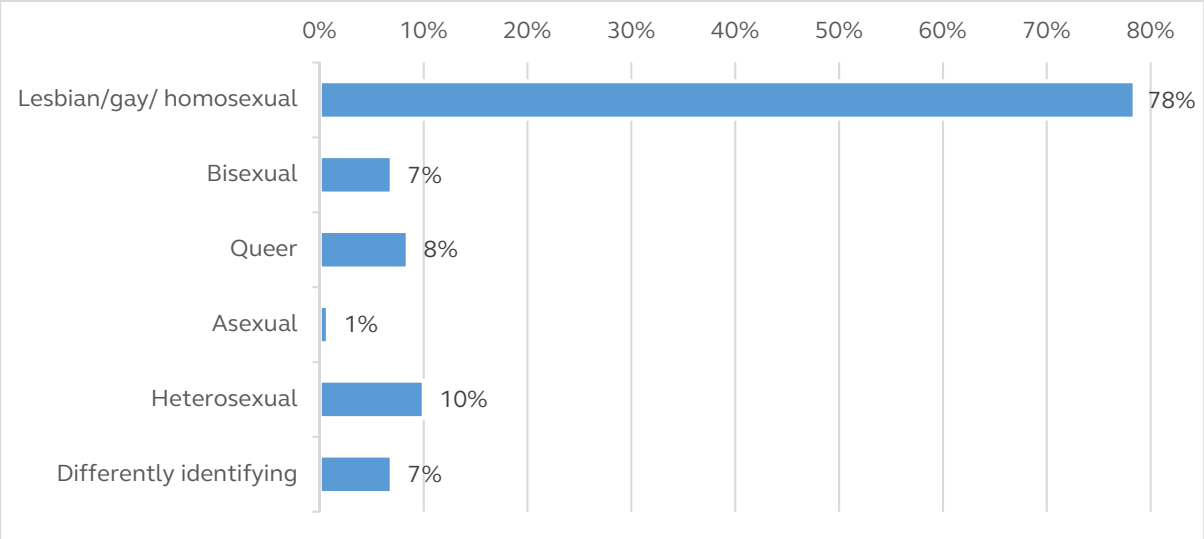
Sex at birth

Due to an administrative error, we are not able to report data for the question, "What sex were you assigned at birth?".

Sexual orientation

Over three quarters of respondents identified as lesbian/gay/homosexual, and around one third identified with another sexual orientation. 5% of respondents selected multiple sexual orientations (not shown). All of these respondents identified as bisexual, queer, or commented they were "pansexual", along with one or more other options. Respondents were able to select more than one response.

Figure 2 – How do you describe your sexual orientation to others, when you choose to reveal it? (n=115)



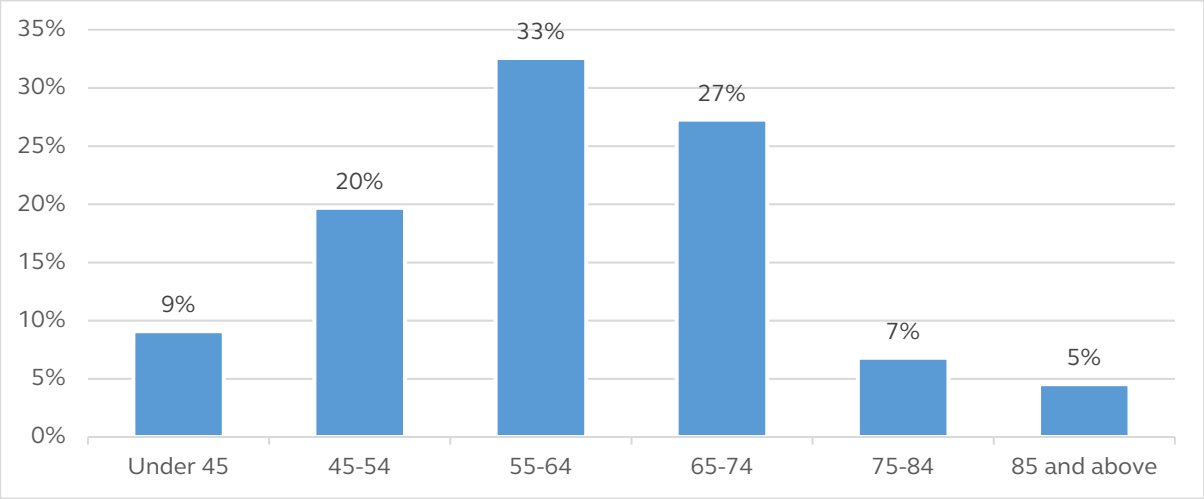
Intersex variation

Due to an administrative error, we were not able to collect consistent data for the question "Were you born with a variation of sex characteristics (sometimes called intersex)?". However, we were able to merge datasets and give indicative data (reported under "Gender identity" above).

Age

Almost two thirds of respondents indicated they were aged 55 or over, which is the range to which Uniting provides aged care services. Around half were at the young end of this range (aged 55-74). Almost two thirds of respondents aged 45 or under indicated they worked in aged care services (see "Contact with aged care services" below; not shown here). One third of this youngest group, and just under two thirds of those aged 45-54, indicated they had no connect to aged care services as a client, worker or advocate.

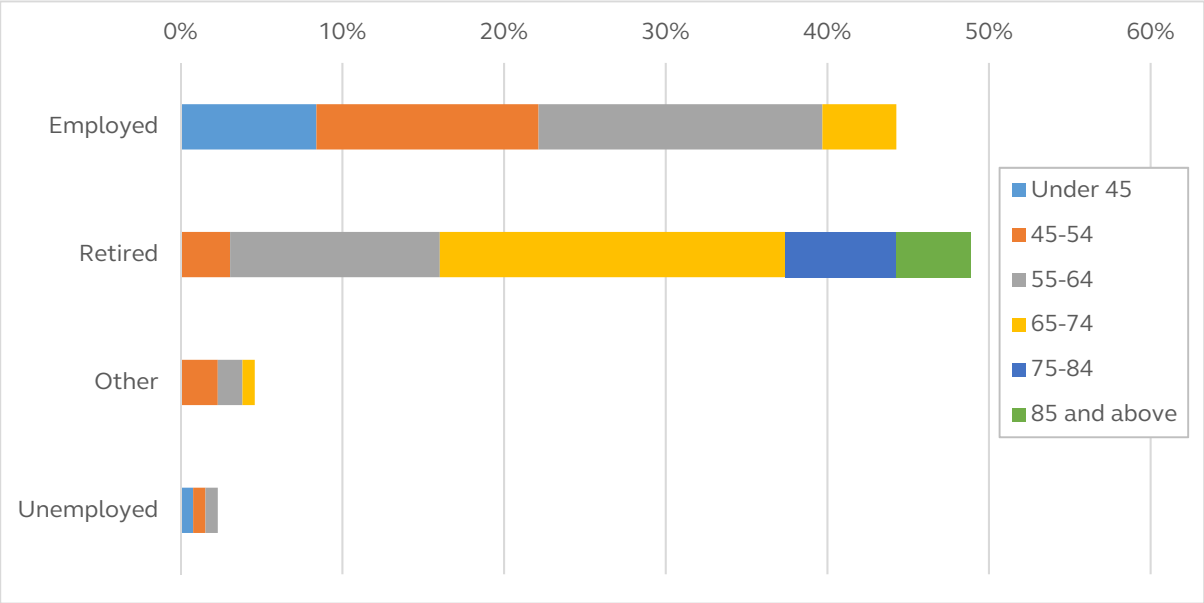
Figure 3 – How old are you? (n=132)



Employment status

Over two fifths of respondents indicated they were employed, and slightly under half indicated they had retired. Unsurprisingly, employment was generally concentrated among younger age-groups, and retirement among older age-groups.

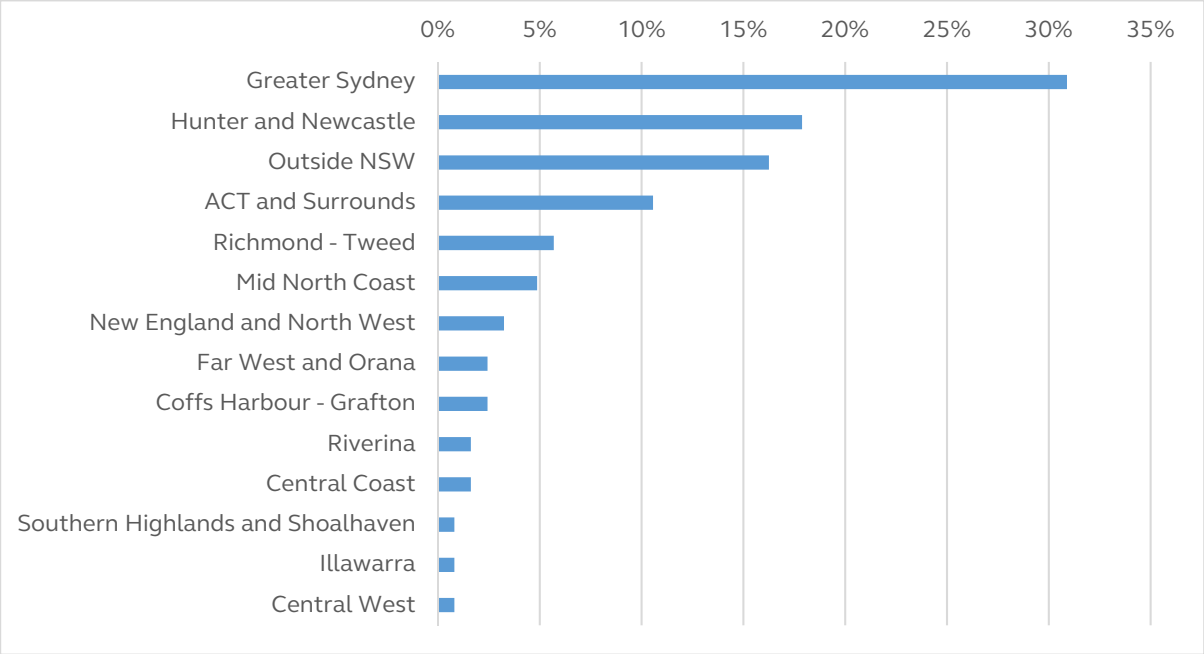
Figure 4 – What is your employment status? (n=131)



Region of usual residence

Respondents to our survey were skewed towards regional NSW compared with the general population. Among those who reported a that they usually lived in NSW, 38% reported that they usually lived Greater Sydney; Sydney accounts for around two thirds of the general NSW population. Substantial pluralities of respondents were in the Hunter/ Newcastle and the northern coastal parts of NSW. Around 15% were not usually resident in NSW at all; we assume they heard of the survey through social media.

Figure 5 – Which postcode do you live in? aggregated to ABS SA4s (n=123)

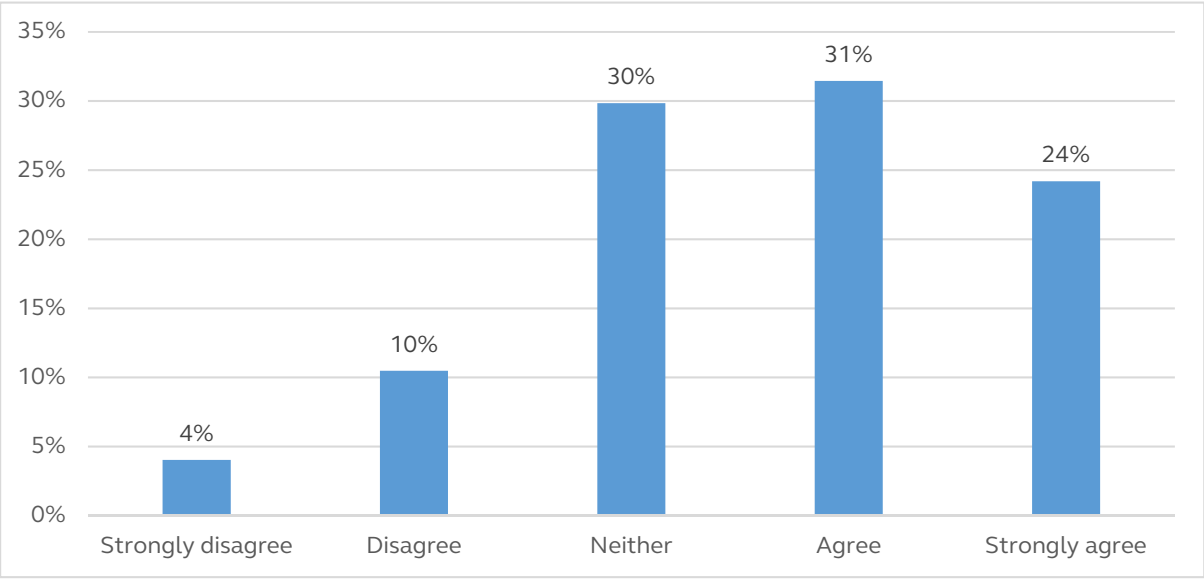


Experience as an LGBTI person

Perceived safety of disclosure

Slightly over half of respondents either agreed or strongly agreed that they generally feel safe to disclose their sexual orientation or gender identity when engaging with support services. Just under a third indicated that it depended on context. None of those who said they felt unsafe identified as heterosexual.

Figure 6 – I feel safe to disclose my sexual orientation or gender identity when engaging with support services (n=124)

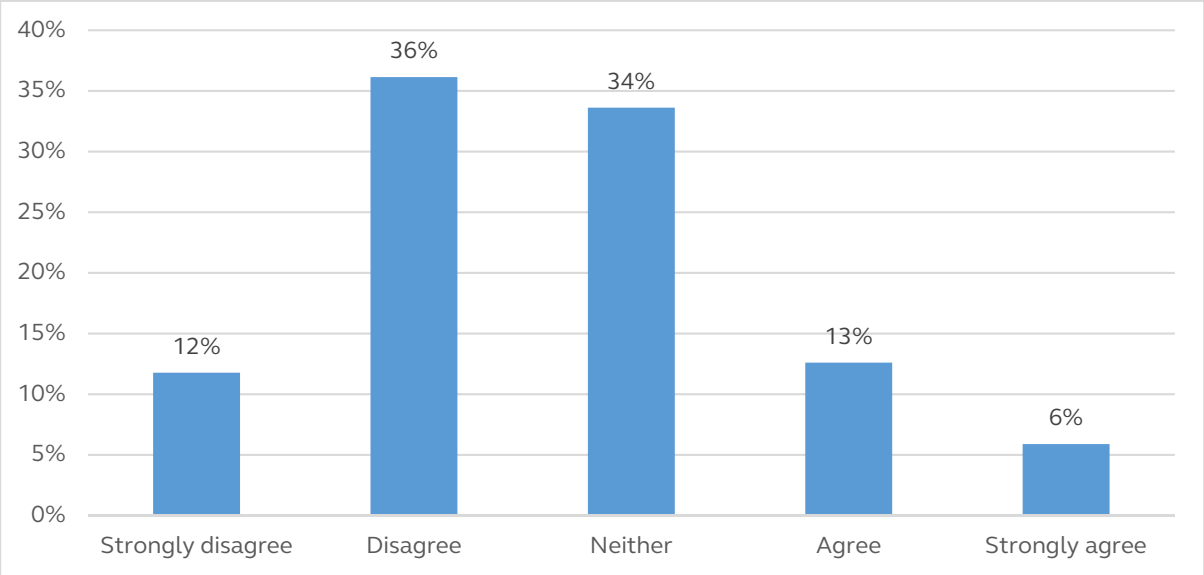


Difficulties accessing services

Slightly under half of respondents disagreed or strongly disagreed that they had experienced difficulties accessing support services because of sexual orientation or

gender identity. A further third indicated that they neither agreed nor disagreed, and it depended on context.

Figure 7 – I have had difficulties accessing support services because of my sexual orientation or gender identity (n=119)

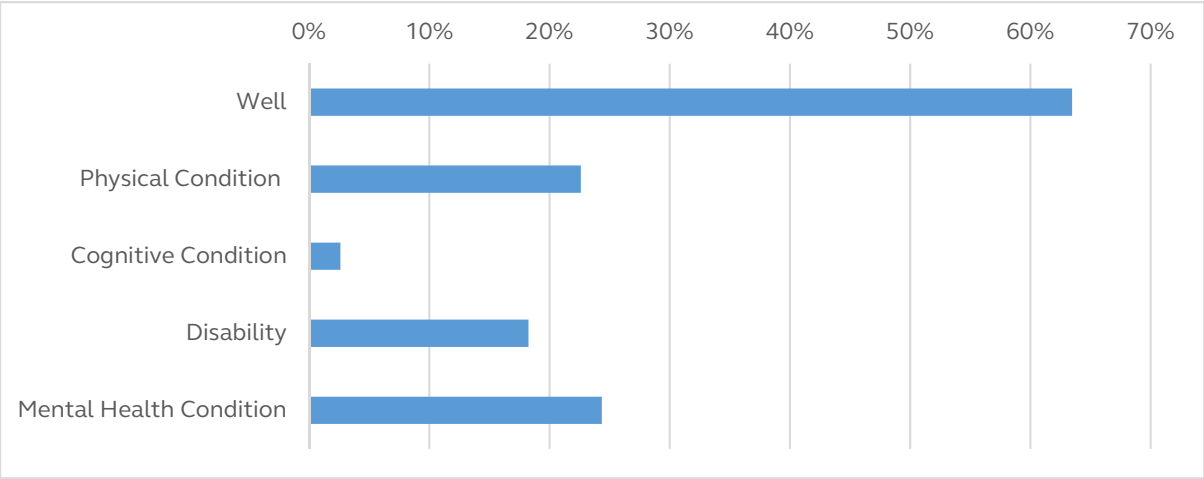


Vulnerability

The survey included a question which sought to identify whether respondents were experiencing a range of intersecting factors associated with vulnerability and disadvantage. The questions were designed to align with categories of disadvantage defined in legislation, and circumstances which are relevant to our practice.

With respect to physical, cognitive and emotional wellness, almost two thirds of those who provided answers reported that they were well. Around a fifth of all respondents reported a degenerative or chronic physical condition, or a mental health condition. Somewhat less than a fifth reported having a disability. These categories overlap. Just under a fifth (18%) of those who reported that they were well also reported having one other of the conditions listed here. One eighth of respondents (13%) reported multiple conditions; only one of these respondents also reported being "well".

Figure 8 – Which of the following describes your current circumstances? Physical, cognitive and emotional categories (n=115)

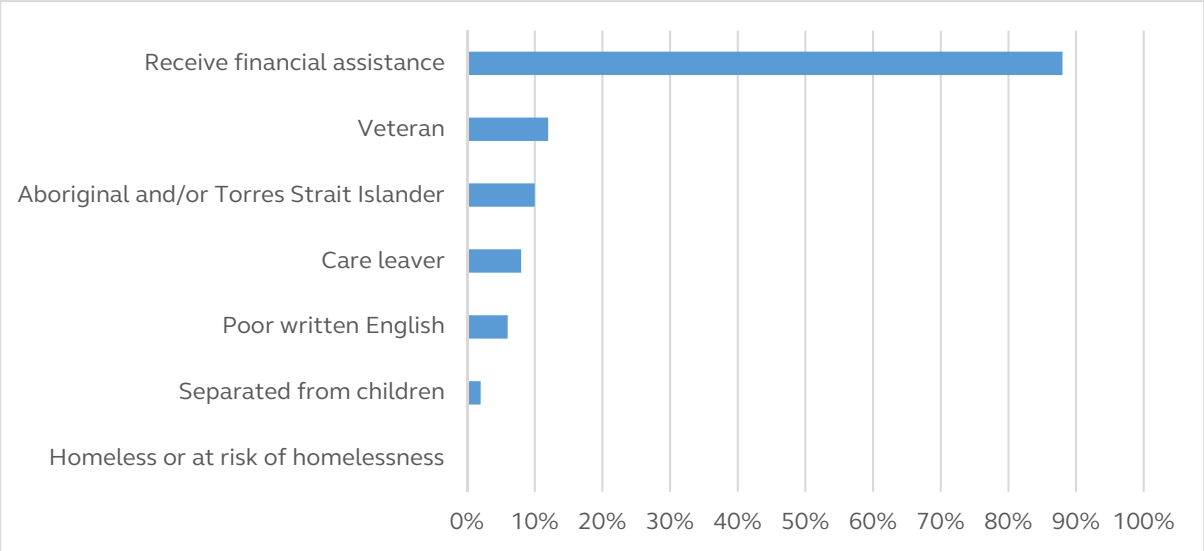


Commonwealth aged care legislation recognises certain special needs groups. This includes being a member of the LGBTI communities, and also:

- people from Aboriginal and Torres Strait Islander communities;
- people from culturally and linguistically diverse backgrounds;
- people who live in rural or remote areas;
- people who are financially or socially disadvantaged;
- veterans;
- people who are homeless or at risk of becoming homeless;
- care leavers; and
- parents separated from their children by forced adoption or removal.

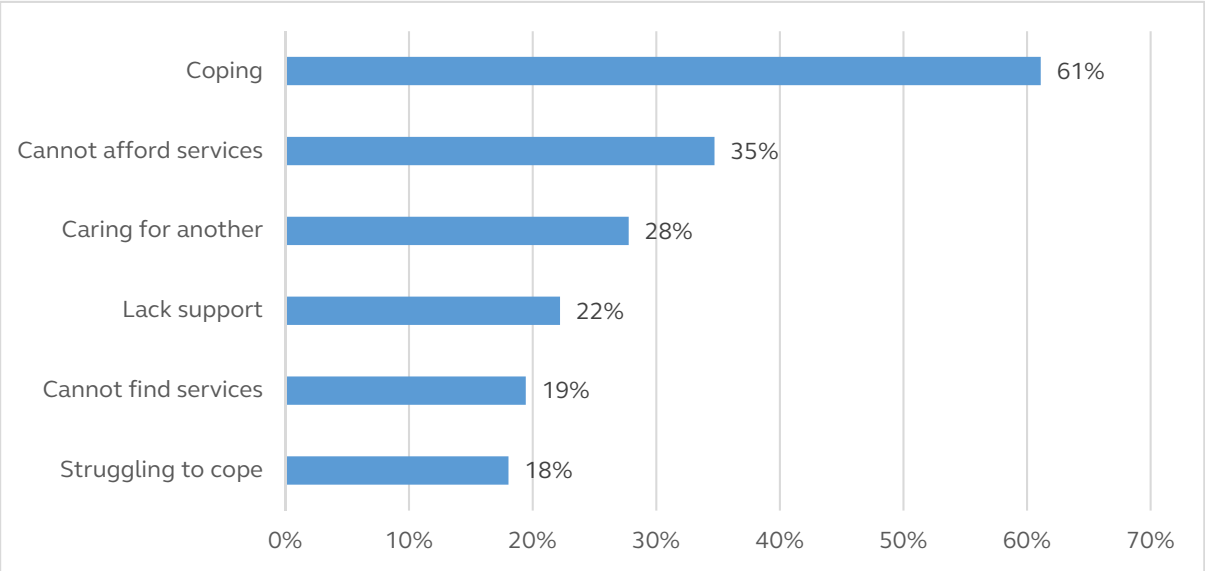
Two thirds (63%) of respondents stated that they were in one of these categories (not counting LGBTI or "regional and remote", both discussed separately earlier in this report). Of these almost 90% stated they received Government financial assistance. This question was intended to serve as a proxy for "financially or socially disadvantaged", but in retrospect it may have been poorly worded. Anyone receiving aged care services receives government assistance in the form of subsidies; if every respondent who reported that they receive aged care services also selected this option because of these subsidies, it would account for around half of all those who selected this option. A small number reported being veterans, identifying as indigenous, being care leavers, and having difficulties with written English (a proxy for CALD status).

Figure 9 – Which of the following describes your current circumstances? Legislatively-recognised categories (n=50)



Just over half (55%) of respondents gave information about their support circumstances and ability to cope. Of these, just under two thirds reported that they were "coping", while just under one fifth reported that they were not coping. There was a great deal of overlap between the categories (not shown). On the positive side, two fifths of those who reported they were coping also reported experiencing one or more of the other challenges listed here. On the negative side, two thirds of those who reported caring for another person reported a lack of social support or troubles accessing/paying for services. Three quarters of those who reported they were not coping reported similar difficulties.

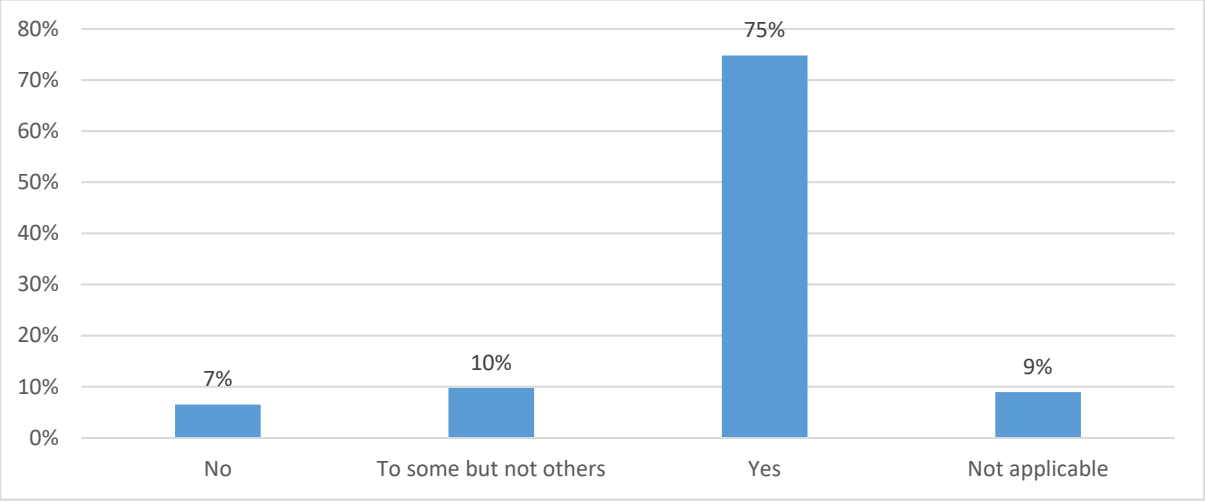
Figure 10 – Which of the following describes your current circumstances? Support needs and coping (n=72)



Out to immediate family

Three quarters of respondents indicated they were "out" to their family, and a further ten percent had come out to some extent. The two who indicated they were not out both identified as bisexual. The respondent who indicated "not applicable" identified their sexual orientation as "other".

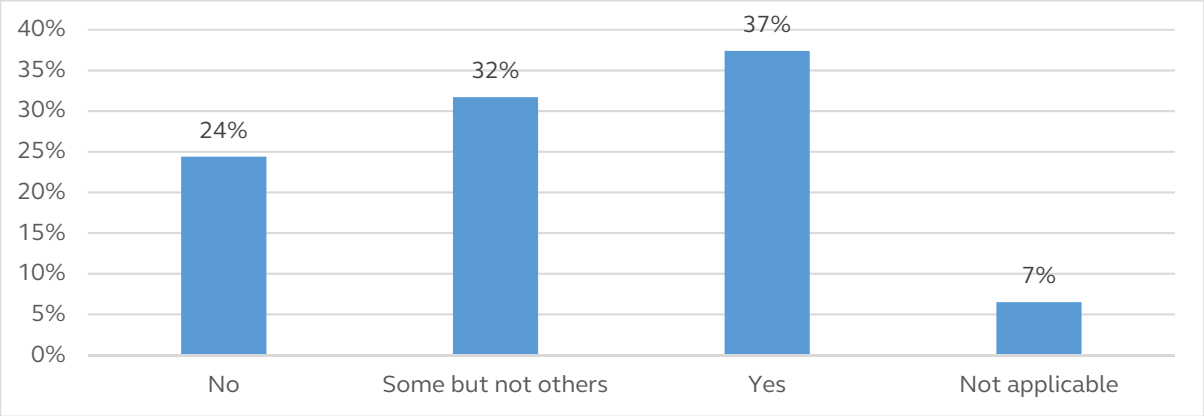
Figure 11 – Have you come out to your immediate family? (n=123)



Support from immediate family

While most LGBTI respondents indicated they had come out to their family, responses were much more mixed about whether immediate family formed part of support networks. Just over a third answered "yes", and a further third to some extent.

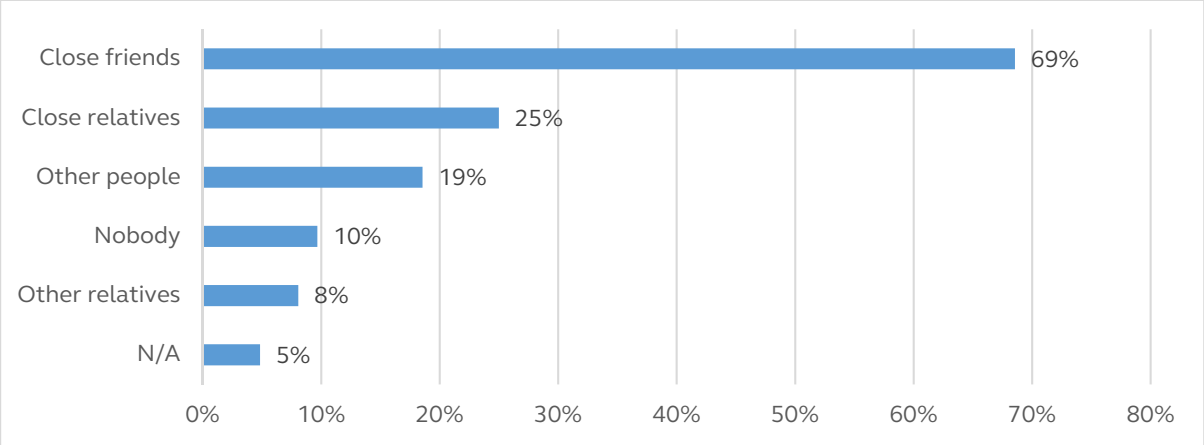
Figure 12 – Are members of your immediate family part of your support network? (n=123)



Composition of support network

Two thirds of respondents indicated that close friends (sometimes also known as a "family of choice") make up their support network. There was significant overlap between these categories: around two thirds of respondents indicated friends were in their support network, regardless of whether or not they had other supports or who those other supports were (including whether close family was in their support network, in response to the question above.

Figure 13 – Other than members of your immediate family, who makes up your support network? (n=124)



Experience and views of aged care

The survey asked a range of questions to identify the nature and extent of respondents' first-hand knowledge of aged care, and their views of it in general.

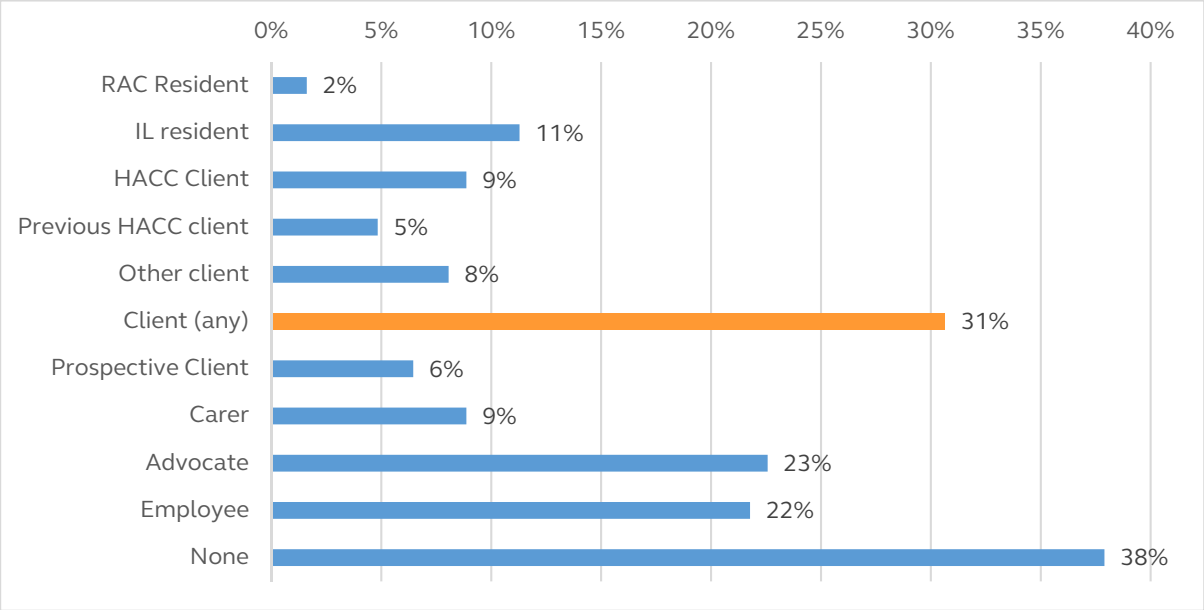
Contact with aged care services

Slightly less than one third of respondents indicated they had experience of receiving aged care services (orange bar), with the single largest category being home and community care services. Around a quarter of respondents indicated that they were either advocates or employees in the care system. The single most common choice was "none".

Demographically, the respondents who reported "no" contact were all members of the LGBTI communities and were slightly more likely than other respondents to be male (53%). They were also somewhat more likely to be either late in their working lives or in

early retirement, and to live outside NSW. It appears that these respondents may have heard about the survey through social media coverage by our partners.

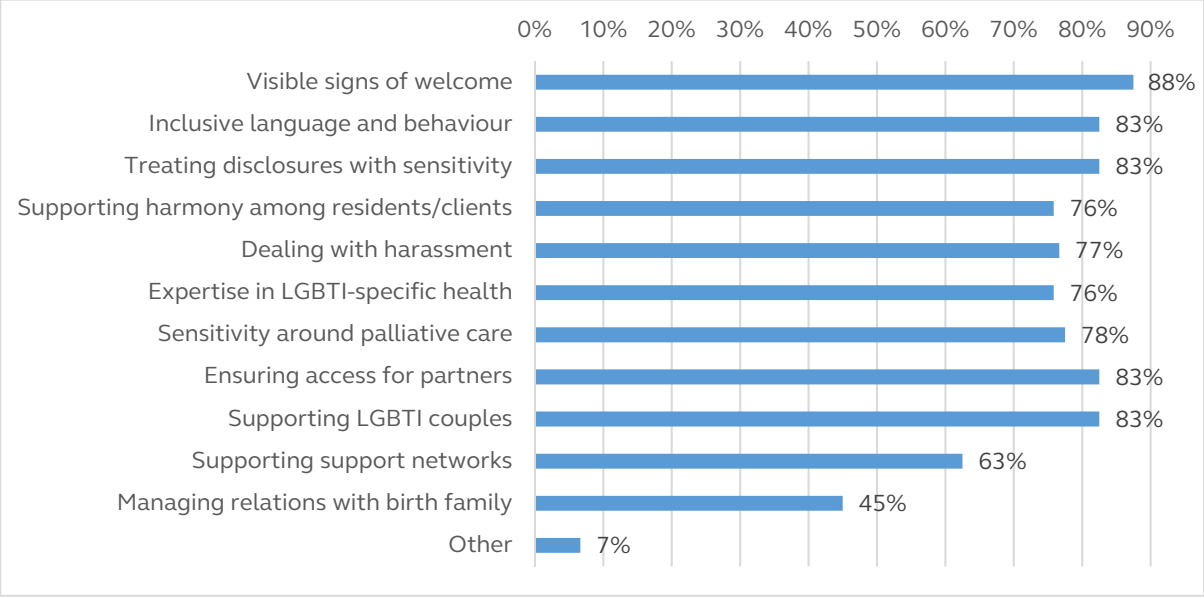
Figure 14 – Which of the following best describes you? (n=124)



Important features of service

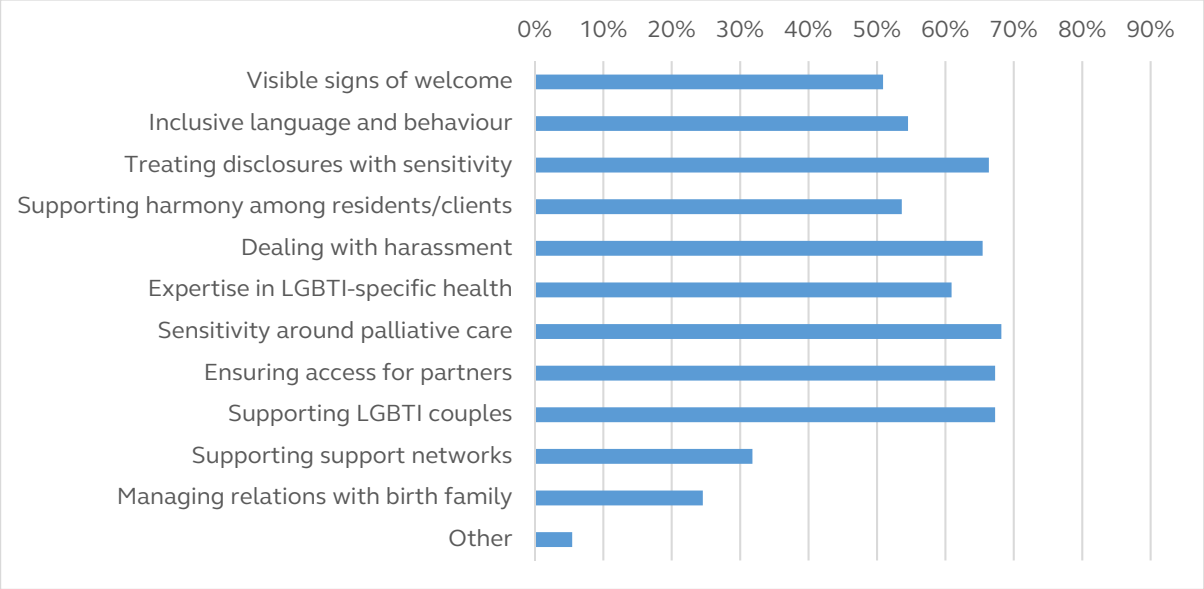
This question was designed to identify factors which respondents believed were empirically important contributors to the quality of life of older members of the LGBTI communities. Almost every issue was identified as important by at least three quarters of respondents. The most popular options relate to visible signs of welcome and inclusive language (symbolic and discursive inclusion), treating disclosures sensitively, and being inclusive of partners (ensuring access and supporting LGBTI couples). The two least popular options related to managing relations with support networks and family.

Figure 15 – How important are the following for the quality of life of older members of the LGBTI community in aged care? (n=120)



By contrast, respondents were more nuanced in their identification of issues which they believe were subjectively important to older members of the LGBTI communities. Most options gained the support of 50-70% of respondents. The most popular related to harassment and disclosures, sensitivity around palliative care, and partners (as above). Symbolic and discursive inclusion still ranked as important, but relatively less so compared with responses to the question above.

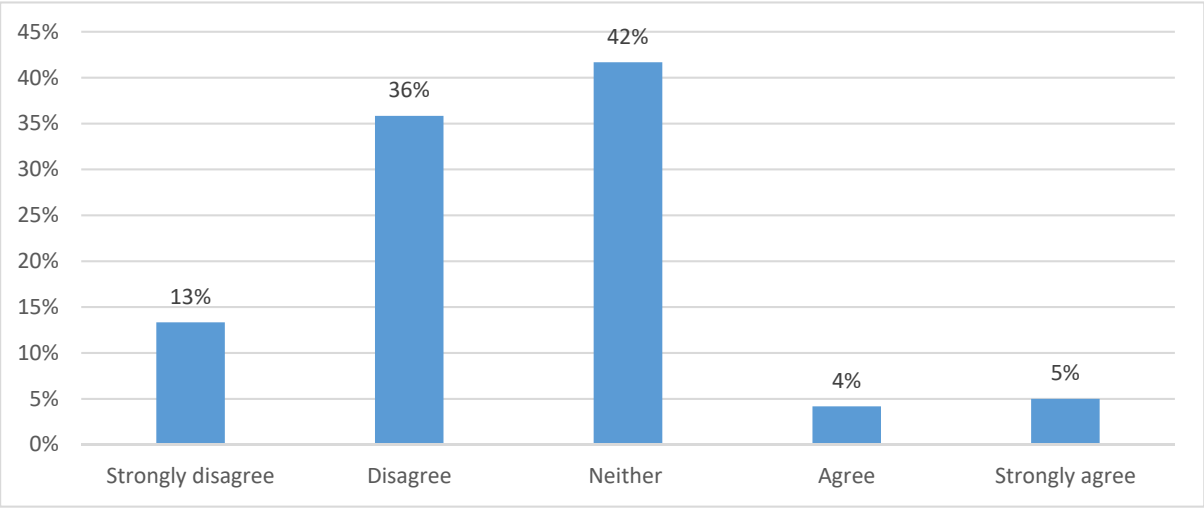
Figure 16 – Which of the following most worry/concern older members of the LGBTI community in relation to aged care? (n=110)



Meeting the needs of the LGBTI communities

Respondents were particularly unfavourable in their assessment of whether aged care services in general meet the needs of the LGBTI communities. Almost half of responses were outright negative, and a further two fifths noncommittal. Fewer than 10% were positive. This negative result stands in stark contrast to others in the survey, which were generally more nuanced, and at least somewhat positive.

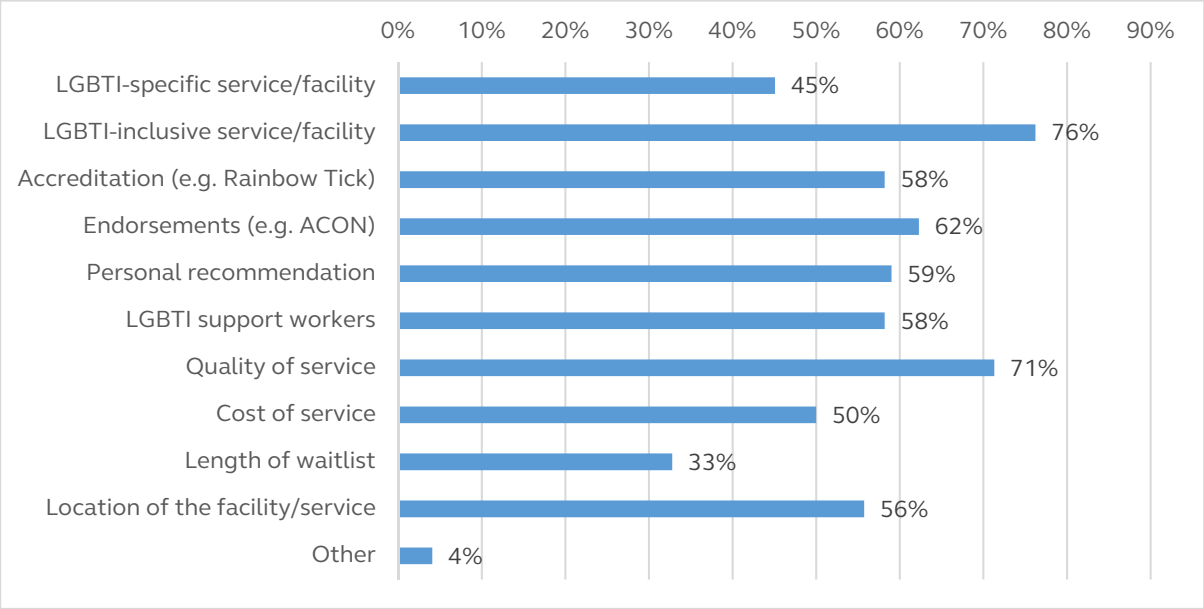
Figure 17 – Overall, aged care services meet the needs of older members of the LGBTI community (n=120)



Influences on decision-making

When asked about the factors which would influence their own personal decision about aged care, around three quarters of respondents indicated a concern with inclusive facilities and quality of the service. Other factors, such as endorsements/ recommendations, LGBTI staff and accreditation were rated as important by slightly over half of respondents (and about on par with location of facilities). The two least popular options were LGBTI-specific services and waitlist.

Figure 18 – If you were to look for an aged care service, which of the following would be most likely to influence your decision? (n=122)



Views about Uniting

The survey asked a number of questions specifically to Uniting's work in relation to LGBTI communities and aged care. We have not included these results in this public report, because they relate to Uniting's internal operations and were intended for internal quality improvement purposes. Readers who are interested in this data should contact Uniting to discuss access. The questions covered:

- Awareness of Uniting's work on LGBTI inclusion;
- Overall assessment of whether Uniting was an LGBTI-inclusive organisation.
- Overall assessment of whether Uniting's services meet the needs of older members of LGBTI communities;
- Ratings of things Uniting is doing well in its work with older members of LGBTI communities, using the same categories as Figure 15 and Figure 16 above; and
- Ratings of things Uniting is doing could improve on in its work with older members of LGBTI communities, using the same categories as Figure 15 and Figure 16 above.

People who work for Uniting

The survey asked a number of questions which sought to tap the views of Uniting's own staff in relation to its work with LGBTI communities and aged care. We have not included these results in this public report, for two reasons. First, they relate to Uniting's internal operations and were intended for internal quality improvement purposes. And second, too

few staff responded to the survey for us to conduct statistical analysis or report results in a way that preserves confidentiality. The questions covered:

- Tenure
- Awareness of having worked with LGBTI clients
- Ratings of the adequacy of support offered to them personally in work with LGBTI clients
- Ratings of the adequacy of support offered to staff overall in their work with LGBTI clients.

Comparison with 2012-13 survey

There were some differences between responses gathered in 2018-19, compared with 2012-13. Respondents to our later survey were slightly less likely to report they felt unsafe disclosing their gender identity or sexual orientation to social care service, and were slightly less likely to report that they had experienced problems as a result of disclosure.[19] This is encouraging, because the 2018-19 cohort was more representative of the cohort of aged care clients as a whole than the 2012-13 cohort; it was older, more likely to be retired, and more likely to have direct experience of services as a client.

The remainder of this section presents comparative observations, where data permit. These observations can only be made in a very general way, and it is not possible to conduct rigorous statistical analysis due to:

- Differences in questions. Our 2019-19 survey asked more questions on a wider range of issues, and gave more answer options for some comparable questions;
- Differences in wording, which we made to improve survey responses or better align with legislative and ethical standards;
- Absence of underlying data. Uniting does not appear to have saved the raw survey results from 2012-13, forcing us to reconstitute results from presentations (thus limiting our ability to recode variables or conduct more sophisticated tests).

Demographics

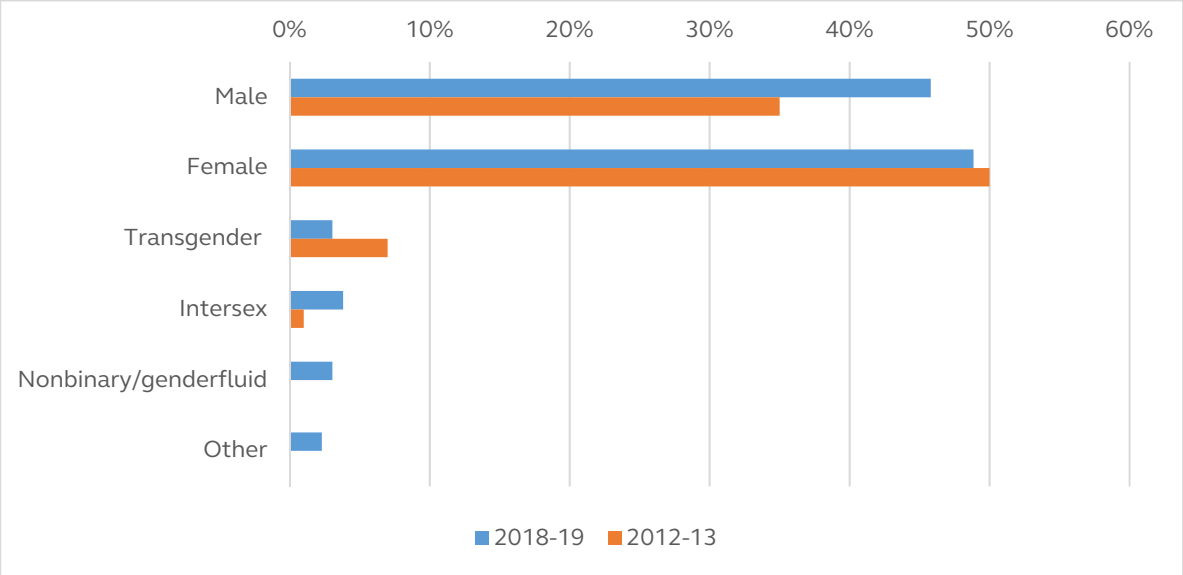
Our 2018-19 sample more closely resembled the characteristics of clients of the aged care system than our 2012-13 sample. However, both include a significant minority of respondents who do appear to be either clients or potential clients. Both include some who appear to have no direct experience of these services at all.

Gender identity

Results are particularly difficult to compare, but it appears we achieved a distribution of gender identities in 2018-19 which is more consistent with the general Australian population: roughly equal proportions of people who identified as male and female, and a small proportion of people identifying as transgender or intersex.

[19] This clumsy use of the double negative is required because it is more accurate – respondents were more likely to say “it depends” than to answer positively.

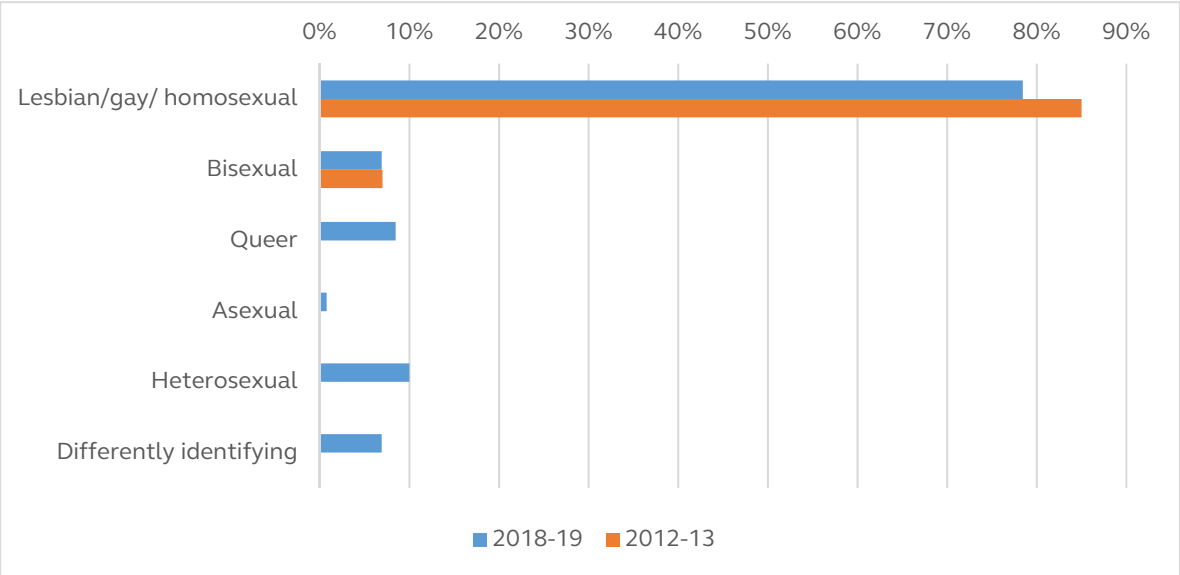
Figure 19 – Comparison of gender identity, 2018-19 and 2012-13



Sexual orientation

In 2018-19, we offered respondents a wider range of options for their sexual orientation. Results were broadly consistent across the two surveys, in that most people identified as gay/ lesbian/ homosexual. However, respondents in our more recent survey identified with a wider range of sexual orientations.

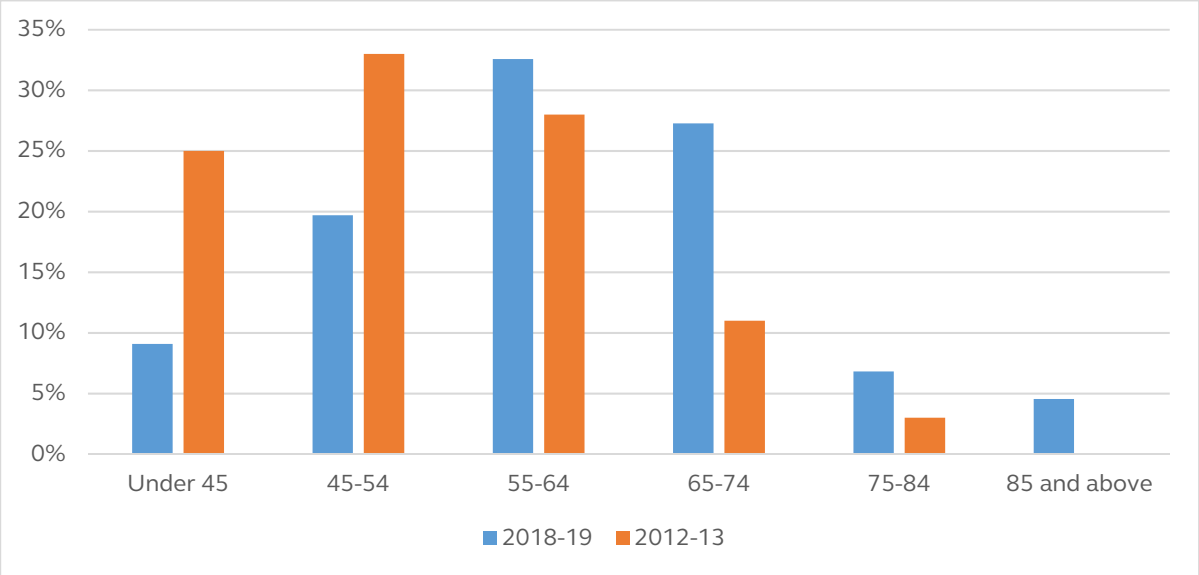
Figure 20 – Comparison of sexual orientation, 2018-19 and 2012-13



Age

Respondents to the 2018-19 survey were much more likely to be aged 55 and over, and therefore to be old enough to qualify as clients or potential clients of the aged care system, than respondents to the 2012-13 survey.

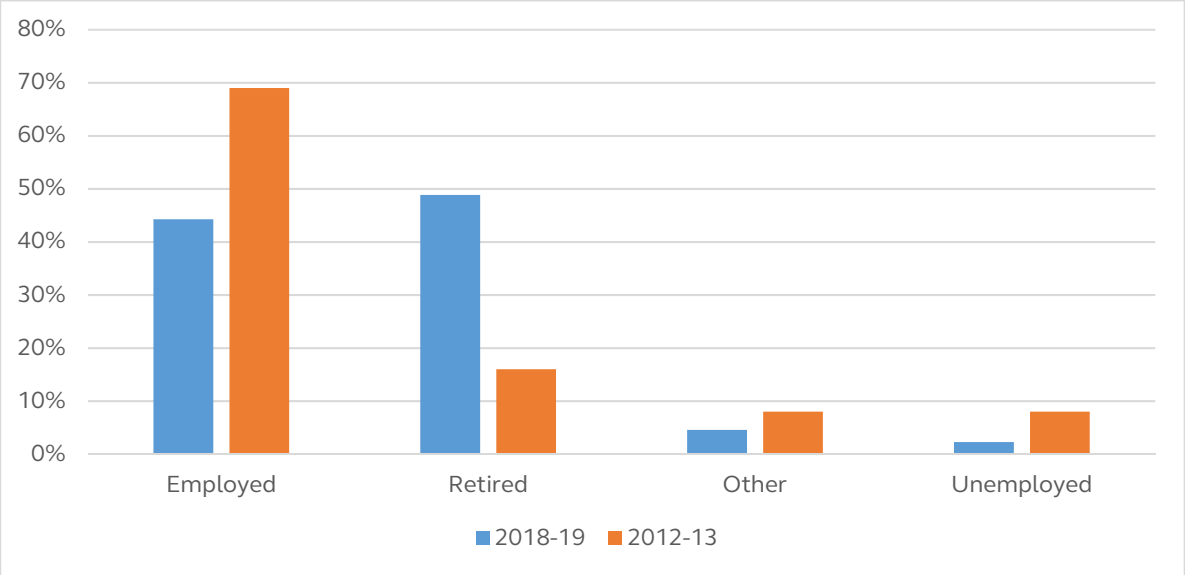
Figure 21 – Comparison of age, 2018-19 and 2012-13



Employment status

Consistent with differences in the age profile, respondents in 2018-19 were much more likely to report their employment status are "retired" than as "employed" when compared with 2012-13.

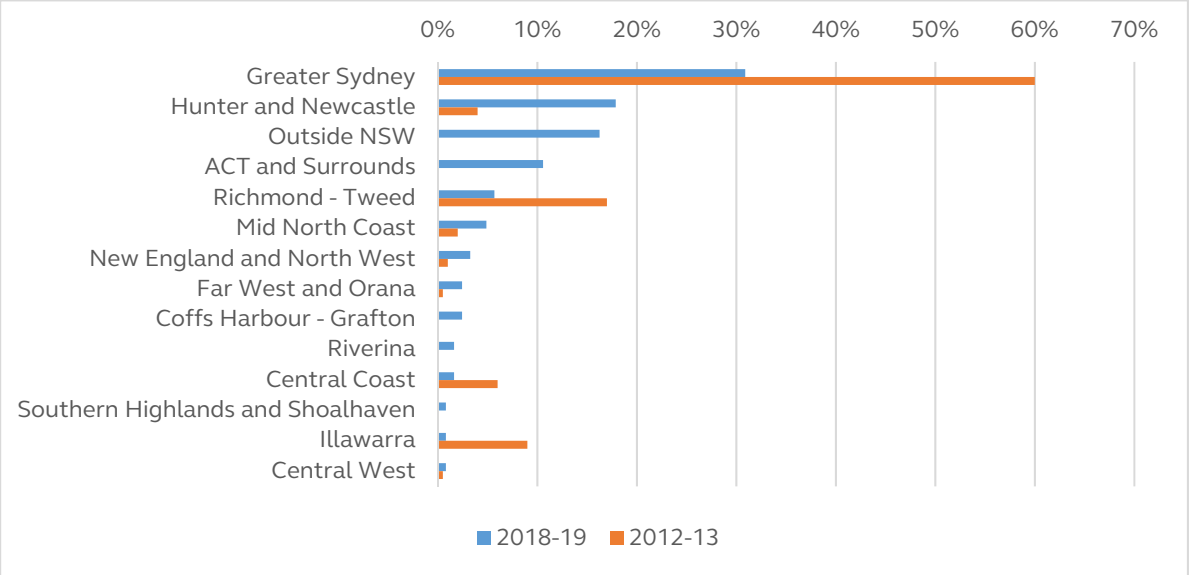
Figure 22 – Comparison of employment status, 2018-19 and 2012-13



Region of usual residence

It is particularly difficult to compare the spatial distribution of respondents to the two surveys, because of the way presentations of our earlier survey aggregated this data. As a group, respondents to the 2018-19 survey seem to have been less Sydney-centric, and more evenly distributed across the State. The peaks in 2012-13 for Richmond, Central Coast and Illawarra may be aggregation artefacts, not substantive differences.

Figure 23 – Comparison of region of usual residence, 2018-19 and 2012-13

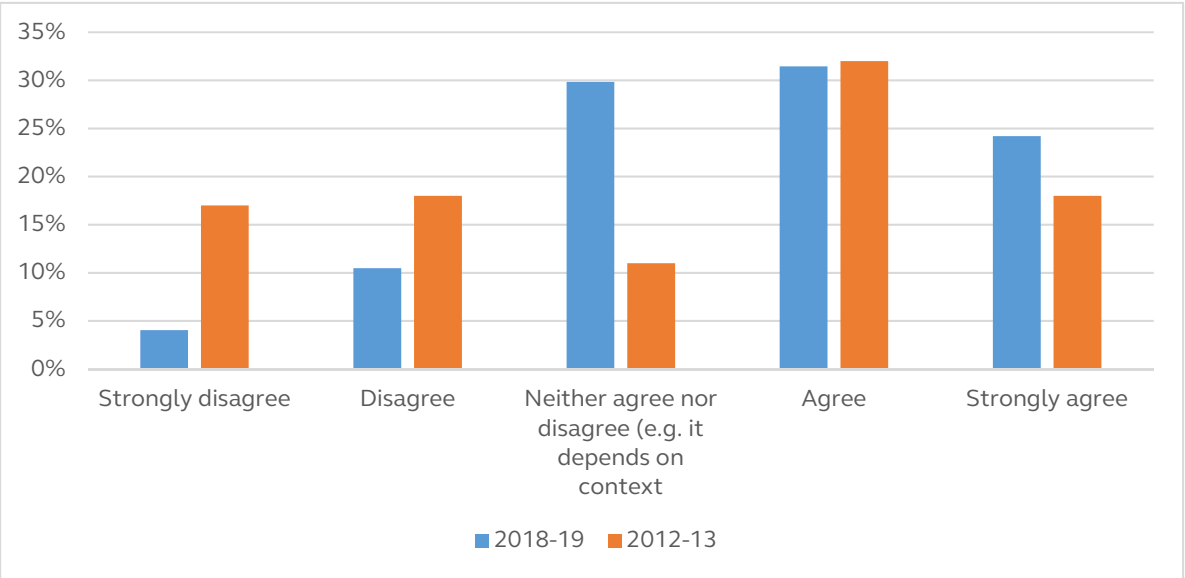


Experience as an LGBTI person

Perceived safety of disclosure

Respondents in 2018-19 were less likely to report they were concerned for their safety when disclosing their sexual orientation or gender identity, than in 2012-13. However, this did not necessarily mean they felt safer. Respondents in 2018-19 were more likely to say their feelings of safety depended on context, rather than indicate they felt safe disclosing. The two surveys are somewhat complicated to compare. In 2018-19, we asked specifically on whether people felt safe disclosing their sexual orientation or gender identity; in 2012-13, we asked the more general question "I prefer not to disclose…". We believe the answers to these two questions are broadly comparable, because our consultations with our LGBTI (staff) working group and (client) reference group indicated that safety is likely to be the main reason people would make a decision not to disclose. We cannot discount the presence of other reasons in 2012-13, however.

Figure 24 – Comparison of perceived safety disclosing, 2018-19 and 2012-13

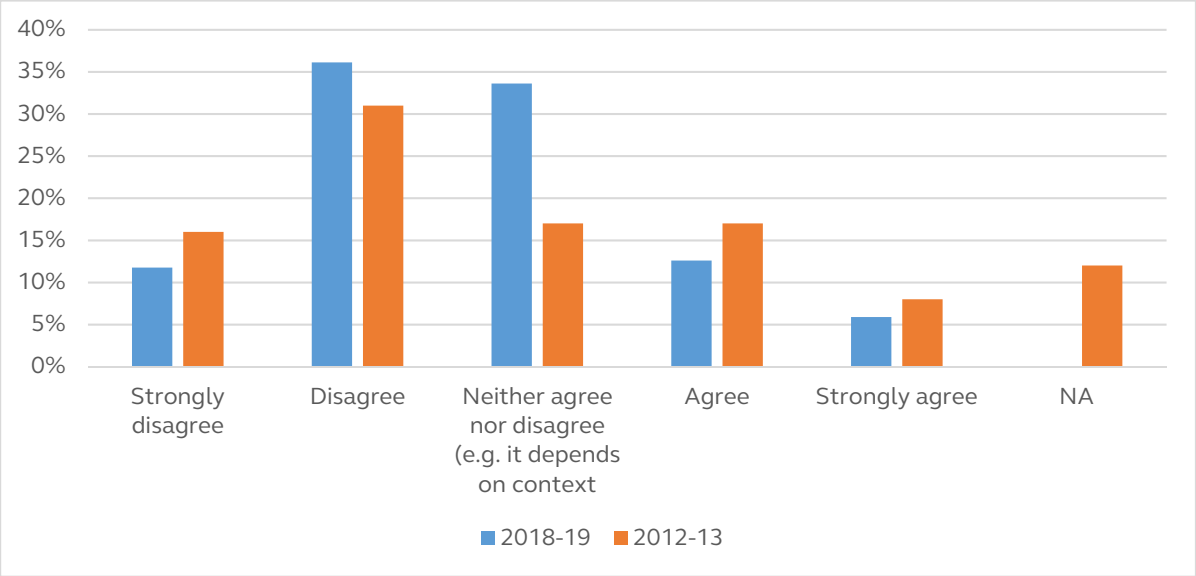


Note: data for 2012-13 reverse coded to improve comparability.

Difficulties accessing services

Respondents in 2018-19 were less likely to report difficulties accessing services due to their sexual orientation or gender identity than in 2012-13. As for the question above, however, this did not necessarily mean that they did not have difficulties. Respondents in 2018-19 were substantially more likely to say it depended on context. The wording for both surveys was the same.

Figure 25 – Comparison of difficulties accessing services, 2018-19 and 2012-13

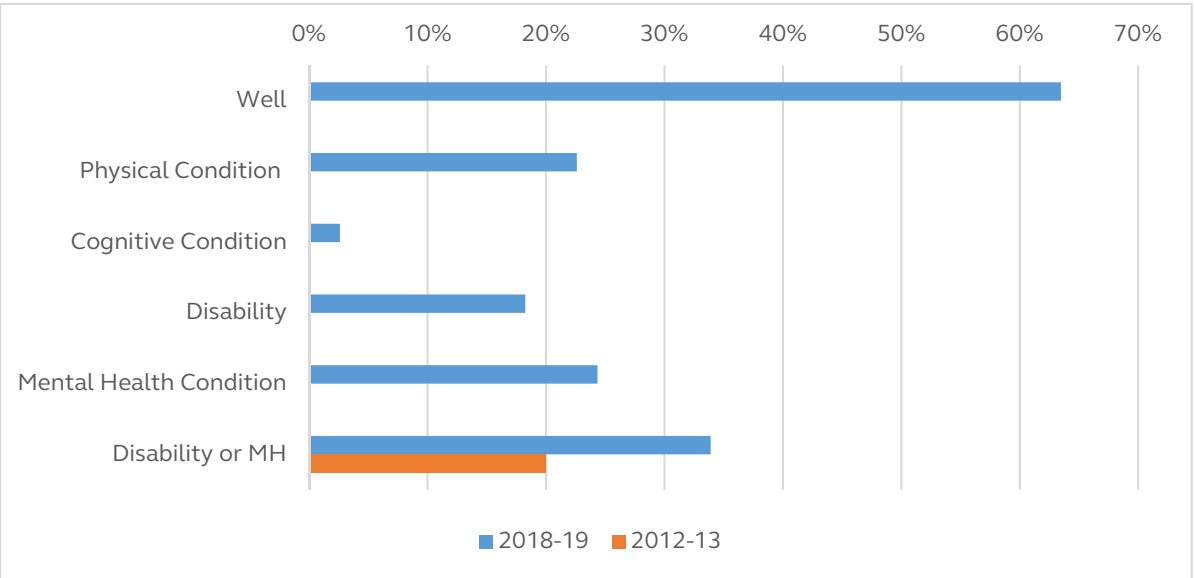


Vulnerability

We do not have the full results of questions relating to vulnerability in 2012-13, so comparisons here are particularly limited.

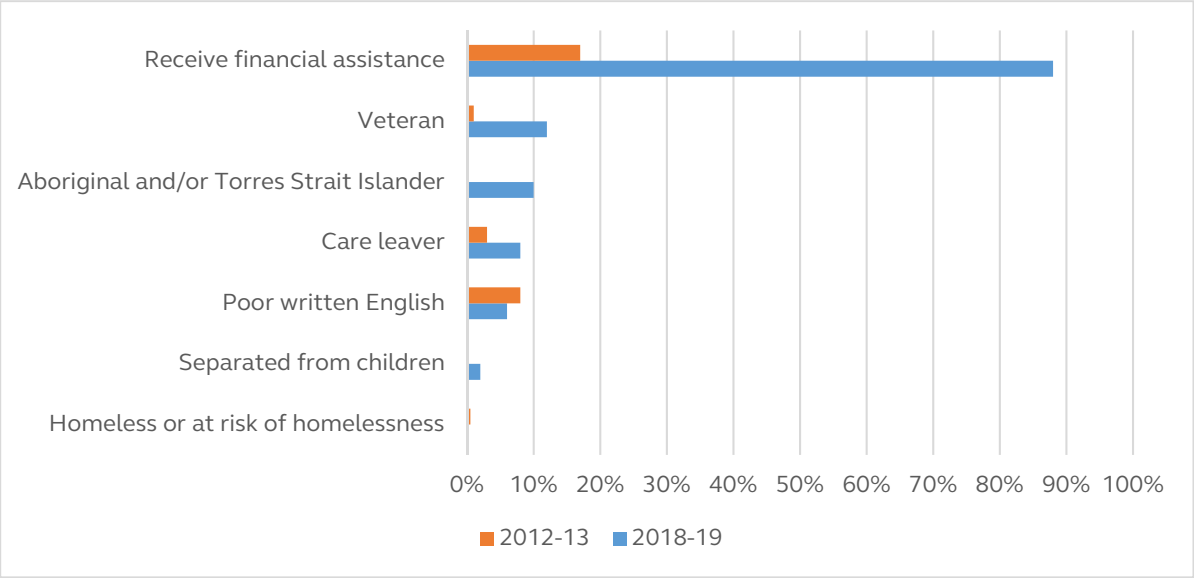
Almost twice as many respondents in 2018-19 indicated that they had a disability or a mental health condition as in 2012-13. This is the only question about wellness which was comparable across the two cohorts. The greater rate is consistent with the older age profile of the 2018-19 cohort.

Figure 26 – Comparison of physical, cognitive and mental conditions, 2018-19 and 2012-13



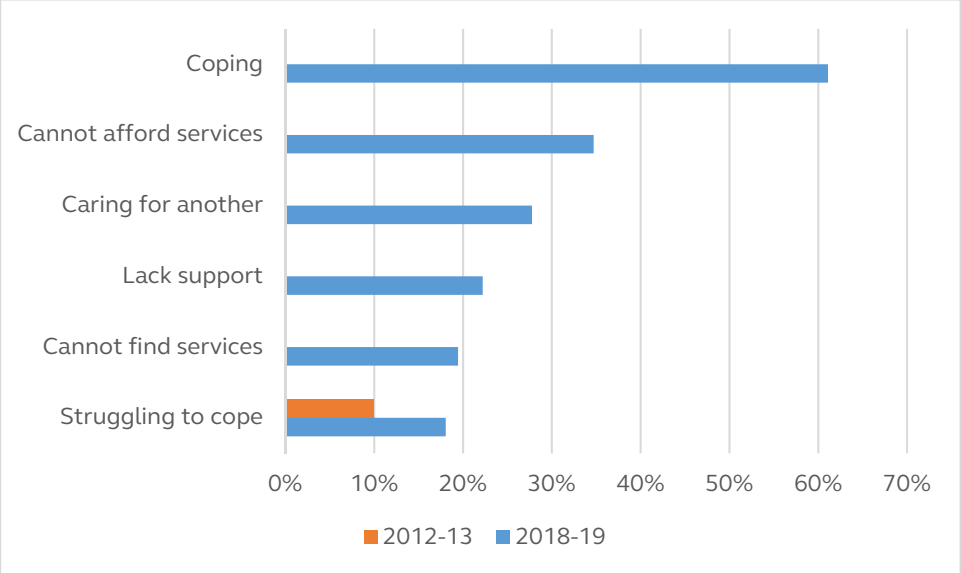
Respondents in 2018-19 identified a wider variety of legislatively-recognised vulnerabilities than in 2012-13, and at higher rates. The very high rate at which respondents identified that they receive financial assistance may be due to the wording of the question, which may have been interpreted by respondents as including government subsidies for aged care. Other differences are likely due to the fact the 2018-19 cohort included a higher proportion of older people/clients.

Figure 27 – Comparison of legislatively-recognised vulnerabilities, 2018-19 and 2012-13



In a similar manner to wellness (above), almost twice as many respondents in 2018-19 indicated that they were struggling to cope as in 2012-13, although the proportion remained small. This is the only question about coping which was comparable across the two cohorts. The greater rate is consistent with the older age profile of the 2018-19 cohort.

Figure 28 – Comparison of care and coping experience, 2018-19 and 2012-13



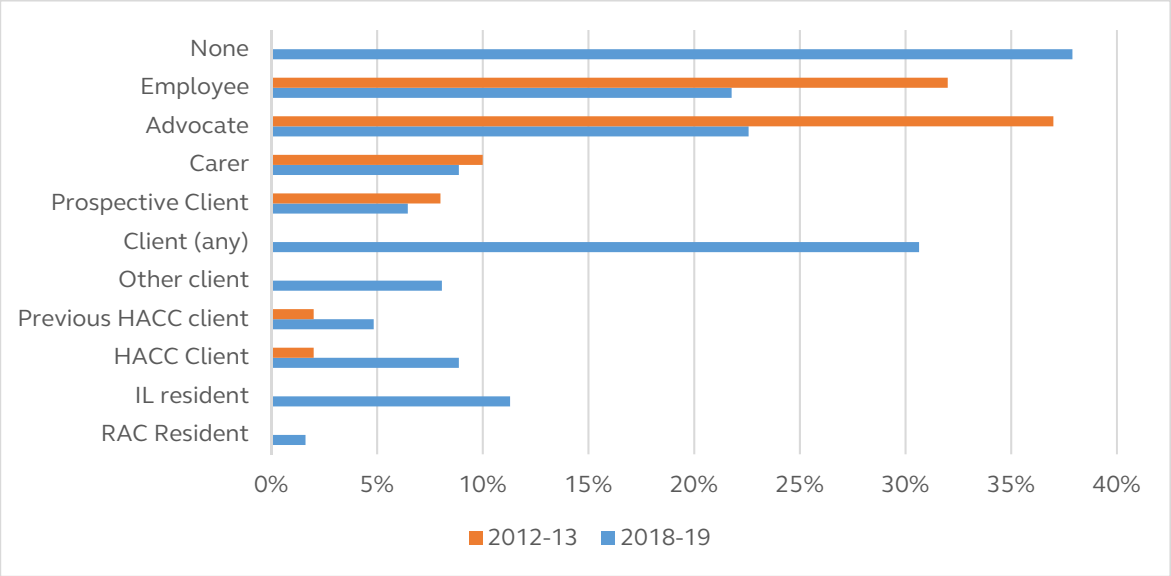
Experience and views of aged care

Our 2018-19 survey was more successful in surveying people with experience as residents/clients of aged care services. Unfortunately, we cannot compare their views because we do not have quantitative data from 2012-13 on this.

Contact with aged care services

The 2018-19 cohort was more likely to identify as a current or past client of those services for which we have comparable data, and less likely to identify as an employee or advocate within the aged care system. Proportions identifying as carers and prospective clients were not dramatically different from 2012-13.

Figure 29 – Comparison of contact with aged care services, 2018-19 and 2012-13



Analysis of associations within 2018-19 data

This section presents analysis on whether responses to outcome measures vary systematically with things like demographic factors and experience of the aged care system. Each of the headings below focuses on a different outcome measure.

We focus on the 2018-19 survey only. We have not attempted to rigorously analyse differences in variations between this and the 2012-13 survey because data for the earlier survey are unavailable. If more detailed data were available, it is likely that the demographic differences between the two cohorts would account for a good deal of any variation observed.

Similarly, we do not analyse correlates of views of Uniting or experience as a Uniting employee, because we do not have sufficient numbers of respondents.

Have LGBTI people felt unsafe disclosing their identity to services?

There were no statistically significant differences (at the $p<0.05$ level) in whether LGBTI respondents felt safe in disclosing orientation or identity when engaging with support services, when broken down by gender identity, sexual orientation, age, employment status, region of usual residence, reported vulnerability, experience as a client of any aged care service, or breadth of composition of support network.

Table 1 - Associations between perceived safety and other factors

Factor	Test	Value	p-value
Gender identity	Kruskal-Wallis χ^2	6,909	0.141
Sexual orientation	Kruskal-Wallis χ^2	1.256	0.739
Age	Kendall τ	0.023	0.767
Employment status	Kruskal-Wallis χ^2	6.459	0.167
Region	Kruskal-Wallis χ^2	30.347	0.299
Vulnerable (Health)	Kendall τ	-0.027	0.723
Vulnerable (Equity)	Kendall τ	-0.129	0.115
Vulnerable (Coping)	Kendall τ	-0.077	0.313
Experience as a client	Kendall τ	-0.006	0.947
Support	Kendall τ	-0.084	0.246

Notes: results for subset of respondents who did not identify as "heterosexual" in their sexual orientation. Vulnerability factors and support were synthesised from the cumulative sum of sub-factors identified by each respondent. Non-parametric tests used because dependent variable is not normally distributed (see Figure 6 on p12 above). *=p<0.1; **=p<0.05

Have LGBTI people experienced difficulties accessing services?

There were no statistically significant differences (at the p<0.05 level) in whether LGBTI respondents reported difficulties accessing support services due to orientation or identity, when broken down by gender identity, sexual orientation, age, employment status, region of usual residence, reported vulnerability, experience as a client of any aged care service, or breadth of composition of support network.

Associations with gender identity and age approached the threshold for significance (i.e. met p<0.1). Respondents who identified as male were more likely to report that they had not experienced difficulties than those who identified as female or another gender identity. Respondents who gave their age as "Under 45" were slightly more likely to report that they had experienced difficulties than older age-groups. Informal advice from members of Uniting's LGBTI Working Group indicates this may be because younger members of these communities are more likely to have actually disclosed, and have therefore had more occasions on which to experience difficulties.

Table 2 - Associations between access difficulties and other factors

Factor	Test	Value	p-value
Gender identity	Kruskal-Wallis χ^2	8.197*	0.085
Sexual orientation	Kruskal-Wallis χ^2	0.647	0.886
Age	Kendall τ	-0.135	0.077
Employment status	Kruskal-Wallis χ^2	4.557	0.335
Region	Kruskal-Wallis χ^2	28.529	0.384
Vulnerable (Health)	Kendall τ	-0.143*	0.076
Vulnerable (Equity)	Kendall τ	0.100	0.228
Vulnerable (Coping)	Kendall τ	0.042	0.590
Experience as a client	Kendall τ	-0.053	0.530
Support	Kendall τ	-0.032	0.665

Notes: as for Table 1.

Do aged care services meet the needs of LGBTI people?

Two factors displayed statistically significant relationships (at the $p<0.05$ level) with whether respondents believed that aged care services in general meet the needs of LGBTI people. Agreement with the statement that services do meet these needs was more common among people who:

- reported a larger number of physical, cognitive and similar health-and-wellbeing vulnerabilities; and
- with more diverse support networks (family, friends, etc.).

The association with employment status approached the threshold for significance (i.e. met $p<0.1$). While respondents were generally negative in their responses to this question (see Figure 17 on p18 above), those who were no longer employed were less negative or even neutral, compared with those still in the workforce.

Table 3 - Associations between belief about whether services meet needs

Factor	Test	Value	p-value
Gender identity	Kruskal-Wallis χ^2	4.536	0.338
Sexual orientation	Kruskal-Wallis χ^2	4.597	0.204
Age	Kendall τ	0.125	0.116
Employment status	Kruskal-Wallis χ^2	8.795*	0.066
Region	Kruskal-Wallis χ^2	31.631	0.246
Vulnerable (Health)	Kendall τ	0.246**	0.003
Vulnerable (Equity)	Kendall τ	-0.048	0.584
Vulnerable (Coping)	Kendall τ	-0.109	0.182
Experience as a client	Kendall τ	0.070	0.427
Support	Kendall τ	0.243**	0.002

Notes: as for Table 1.

Issues of importance

The survey included a question asking respondents to indicate which issues they considered to be important (i.e. empirically influential) for the quality of life of older members of the LGBTI communities receiving aged care services. The table below shows the value of the test statistics for those statistically-significant associations in the frequency with which different issues were identified (at $p<0.05$, marked with **), when broken down by various demographic factors and life circumstances. It also shows relationships approaching the threshold for significance ($p<0.1$, marked with *). The table shows that:

- the importance of signs of inclusion were more likely to vary significantly between groups, although the only significant variations are with age (signs are slightly less important to older people) and the composition of support networks (more important to people with more diverse support networks). The associations are not large, despite being statistically significant, in either case.
- The importance of issues relating to end of life, and sensitive handling of social and family relations, varied with sexual orientation. While support for couples within care contexts was important to all groups, it was significantly more important to people who reported a sexual orientation rather than simply "lesbian, gay or homosexual". These issues were also significantly more important to people with more diverse support networks.

Table 4 - Matrix of associations between issues of importance and factors

Factor	Test	Signs	Inclusivity	Disclosures	Harmony	Harassment	LGBTI Health	End of Life	Partner Access	Couple Support	Networks	Birth Family	Other
Gender identity	Kruskal-Wallis χ^2	8.377	5.596*	3.523	2.847	4.208	3.941	3.717	6.511	4.424	4.984	2.795	16.166
Sexual orientation	Kruskal-Wallis χ^2	1.825	8.767	5.033**	3.926	2.851	8.230	8.020**	9.390**	14.323**	0.762**	2.541	13.686
Age	Kendall τ	-0.082**	-0.147	-0.120	-0.125	-0.099	-0.128	-0.083	-0.128	-0.105	-0.176	-0.198	0.021**
Employment status	Kruskal-Wallis χ^2	2.309	5.306	3.384	5.761	4.949	5.113	5.256	3.195	3.195	3.832	3.645	1.613
Region	Kruskal-Wallis χ^2	34.131	28.494	18.767	21.484	27.173	35.819	28.454	38.166	20.046*	27.216	19.800	27.380
Vulnerable (Health)	Kendall τ	-0.030*	-0.010	0.233	0.086**	0.072	0.058	0.084	0.051	-0.014	0.009	0.096	0.080
Vulnerable (Equity)	Kendall τ	0.050*	-0.013	0.049	0.101	-0.015	-0.022	-0.022	-0.085	0.084	-0.013	0.095	0.087
Vulnerable (Coping)	Kendall τ	0.013*	-0.087	0.057	0.153	0.046*	0.007	-0.025	-0.025	0.001	0.088	0.117	0.069
Experience as a client	Kendall τ	0.101	0.122	0.046	0.012	-0.010	0.019	0.030	-0.065	-0.021	-0.056	0.130	0.131

Support	Kendall τ	0.108**	0.354	0.176**	0.043**	0.163	0.190**	0.265**	0.214**	0.246**	0.189**	0.099**	0.003

Notes: as for Table 1.

Issues of concern

The survey included a question asking respondents to indicate which issues they considered to be of concern (i.e. subjectively important) to older members of the LGBTI communities receiving aged care services. The table above shows the value of the test statistics for those statistically-significant associations in the frequency with which different issues were identified (at $p<0.05$, marked with **), when broken down by various demographic factors and life circumstances. It also shows relationships approaching the threshold for significance ($p<0.1$, marked with *). The table shows that:

- the importance of signs of inclusion was more likely to vary significantly between groups, although the only significant variations are with age, experience as a client (slightly less important to older people and those with experience), and the composition of support networks (more important to people with more diverse support networks).
- Excellence in handling end of life issues was important for more marginal groups, such as those identifying with particularly diverse gender identities and sexual orientations, and those who reported greater health-, equity- or coping-related vulnerability
- People who reported troubles with coping or responsibilities caring for others were more likely to identify as concerns things like effective harassment policies, and clinical experience in LGBTI-specific health and end-of-life issues.
- People with more diverse support networks were more likely to value symbolic and discursive inclusion and sensitivity.

Table 5 - Matrix of associations between issues of concern and factors

Factor	Test	Signs	Inclusivity	Disclosures	Harmony	Harrassment	LGBTI Health	End of Life	Partner Access	Couple Support	Networks	Birth Family	Other
Gender identity	Kruskal-Wallis χ^2	6.287	4.308	6.054	4.989	9.080	8.453*	4.617*	3.701	4.726	4.208	4.161	21.419
Sexual orientation	Kruskal-Wallis χ^2	2.851	3.405	3.049	2.134	4.033	8.026	5.064**	7.597	5.398*	3.144	0.278	3.962
Age	Kendall τ	-0.148**	-0.131	-0.038	-0.027	-0.136	-0.128	-0.205	-0.128	-0.135	-0.028	-0.076	-0.099
Employment status	Kruskal-Wallis χ^2	2.903	2.091	3.280	2.290	3.959	4.106	2.429	3.217	3.737	2.678	1.508	2.316
Region	Kruskal-Wallis χ^2	28.345	23.395	24.335	23.067	25.759	30.345	28.404	33.038	30.020	29.933	27.279	35.594
Vulnerable (Health)	Kendall τ	0.079*	0.017	0.074	0.045	0.155	0.031*	0.026	0.012	0.012	0.001	-0.031	0.067

Vulnerable (Equity)	Kendall τ	0.007	0.075	0.006	0.196	0.100**	0.184	0.015**	0.028	0.028	0.015	0.086	0.129
Vulnerable (Coping)	Kendall τ	0.022**	0.020	0.086	0.196	0.178**	0.295**	0.101**	0.038	-0.020	0.137	0.036	0.084
Experience as a client	Kendall τ	-0.028**	-0.032	0.102	-0.028	0.112	0.063	-0.087	-0.066	0.072	0.010	0.168	0.028**
Support	Kendall τ	0.142**	0.163*	0.166**	0.022**	0.020	-0.111	0.047	0.043	0.048	0.159	0.048**	-0.016

Notes: as for Table 1.

Factors influencing decision

The survey included a question asking what factors the respondents would take into account if they were selecting care services. The table above shows the value of the test statistics for those statistically-significant associations in the frequency with which different issues were identified (at $p<0.05$, marked with **), when broken down by various demographic factors and life circumstances. It also shows relationships approaching the threshold for significance ($p<0.1$, marked with *). The table shows that:

- Respondents who reported vulnerabilities, particularly difficulties coping or caring, were more likely to be concerned about non-LGBTI-specific aspects of service such as quality, cost and waitlists.
- Age and experience as a client were slightly, but negatively, associated with concern over whether a service was LGBTI-specific.
- Reporting a diverse sexual orientation (i.e. other than lesbian/gay/homosexual) was associated with greater concern over LGBTI inclusion, cost and location.
- Living in a regional area was associated with concern over waitlists.

Table 6 - Matrix of associations between influences on care choices and factors

Factor	Test	LGBTI Specific	LGBTI Inclusive	Accreditation	Endorsement	Personal Rec	LGBTI Employer	Quality	Cost	Waitlist	Location
Gender identity	Kruskal-Wallis χ^2	3.057	3.797	4.113	4.627	1.920	3.294	2.666	3.163	6.224	3.017
Sexual orientation	Kruskal-Wallis χ^2	1.366	12.727**	0.806	3.124	1.288	0.110	2.348	8.086**	4.347	8.395**
Age	Kendall τ	-0.221**	-0.084	-0.075	-0.058	-0.128	-0.100	-0.078	0.048	0.027	-0.078
Employment status	Kruskal-Wallis χ^2	3.293	3.553	3.136	2.902	4.371	3.142	1.967	2.316	2.543	1.878

Region	Kruskal-Wallis χ^2	20.077	28.083	23.436	26.198	23.911	23.537	17.835	18.932	40.707**	15.725
Vulnerable (Health)	Kendall τ	0.063	0.051	0.095	0.081	0.136	0.002	0.044	0.078	0.143*	0.025
Vulnerable (Equity)	Kendall τ	-0.053	-0.052	0.040	-0.039	0.113	0.082	0.156*	0.016	-0.012	-0.028
Vulnerable (Coping)	Kendall τ	0.073	0.055	0.126	0.043	0.214**	0.151*	0.174**	0.219**	0.163*	0.123
Experience as a client	Kendall τ	-0.223**	0.027	0.065	0.089	0.086	0.018	0.152*	0.140	0.123	-0.077
Support	Kendall τ	-0.086	0.115	0.112	0.094	0.157**	0.146*	0.043	0.037	-0.044	0.093

Notes: as for Table 1.

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