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Creating Supportive Environments for LGBT Older Adults: An Efficacy Evaluation of Staff Training in a Senior Living Facility

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Abstract

Supportive housing later in life tends to be a key concern for lesbian, gay, bisexual, and transgender (LGBT) elders. Most senior care providers are un(der)prepared to meet the needs of older LGBT adults. This study evaluated the efficacy of a 4 hours, face-to-face, research-based, LGBT-diversity training designed to improve senior housing facility staff′s cultural competency regarding the needs of LGBT elders. Findings from this study found a significant increase in LGBT content knowledge between pre- and post-intervention assessments and a significant decrease in perceived preparedness when working with LGBT elders. These effects remained significant after controlling for staff designation, religion, educational attainment, and training session. Findings suggest that staff′s cultural competence affected their perceived readiness to address LGBT elders′ needs. Implications are related to the concept of cultural humility or the lifelong process of understanding others′ experiences based on the recognition of lack of un(der)preparedness to create a culturally supportive residential environment.

Keywords

Cultural competence; housing; LGBT; older adults; senior care facilities; staff training

The Older Americans Act (2006) entitles all older adults the right to age with dignity, including those who identify as lesbian, gay, bisexual, and transgender (LGBT). In 2017, it was estimated that approximately 10 million adults in the United States identify as LGBT (Gates, 2017). Anywhere between 1.75 and 4 million of these Americans are over the age of 60, with projections that LGBT adults age 60+ will reflect 5 million people by 2030 (Administration on Aging, 2014). With so many LGBT older adults, it is imperative that scholars and practitioners are aware of and responsive to the unique needs of this population.

Supportive housing later in life tends to be a key concern for LGBT elders. Although attitudes toward sexual minority adults have been increasingly more positive (Fingerhut,

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2016), LGBT elders remain wary of senior living facilities[1] and are unsure of the level of support or discrimination they may face. There tends to be an avoidance of formal housing services based on the fear of discrimination or culturally incompetent care (Gabrielson, 2011; Goldberg et al., 2005). Safety, discrimination, and abuse around their identities are primary concerns of LGBT older adults when considering a transition to senior living facilities (see Moone et al., 2016). However, in one study, 92% of older lesbians and gay men noted that feeling accepted is an important factor in residential choice (Gardner et al., 2014).

Despite the need for culturally sensitive and supportive senior living facilities, senior service providers acknowledge a lack of training and competency regarding the unique concerns of LGBT adults (Bell et al., 2010; Hughes et al., 2011). Although online trainings exist (see the National Resource Center on LGBT Aging, 2020) few facilities require staff to participate or demonstrate knowledge on LGBT older adults. This results in senior care providers who are un(der) prepared to support LGBT older adults and their families.

To address this disparity of care in senior living facilities, the authors developed a face-to-face LGBT staff training to educate staff on how to create a more supportive living environment for LGBT elders. The goal of the staff training was to increase understanding of the unique concerns of LGBT elders, build practical and culturally cognizant staff senior living skills, and promote empathy toward all elders and their families. The current study provides evidence of the efficacy of that staff training.

Stigma and housing for LGBT older adults

Population-based studies demonstrate that LGBT older adults disproportionately experience poor physical and mental health relative to their heterosexual peers (Fredriksen-Goldsen et al., 2014). Minority stress theory (Meyer, 2003) purports that stressors specific to an LGBT identity – for instance, direct discrimination, fear of stigma, internalized homophobia, and concealment of a minority identity – helps to explain sexual orientation and gender identity differences in health. Indeed, a recent review of the literature showed that exposure to chronic minority stress is related to health declines among LGBT older adults (Correro & Nielson, 2019).

LGBT adults often face discrimination and stress related to their sexual orientation or gender identity when seeking housing later in life. Challenges arise, based on perceived or real discrimination for LGBT older adults when attempting to access mainstream housing services which begin with seeking accessible and affordable housing (Brennan-Ing et al., 2014). The Michigan Fair Housing Centers (2007) found that 26% of the senior living facilities that were contacted either quoted a higher monthly rent or outright denied a housing application to same-sex couples. LGBT older adults are also more likely to be refused housing or evicted based on homophobic and transphobic beliefs (Cahill & South, 2002; Equal Rights Center, 2014; Grant et al., 2011) and some nursing homes directly ban same-sex partners from facilities or refuse to make accommodations for private space (Cahill et al., 2000).

LGBT elders also face more discriminatory and hostile attitudes from the staff at senior living facilities. LGBT residents in senior living facilities encounter and fear heterosexism, involuntary 'outing,' abuse/neglect, and homophobia that contribute to marginalization, isolation, and discrimination in treatment services ranging from care to payment (see Addis et al., 2009). Hovey (2009) states that "LGBT elders are more vulnerable because they are … often submitted to emotional and physical hostility and they are often the first targets of abuse, neglect and discrimination in nursing homes" (p. 95). In one study, 73% of the gay and lesbian older adults believed that discrimination occurred in a residential care setting (Johnson et al., 2005). Another survey conducted by The National Senior Citizens Law Center (NSCLC, 2011), and other organizations supporting LGBT older adults showed that 89% of respondents (including LGBT older adults and service providers) believed that staff would discriminate against an LGBT resident and 53% believed that staff would abuse or neglect an LGBT resident. These fears are not unfounded as studies have found that staff at senior living facilities hold more negative views about same-sex sexual intimacy between residents relative to different-sex intimate contact (Hinrichs & Vacha-Haase, 2010). Resident peers also have homophobic prejudices and heterosexist assumptions that can contribute to feelings of shame and fear for LGBT older adults (Gallanis, 2002).

Even when individuals seek out senior housing and other supports later in life, the fear of stigma and discrimination leads many older LGBT adults to conceal their identity (Choi & Meyer, 2016). In one study, nearly one-third of participants expressed fear about being open about their sexual orientation (Gardner et al., 2014). Fewer than one in four LGBT older adults disclose their sexual orientation to care providers specifically, and approximately one-third would not disclose their sexual orientation if they moved to a residential facility (Fredriksen-Goldsen et al., 2014). Gates (2010) found that LGBT individuals over age 55 are 83% more likely to conceal their identity when compared to LGBT individuals under age 30. This fear may be especially prominent for older adults who feel more vulnerable in this stage of their life. As minority stress theory describes, concealment alone can increase stress in LGBT individuals' lives and negatively affect health outcomes (Meyer, 2003). LGBT diversity training for senior living facility staff could mitigate housing discrimination and the associated health risks.

LGBT-competency training

Cultural sensitivity training is necessary to improve support for LGBT elders (Choi & Meyer, 2016). Beginning in the 1970's, the American Society on Aging's Lesbian and Gay Aging Issues Network made recommendations to the White House Conference on Aging to address these concerns (see American Society on Aging, 2020). The federal Patient Protection and Affordable Care Act (2010) mandates culturally competent practice to reduce health disparities. However, California is the only state to mandate LGBT-specific diversity training for licensed health-care professionals (Gratwick et al., 2014; Leyva et al., 2014). Results suggest that staff who were offered such trainings are willing to engage; 93% of retirement care facility staff were in favor of diversity/sensitivity training and 98% felt that a LGBT-friendly facility would be a positive development for LGBT elders (Johnson et al., 2005). In a survey of older adult agencies, 80% of providers expressed an interest in

receiving LGBT training that was 2 h or less in duration and in an online format (Moone et al., 2014).

Despite the call for LGBT-competent service (Choi & Meyer, 2016) and staff's apparent interest (Johnson et al., 2005; Moone et al., 2014), few senior living facility service providers have engaged in LGBT-specific professional development. In a national survey of nursing home directors, only 24% reported at least 1 hour of homophobia training (Bell et al., 2010). Although local and institutionally specific trainings exist, the most well-known training is a face-to-face program run through the National Resource Center on LGBT Aging, which was created by SAGE in 2010 (Doherty et al., 2016). One of the primary aims is to train senior service providers on the needs of LGBT people (Meyer & Johnston, 2014). Through discussion and role-playing, the 4-h training educates participants on LGBT-related culture and the concerns to help LGBT older adults feel more accepted in their organization.

Efficacy of trainings

There remains a limited evaluation of these programs. In one (Doherty et al., 2016) pre/post design of 904 individuals who completed the National Resource Center on LGBT Aging training program, knowledge about LGBT issues and the ability to identify biases toward LGBT individuals increased. The majority of this sample (86%) also reported feeling more prepared to address LGBT-related bias in senior living facilities following the training program. Other studies show the positive changes resulting from similar trainings (Leyva et al., 2014; Porter & Krinsky, 2014). Porter and Krinsky (2014) found that staff who participated in a 5-h LGBT training felt a greater comfort level in challenging homophobic remarks and advocating for safe residential spaces. Leyva et al. (2014) similarly found that LGBT-diversity training increased the knowledge about, attitudes toward, and skills for working with LGBT older adults.

Given the documented health and care disparities for LGBT older adults, it is critical to properly train and educate senior care providers, particularly in senior housing contexts. Despite the few studies that have evaluated the efficacy of such trainings, more work is needed to ensure the consistent impact of completing LGBT cultural competency trainings, particularly in diverse geographical regions (e.g., the Midwest). Therefore, we assess the efficacy of an LGBT-diversity training designed to improve senior housing facility staff's cultural competency regarding the needs of LGBT elders. Given previous results from coastal studies (Leyva et al., 2014; Porter & Krinsky, 2014) and one nationally representative sample (Doherty et al., 2016), we hypothesize a positive shift in staff's knowledge, attitudes, and perceived competency following participation in an LGBT training in the Midwest.

Methods

Procedures

Three identical face-to-face, 4 hour, on-site training programs occurred at one senior living facility in Ohio – specifically an assisted living program – between March and April 2018. The same facilitators offered the training at varied times in order to accommodate staff

scheduling. The training facilitators collaborated with the organization's directors to market the training and register staff for training sessions. The organization's directors mandated staff attendance for the 4-hour training and staff were instructed to 'clock in' so as to be paid for their time attending. Participation in the pre- and posttest surveys was voluntary; participants provided written informed consent prior to the survey.

LGBT training workshop

The LGBT training covered several broad topics, similar to topics addressed by the National Resource Center on LGBT Aging. First, participants were introduced to language and terminology used within the LGBT community, and reflected on the power of language and the importance of individual identity descriptors. Next, participants engaged in an activity that highlighted important cultural events for LGBT populations throughout history to help participants understand the evolving sociopolitical contexts affecting LGBT elders across their lifespan. The unique concerns and needs of this population were framed within this context. Facilitators then provided best-practices and practical skills for better serving and supporting sexual and gender minority older adults. Participants engaged in role-play scenarios to increase their skills and practice in implementing inclusive practices. More information about the training implementation can be found in the self-published training module (Holman & Landry-Meyer, 2018).

Sample

Approximately 90% of the facility's staff – including nursing care, social supports, activity directors, janitorial crew, kitchen staff, dieticians, and administrative assistants – completed the training; 59 of the 63 attendees agreed to participate in the pre- and posttest surveys, which were distributed at the beginning and end of each session. The sample for the current study was restricted to participants who provided valid data for all pre- and postsurvey measures (see below; $n = 43$). Participants were, on average 34.21 years old. Staff reported an average of 9.52 years in the field of elder care, working an average of 2.96 years at this particular location. Full sample characteristics are presented in Table 1.

Measures

LGBT content knowledge—Knowledge and awareness of LGBT issues were assessed using nine multiple choice questions about terminology (e.g., "What does it mean if someone identifies as transgender?"), discrimination (e.g., "What is a stressor that is *unique* to LGBT people?"), and history related to LGBT populations (e.g., "What is considered the beginning of gay activism in the United States?"). All questions were dummy coded with "0 = incorrect response" and "1 = correct response." The nine items were then sum scored with responses ranging from 0 to 9, with a higher number indicating more accurate knowledge of LGBT-related information. The measure demonstrated adequate reliability (pretest Chronbach's alpha α =.84; posttest α = .76).

LGBT supportive attitudes—Supportive attitudes toward LGBT populations were assessed with a 12-item measure (LaMar & Kite, 1998). An example item includes, "LGBT people should not be discriminated against because of their sexual orientation" with response options from "1 = strongly disagree" to "5 = strongly agree." Negatively worded

items were reverse coded and a mean for the 12 items were calculated, with higher numbers indicating more supportive attitudes. The measure demonstrated adequate reliability (pretest α = .94; posttest α = .80).

Perceived preparedness—Perceptions of preparedness to work with and serve LGBT older adults were measured by one item. Participants were asked "How prepared do you feel to meet the needs of an LGBT resident in your current position?" Response options ranged from "1 = very unprepared" to "5 = very prepared."

Sample characteristics and covariates—Previous research indicates associations between attitudes toward LGBT communities and various sociodemographic characteristics, such as gender, religion, and education (see Schwartz, 2010); thus, sample characteristics were analyzed for pretest differences (see Table 2). Models were adjusted for staff designation (healthcare services [i.e. nursing staff, occupational and recreational therapists] vs. facilities services [i.e. janitorial staff, kitchen staff, and secretarial team]), employment characteristics (full time vs. part time), educational achievement (less than a college degree vs. some college education and more), race (White vs. people of color), religion (Christian vs. other), gender (female vs. male), and training session attended (as it was offered on three different days).

Analytic plan

First, we used independent sample *t*-tests to assess whether pre- and post-training intervention measures varied on the basis of participant sociodemographic characteristics. Next, we used repeated measures ANOVA to tested whether participant's knowledge, perceived preparedness, and supportive attitudes changed from pre- to posttest. Informed by bivariate results, final ANCOVA models were adjusted for participant religion, educational attainment, and training session attended (StataCorp, 2017). Multiple imputations were employed to account for missing data on covariates (<1% across all variables).

Results

Results from independent sample *t*-tests (see Table 2) showed that post-training intervention perceived preparedness scores differed by staff designation ($t = 2.39$, $p = .045$), whereby those in facilities services reported higher perceived preparedness than healthcare service staff. LGBT content knowledge prior to the training intervention was higher among those with at least some college education relative to those without ($t = -3.92$, $p = .001$). Preintervention LGBT content knowledge and post-intervention supportive attitudes also varied by religion. Specifically, compared to those reporting Agnostic and "Other" religions, those who reported being Christian had lower post-intervention content knowledge ($t = -2.20$, $p = .035$) and lower post-intervention supportive attitudes ($t = -2.32$, $p = .027$). Given these findings, we include these variables as covariates in our repeated measures ANCOVA. We also include which training session participants attended in an attempt to account for any possible implementation differences across the three training sessions.

Repeated measures ANOVA and ANCOVA results are presented in Table 3. Results from ANOVA models showed a significant increase in LGBT content knowledge between pre-

and post-intervention assessments, and a significant decrease in perceived preparedness when working with LGBT elders. These effects remained significant after controlling for staff designation, religion, educational attainment, and training session.

Discussion

LGBT older adults intentionally seek senior living facilities that are welcoming to gender and sexual minorities (Croghan et al., 2012; Gardner et al., 2014; Moone et al., 2016). This study evaluated the efficacy of a 4 h, face-to-face, research-informed, LGBT-diversity training designed to improve LGBT-specfic cultural competency among senior living facility staff. Consistent with previous work (e.g., Doherty et al., 2016), findings from this study indicate that short-term trainings can increase LGBT-related knowledge of the staff.

Interestingly, as LGBT-related knowledge increased, staff's perceived preparedness for working with LGBT elders decreased. This finding actually contrasts with what Doherty et al. (2016) reported, which may be related to methodological differences. Whereas Doherty et al. found that 86% of participants reported feeling more prepared in a posttest question (with no pretest), the current study found a statistically significant decrease in perceived preparedness in a pre- to posttest comparison. Perhaps this finding speaks to the difference between cultural competence and cultural humility. Cultural humility is considered a lifelong process of self-awareness to understand others' contexts (Tervalon & Murray-Garcia, 1998). Competence refers to specific proficiencies rather than a self-reflective shift in personal awareness. The results suggest that the intervention impacted staff's sense of cultural competence (i.e. an increase in knowledge of LGBT-related issues) and cultural humility (i.e., a decrease in their perceived readiness to address the needs of LGBT elders). Indeed, the commencement of a lifelong process of understanding others' experiences may begin with recognizing how unprepared one truly is to create a supportive environment.

These divergent findings may highlight the distinction between equality and equity (Bronfenbrenner, 1973). For example, the societal norm of advocating for equality dictates that staff 'treat everyone the same.' Thus, with nearly 9.5 years of experience working in the field of eldercare, our sample may have believed that their preparedness to work with *all* elders also translated to preparedness to work with LGBT elders. Following the training, however, staff's increased knowledge of the unique stressors and experiences of LGBT people coincided with staff's recognition that more equitable approaches of support consider distinct issues and may raise awareness of how 'treating everyone the same' may be insensitive and heteronormative.

Finally, supportive attitudes did not statistically change from pre- to post-training. It may be that the pre-training supportive attitude scores were positively skewed (4.42 on a 5-point scale), leaving little room for change (i.e., a ceiling effect). At the same time, the training content and pedagogy were intentionally focused on learning about identities and experiences to increase professional competence and skills. This goal appears to have been met. Supportive attitudes, however, reflect overall beliefs toward LGBT communities. It is unrealistic to assume that a 4-hour training could shift individuals' overall belief system. Given the context of cultural humility, perhaps reflecting and internalizing knowledge could

influence beliefs in the long-term, but this supposition would need to be tested with longer posttreatment assessments.

The implications of our findings must be interpreted alongside our limitations. First, our study reflects a small and fairly homogenous sample in one location. This limited the power of analysis and generalizability of the findings. Although these findings diversify the current body of knowledge regarding the efficacy of trainings, particularly by adding a study in the Midwest, future research should include multiple senior living facilities with more diverse staff across geographically and socially diverse locations. Further, various types of senior living facilities across the continuum of care need to be compared to understand the potential for the heightened vulnerability of LGBT older adults in specific settings.

Second, there was a limited timeframe for the post-intervention survey. Participants completed the posttest immediately following the completion of the 4-hour training. It is possible that the retention of information may change over time. Longitudinal studies that collect follow-up data from staff once they have had an opportunity to reflect on the training and apply knowledge in real-world settings would be ideal to determine the true impact of the intervention.

Conclusion

This study provides evidence that a 4 hour, face-to-face LGBT-diversity training can help create a more supportive housing climate for LGBT elders by increasing staff knowledge and competency. Given the dearth of senior living services specifically designed for LGBT elders (Portz et al., 2014), it is imperative to increase the competency of staff in general senior living facilities. Although it is encouraging that staff LGBT knowledge increased, the decrease in perceived preparedness should not be overlooked. An equality approach (i.e. treating everyone the same) is different from an equitable approach to care; a health-equity approach calls for environmental shifts that intentionally enhance support for well-being (Fredriksen-Goldsen et al., 2014; Fredriksen-Goldsen & Espinoza, 2014). This educational staff training model offers a framework to strengthen LGBT older adults' optimal aging through the creation of supportive living environments, and ultimately a safe and healthy environment for LGBT elders.

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Table 1.

Sample demographic characteristics.

	n	%
Staff Designation		
Facilities Services	7	15.91
Healthcare Services	37	84.09
Educational Attainment		
Less than college	12	27.27
Some college or more	32	72.73
Gender		
Female	37	84.09
Male	7	15.91
Race		
White	33	75.00
Other	11	25.00
Religion		
Christian	34	77.27
Other	10	22.73
Training Session		
1	8	18.18
2	23	52.27
3	13	29.55

Table 2.

Mean differences in pre and post-intervention measures by sociodemographic characteristics.

	Content Knowledge								Supportive Attitudes								Perceived			
	Pre				Post				Pre				Post				Pre			
	M	*SD*	*t/F*	*p*	*M*	*SD*	*t/F*	*p*	*M*	*SD*	*t/F*	*p*	*M*	*SD*	*t/F*	*p*	*M*	*SD*	*t/F*	*p*
Full Sample	4.32	2.86			7.56	1.61			4.42	1.56			4.27	1.88			1.87	0.84		
Staff Designation			−2.34	.052			−1.47	.187			0.58	.557			0.71	.482			1.88	.105
Facilities Services	2.00	2.61			6.33	1.86			4.60	0.33			4.50	0.49			2.50	0.84		
Healthcare	4.71	2.73			7.54	1.94			4.41	1.64			4.22	2.00			1.81	0.81		
Services																				
Educational			−3.92***	.001			−1.85	.082			−1.46	.913			0.47	.644			−1.64	.116
Attainment																				
Less than college	2.25	1.86			6.42	2.23			3.50	2.87			4.40	0.69			1.58	0.79		
Some college or more	5.12	2.77			7.74	1.73			4.77	0.28			4.20	2.17			2.03	0.83		
Gender			1.15	.280			−2.02	.062			−1.20	.237			0.74	.484			1.74	.058
Female	4.53	2.89			7.19	2.04			4.38	1.68			4.42	1.48			2.00	0.82		
Male	3.28	2.56			8.28	1.11			4.74	0.24			3.48	3.24			1.42	0.79		
Race			1.03	.318			0.59	.562			1.09	.301			−0.66	.512			−0.68	.511
White	4.59	2.81			7.47	2.03			4.69	0.43			4.19	0.22			1.84	0.72		
Other	3.55	2.95			7.09	0.53			3.73	2.91			4.46	0.42			2.09	1.13		
Religion			−1.88	.081			−2.20*	.035			−2.00	.054			−2.32*	.027			0.90	.381
Christian	3.88	2.74			7.12	2.10			4.28	1.75			4.06	2.10			1.97	0.84		
Agnostic Other	5.80	2.86			8.20	1.03			4.92	0.16			4.93	0.16			1.70	0.82		
Training Session			1.88	.166			0.73	.487			1.91	.161			1.48	.240			.11	.896
1	4.00	2.72			7.13	1.95			3.53	3.38			3.55	2.94			1.88	0.83		
2	5.09	3.06			7.13	2.34			4.75	0.50			4.73	0.35			1.86	0.88		
3	3.23	2.27			7.92	1.04			4.46	0.59			3.94	2.41			2.00	.82		

* $p < .05$

** $p < .01$

*** $p < .00$.

Table 3.

Repeated measures ANOVA and ANCOVA.

	Unadjusted Models (ANOVA)				Adjusted Models (ANCOVA)[a]			
	Pre	**Post**	***F***	***p***	**Pre**	**Post**	***F***	***p***
Content Knowledge	4.32	7.37	46.83	<.0001	4.32	7.37	26.50	<.0001
Supportive Attitudes	4.42	4.27	0.17	.678	4.41	4.27	.06	.805
Perceived Preparedness	1.90	1.45	13.35	.001	1.91	1.45	5.64	.023

[a]Adjusted models controlling for staff designation, religion, education, and training session attended, none of which were significant predictors of change at $p < .05$