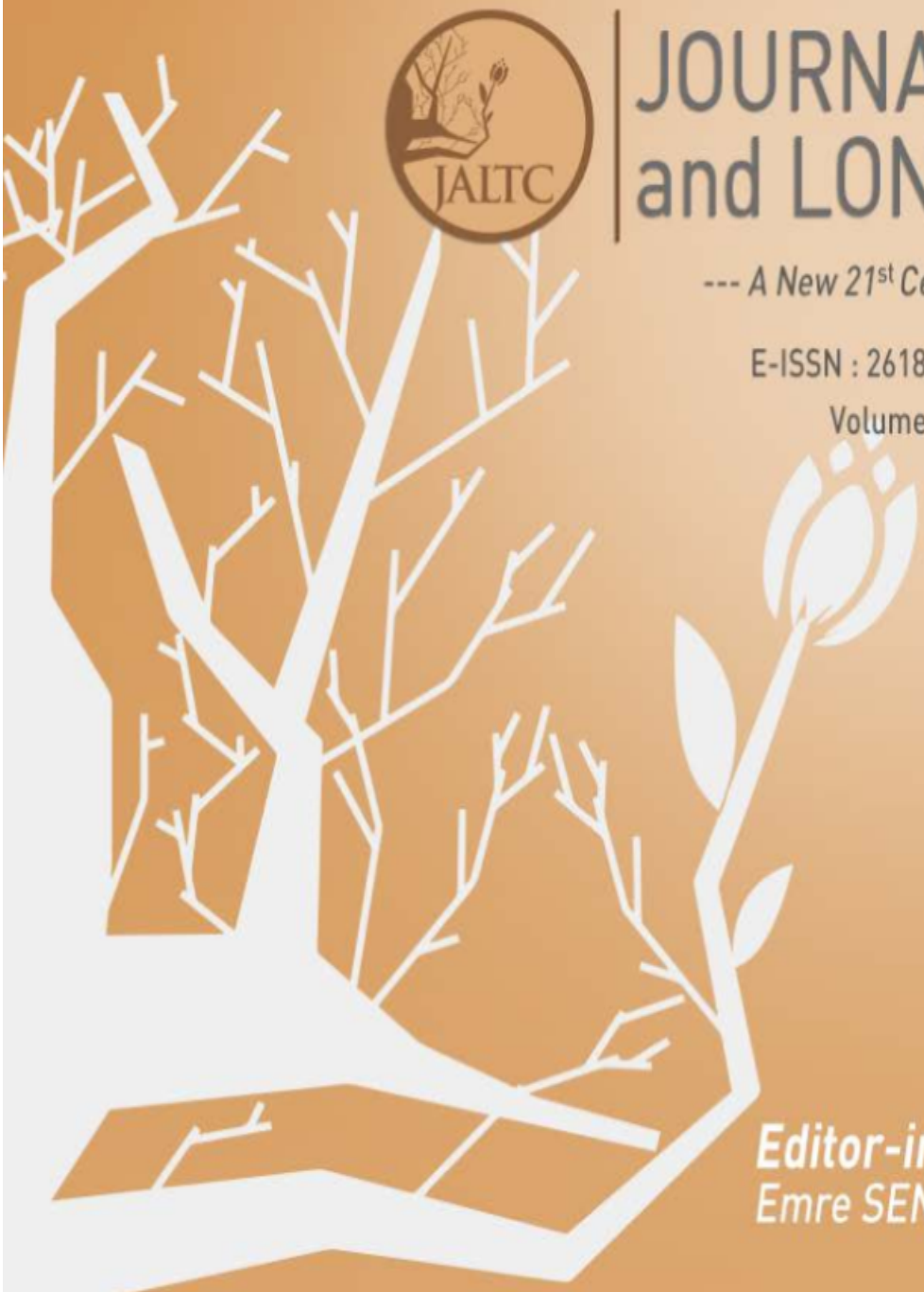

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Animal-Assisted Interventions: Social Work Practice for Older Adults with Dementia

Yvonne Eaton-Stull[1] Adelle Williams[1]

Abstract

Many older persons experience neurocognitive impairments as they age, experiencing cognitive and behavioral symptoms which may cause serious disruptions and lead to residential placements. As there is no cure, these care facilities strive to manage symptoms and provide comfortable and supportive care. Numerous therapeutic approaches have been used to manage cognitive and behavioral disturbances in older persons with dementia with mixed success. Animal-assisted interventions (AAI) are emerging as an innovative therapeutic modality which holds benefit for minimizing distressing behaviors experienced by older persons. Human-animal contact has been shown to positively benefit the quality of life of older adults. Specific research on the use of AAI in social work practice is limited. An exhaustive review of the literature was conducted to summarize relevant research, identify the practice of AAI, and determine implications for social work practitioners who work to enhance the lives of older adults in various settings. This unique article integrates these benefits as they relate to older people with dementia and aims to provide concrete strategies for implementation of animal-assisted interventions.

Keywords: Animal-assisted intervention, animal-assisted activities, animal-assisted therapy, animal-assisted crisis response

Key Practitioners Message

- Animal-assisted interventions (AAI) shows promise as a therapeutic modality for social workers
- Social workers can utilize AAI to assist in addressing cognitive, social and behavioral issues with older adults
- AAI can be beneficial to social workers at the micro and meso levels
- Integration of AAI into existing treatment plans may decrease agitation, depression, and isolation among older adults with dementia

One out of every three seniors dies with Alzheimer's disease or another dementia (Alzheimer's Association, 2017). With these numbers expected to increase, more and more seniors and families will face these neurocognitive diseases. These diseases have varying levels of cognitive decline and behavioral disturbances. According to the DSM-5, cognitive impairments include difficulties with attention, learning, memory, language, or social interaction (APA, 2013). Behavioral disturbances may include agitation, changes in mood, psychotic symptoms, or apathy (APA, 2013). Effective man-

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agement and treatment of these symptoms are essential to provide quality care and promote a positive quality of life.

One of the most common diseases to strike the older population is dementia (Almeida, Hicker, & Rees, 2014). Dementia can negatively affect patients' level of well-being due to symptoms such as delusions, depression, apathy, irritability, anxiety, sleep disorders, and difficulty engaging in social activities (Bunn et al., 2014). Agitation is a common occurrence in those with dementia (Kyomen & Whitfield, 2008).

Dementia can result in poor outcomes for older adults. Older adults with dementia reportedly have higher rates of institutionalization and mortality (Almeida et al., 2014). There is also a high occurrence of dementia and other chronic health conditions (Richards & Brayne, 2010; Skoog, 2000). Older adults with dementia are more likely to have difficulty managing other health conditions (Bunn et al., 2014).

Much of the treatment for dementia focuses on the use of medication or herbal remedies and dietary supplements. Medication management presents a definite challenge with this population due to drug interactions, frailty of the older person, side effects, and inappropriate prescribing; rather than automatically reaching for the prescription pad, one should ask if there are alternative, non-pharmacological treatments (Webber, 2017; Woodhouse, 2013). One growing intervention with older adults is the use of animal-assisted interventions. The goal of this article is to review research that includes both animal-assisted interventions and neurocognitive symptoms, summarize the findings related to this specific area, identify research limitations, and offer practical, concrete suggestions for the practitioner working with older adults.

Review of Research

The use of specially trained dogs in social work practice is a growing field. Animal-assisted interventions (AAI) is an umbrella term used to describe the various strategies for integrating animals into practice settings. AAI encompasses animal-assisted activities (AAA), animal-assisted therapy (AAT), and animal-assisted crisis response (AACR). AAA refers to informal enrichment activities with motivational, educational or recreational benefits (Pet Partners, 2019). AAA may or may not be provided by registered, evaluated animals. AAT is a formal goal-oriented intervention directed by professionals (Pet Partners, 2019). AAT should be provided by registered, evaluated therapy animals. AACR refers to experienced, registered AAA/AAT Teams who are screened and trained to respond to intense emotional and environmental situations, such as disasters and other crises (HOPE AACR, 2019). The utilization of specially trained and registered therapy dogs in treating and managing neurocognitive symptoms should be considered. A summary of the research results of the benefits of animal-assisted intervention will be provided along with implications for social work practice with older adults.

Cognitive Benefits of AAI

Currently, there is no cure or method of prevention for the neurocognitive decline; the primary goal of most interventions is to maintain function and improve quality of life (ASPE, 2015). Social and recreational activities are important for achieving these goals. Implementing appropriate activities for people with dementia is challenging due to cognitive and communication difficulties. One way to promote cognition is through AAT (Pope, Hunt & Elison, 2016). AAT can affect various behaviors associated with dementia. Interaction with the animal can decrease withdrawal, improve memory, and enhance communication skills (Cherniack & Cherniack, 2014).

AAI also encourages expression and cognitive stimulation through discussions and reminiscing. Buetter, Fitzsimmons, and Barba (2011) suggest beneficial goals for clients with dementia include focusing and paying attention to certain tasks. Demonstrations with dogs offer a desirable target for concentration.

Laun (2003) claims animal-assisted therapy, although a previously used intervention, is just

now being validated with research. AAT is recommended for persons with dementia to reinforce or teach cognitive and memory skills, tasks of daily living, spatial skills, sequencing, motor and social skills (Laun, 2003).

Katsinas (2000) incorporated a therapy dog into a day program for elderly patients with dementia. While the patients visited, they recalled memories about prior visits and previous pets and talked with others (Katsinas, 2000). These therapy dog visits gave patients something to look forward to and helped with focus and orientation for the next day the dogs were coming (Katsinas, 2000).

The cognitive benefits potentially lead to increased social benefits as well when people ask others if they know when the therapy dogs are coming or when they tell friends that today is the day the therapy dogs are visiting.

Social Benefits of AAI

Enhancing social interaction helps to create a sense of belonging and enjoyment. One study of 56 nursing home residents with dementia found that therapy dogs improved engagement of residents (Marx et al., 2010). These same residents also demonstrated positive attitudes when interacting with these animals (Marx et al., 2010). A similar review found enhanced social interaction, pleasure, laughter, and enjoyment (Pope et al., 2016).

In another review, AAT interventions reduced agitation and improved social interaction and communication (Bernabei et al., 2012). Perkins, Bartlett, Travers, and Rand (2008) evaluated nine studies involving AAI and dementia; they found improved social behavior regardless of the severity of dementia.

Social activities that provide opportunities for mutual interactions enhance self-esteem. AAI offers physical comfort and support, an experience that may be few and far between for someone in a long-term care facility. Buettner and her colleagues (2011) believe these animals offer diversion and something to look forward to when the days are long.

Perkins and her colleagues (2008) indicated that the tactile comfort, companionship and social engagement with the dogs were beneficial. AAI induced a positive attitude and reduced the negative perceptions of living in a residential care facility.

When used with people who have been diagnosed with dementia, AAT takes advantage of the human-animal bond to decrease behavioral and emotional problems and to increase social engagement and communication. People with dementia may experience difficulty finding the right words or forget what they wanted to say. Increased communication, both verbal and nonverbal, is an important benefit of AAT because it allows people with dementia to express their emotions and ideas and to relate to others. The ability to communicate can decrease the isolation and depression felt by those who have been diagnosed with dementia and decrease behavioral disturbances.

Behavioral Benefits of AAI

Successful management of behavioral symptoms is challenging for both families and treatment providers. The utilization of AAI provides a potentially useful and cost-effective strategy that doesn't run the risk of over-medication or side effects for the older person. Much of the existing research on AAI and dementia focuses on measuring changes in agitation.

In a literature review of eighteen articles about dementia and AAI, it was determined that AAI can reduce agitation (Bernabei et al., 2013). An earlier review of the literature also found that AAI decreases agitation (Perkins et al., 2008). A specific research study investigated the effectiveness of AAT on agitation, aggression, and depression by randomly assigning nursing home residents to 10 weeks with or without AAT (Majic, Gutzmann, Heinz, Lang & Rapp, 2013). Significant decreases were found in both frequency and severity of symptoms, implying that perhaps AAT may delay the progression of dementia-related symptoms (Majic et al., 2013).

Changes in mood may likely have a direct impact on agitation and aggression; therefore it is important to review the research on AAI and mood.

A recent study including 58 nursing home residents with dementia found significant changes in depression scores (Cornell Depression Scale) for those receiving AAT (Olsen et al., 2016). In a similar study with 55 residents, researchers also discovered significantly improved depression scores for residents receiving animal-assisted therapy versus those receiving therapy with only the therapist (Travers, Perkins, Rand, Bartlett & Morton, 2013). Other researchers used the Geriatric Depression Scale and divided 50 residents into three groups: one receiving AAT with reality orientation therapy, one receiving strictly reality orientation therapy and a final smaller control group (Menna, Santaineillo, Gerardi, DiMaggio & Milan, 2016). Menna and her colleagues (2016) found statistically significant differences between groups, particularly between the AAT group and the other two groups.

One smaller study with 21 participants also utilized the Geriatric Depression Scale (GDS) and found symptoms of those in the AAI group decreased by 50% (Moretti et al., 2011). A similar study of 19 participants also utilizing the GDS failed to demonstrate significant changes; however, this study also involved some AAI occurring during physical therapy (Berry, Borgi, Terranova, Chiarotti, Alleva, & Cirulli, 2012). As physical therapy can be difficult and painful at times, perhaps participant's self-evaluations were impacted by these factors. This study, however, did identify significant visible changes in smiling of those receiving AAI. LeRoux and Kemp (2009) utilized a different depression measure (Beck Depression Inventory) with 16 residents. The residents in the AAI group had significant differences between their pre- and post-test measures on this depression scale.

One exploratory study evaluated the effect of an animal-assisted activity with dogs for ten patients affected by dementia in an adult day care center. Mosello, Ridolfi, and Mello (2011) measured cognitive, behavioral and physiological symptoms as participants were evaluated without dogs, with plush animals, and with dogs. An increase in pleasure and alertness and a decrease in sadness were observed with the animal-assisted activity, and the decrease in sadness lasted for several hours (Mosello, et al., 2011). Although not significant, depressive symptoms were reduced, and participants did have significant decreases in anxiety in the AAA compared to the control conditions (Mosello, et al., 2011).

One difficult behavioral symptom of dementia may include hallucinations. Caregivers of those with dementia often identify these symptoms when residents are talking to someone who is not present or complaining about something that is not a reality (Cohen-Mansfield & Golander, 2012). Of the AAI dementia research reviewed, none appeared to utilize any measures of psychotic symptoms, such as hallucinations or paranoia. Consequently, a review of mental health research and AAI may offer suggestions for future research. Very few psychiatric studies were located that evaluated positive symptoms of schizophrenia, such as hallucinations and paranoia. Two of the three research studies reviewed utilized the Positive & Negative Syndrome Scale (PANSS). The PANSS measures positive symptoms, such as hallucinations and paranoia, negative symptoms, such as withdrawal and lack of spontaneity, and general psychopathology, such as anxiety and disorientation (Kay, Opler, Fiszbein & Ramirez, 2000). In one study, twice weekly AAT was provided to fourteen individuals with schizophrenia in addition to regular treatment (Calvo et al., 2016). Both this treatment group and the control group (eight individuals who did not receive AAT) showed significant improvement in positive symptoms and general psychopathology, but only the AAT group showed significant improvement in the negative symptoms (Calvo et al., 2016). A similar study provided twelve patients with AAT and compared a control group of nine who did not receive AAT (Villalta-Gil et al., 2009). Both of these groups demonstrated significant improvement in positive and general symptoms, but again only the group with the dog demonstrated significant changes in negative symptoms (Villalta-Gil et al., 2009). In the final study, twelve individuals participated in an AAA group with a dog and 15 in a control group without a dog (Chu, Liu, Sun, & Lin, 2009). This study utilized a modified measure to assess

positive, negative and emotional symptoms; they found significant improvements in positive and emotional symptoms but not negative symptoms (Chu et al., 2009).

Many individuals suffering from neurocognitive diseases experience apathy, a lack of interest. Two studies from Japan have demonstrated the benefits of AAA and AAT on this symptom. In the first study, eight elderly nursing home residents (all women) were involved in AAA for two years, and interview results revealed AAA "awakened their interest in themselves, their fellow residents, and their surroundings" (Kawamura, Niiyama, Niiyama, 2009, p. 45). Similarly, Motomura, Yagi, and Ohyama (2004) provided AAT to eight nursing home residents with dementia, and all showed significant improvement in the apathy scale.

Williams and Jenkins (2008) found anecdotal evidence that dog visits in dementia care settings result in relaxation, reduction in apathy, agitation, and aggression. Similarly, the presence of a residential dog in an Alzheimer's special care unit reportedly decreased the occurrence of behavioral disturbance of residents during the daytime (McCabe, Baun, Speich, & Agrawal, 2002). The above research results provide an abundance of relevant support for the gerontological social worker who is attempting to care for and treat the elderly client.

Summary

It is clear from the existing AAI research that dogs provide many cognitive, social and behavioral benefits to older adults with neurocognitive impairments, such as dementia. Previous research has determined cognitive benefits, such as enhanced memory, focus, attention, and orientation. AAI offers unique strategies to enhance the cognitive skills of those with dementia; including recalling the dog's name, remembering how to give them a command, focusing attention on their tricks, or orienting themselves to the calendar with the dog picture on it, so they realize the therapy dogs are visiting. Social benefits are also well supported in the literature. Increased interactions, engagement, pleasure and laughter can create a better quality of life for those living in a residential care facility. Sharing stories of pets or reminiscing with others can create a feeling of belonging. Finally, behavioral benefits are well documented as well. Decreased agitation, aggression, depression, anxiety, hallucinations and apathy can occur with AAI. AAI can enhance the quality of life by managing cognitive, social and behavioral symptoms faced by older adults. It can create a safer and enjoyable environment for the patient, staff and other residents.

Recommendations

To aid in the development of innovative animal-assisted interventions, several suggestions will be offered. Finding specially trained and evaluated therapy dogs is fairly easy for the social work practitioner. There are many national organizations that evaluate and register these canines; the largest is Pet Partners. Pet Partners registers nine different species of animals, requires the animal handler to complete educational training before testing with their animal, and involves re-evaluation every two years which includes an animal health update (Pet Partners, 2019). Social work practitioners can contact this organization to locate qualified volunteers in their area. It is important to stress that these dogs are not service dogs that are permitted anywhere, but rather these are dogs are invited and welcomed into facilities for a purpose. There is no charge for these volunteer visitors and the organization provides liability insurance for registered volunteers. Practitioners are encouraged to fully review the requirements of these therapy animal organizations to assure they are comfortable with them. Also, despite these organization's processes, each animal has a different personality and temperament. Calm, obedient, quiet, affectionate, friendly dogs that do not react to noise and activity are best suited for this work (Chandler, 2005). It is also a good idea to meet and observe the animal before utilizing them with clients/patients/residents to assure practitioner comfort with the animal and handler.

Based on the author's experience, a few other considerations are recommended for successful

AAI. One concern is to consider the size of the animal. For example, if an older adult is bed bound, a small animal that can be placed on their lap or bed may be best as many medium-sized dogs cannot be easily reached from the bed. Many individuals are attracted to very large dogs as well that can be reached from the bed; however, clients may be more fearful of such large animals. A second consideration is to determine the location of the AAI. Many facilities offer individual room-to-room visits, but others utilize an activity room or similar setting for group AAI. Individual room visits benefit the client by occurring in the comfort of their room or bed. Multi-bed rooms, however, may cause an uninterested client to be afraid or to be exposed to potential allergens. Individual room visits can be very time consuming and tiring for the animal, so this should also be taken into consideration. There are other items one will need to address, such as client eligibility, agency requirements, and other policies and procedures, such as infection control. There are many resources available online or through pet partners.org to assist practitioners who are considering the development and implementation of AAI. Another thorough resource for the practitioner is the *Handbook on Animal-Assisted Therapy* (Fine, 2015).

More social workers are finding that animals are good assistants in the therapeutic process. Social workers, counselors, and therapists may use animals to aid in a therapy session (Blank, 2015). AAI can also be a useful tool for social workers to teach socialization skills, provide comfort, enhance physical health, among other therapeutic goals. The animal essentially acts as a go-between to foster a relationship between a social worker and a client, which promotes comfort and a sense of safety to expedite the therapeutic response. Animals can be a valuable bridge to establishing rapport and a therapeutic relationship (Tedeschi, 2015).

Social work practitioners are very familiar with the types of social work practice. Strategies for AAI in micro practice (with individuals and families) and meso (mezzo) practice (within groups and organizations) will be discussed. These concrete interventions will be focused on residential treatment for older persons, such as retirement communities, assisted or skilled care facilities, and hospitals.

Micro Practice

AAA can occur where the handler brings the animal to individual client rooms to inquire if they would like a visit. The handler and animal then interact with the older person. In the author's experience, these types of visits generally occur in one of two ways. Some facilities create a pre-determined list of clients and room numbers who indicated, based on inquiry earlier in the week, they would like a visit. The handler is then given this list and conducts independent visits room by room with the clients on the list. A second option is to have a staff member accompany the handler and animal. In this situation, the staff member who knows the clients enters the rooms and inquires if they would like a visit from the therapy dog. Depending on the size of the facility, these approaches may take some time to accomplish these visits. These visits typically last 1-1 ½ hours and can be scheduled and included on an activity calendar for residents.

AAA is also increasing in many facilities via a resident animal, a cat or dog that lives as a pet at the facility. This strategy then enables the older person to have more frequent access to a support animal. Obviously this example takes a lot of planning and policy development to assure that the animal has its own private place to escape from constant petting and stimulation. In this situation, questions must be addressed such as who will arrange and take the animal to the veterinarian, who pays for the care of the animal, and who will feed and take the animal out. In these situations, these are not registered therapy animals that are evaluated and handled by a designated person. Therefore, it is critical that an appropriate animal behavior professional has evaluated the animal for sound temperament and behavior so as to not present unnecessary risks to residents or visitors.

AAT is frequently utilized in settings and can be easily linked with the goals of existing treatment

providers. Social workers in facilities for older persons are often involved in acclimating new residents during the admissions process and helping them to feel comfortable. AAT can be useful for this purpose to establish rapport with the older person and provide comfort and support throughout a difficult change. AAT can be paired with other treatment providers as well, such as Physical therapists (PT), Occupational therapists (OT), and Speech therapists (ST). For example, the PT can utilize the animal to increase a client's range of motion by placing the dog on one side of the client for petting. Speech therapists may also find benefit in AAT. For example, they may encourage the client to give certain commands to the therapy dog to improve their speech. OT Melissa Winkle (2013) offers practical, detailed activities with therapeutic benefits to integrate into healthcare settings.

For individuals with fears or allergies, AAA and AAT can still be beneficial. For example, an AAA activity where therapy dogs are doing tricks or activities can elicit laughter and enjoyment without the resident having to pet or hold the animal. They can be seated toward the back of the room where they feel more comfortable and not within close proximity of the animal. Hypoallergenic dogs, such as Shih Tzus or Havanese, may also be another option for those who wish to engage with therapy dogs but who have allergies or compromised immune systems. Finally, there are several robotic animals on the market that could present an alternative to real animals.

A final micro AAA intervention may include family support. Families often have an emotionally difficult time making long-term care decisions. Sharing the option of a therapy animal may provide a little comfort during family meetings and demonstrate the homelike nature of the facility. Therapy animals could also accompany the families during case review meetings, especially where difficult information or decisions may be addressed.

Meso Practice

Offering AAI in groups is often more time and resource friendly than other strategies. The activities department in many facilities often plans and executes a variety of options to benefit the older person and enhance their quality of life. Many animal-assisted interventions can help facilities fulfill these goals.

Recreational benefits can be enhanced by offering trips that involve animals. AAA can include outings to Humane Societies or other shelters, zoos, or farms. According to the American Pet Products Association (APPA, 2017), almost 80 million households have pets; therefore outings involving animals will likely be very attractive to the older person who most likely had pets in their past. If an outing is not feasible, many of these organizations may offer traveling programs to facilities.

Another form of AAA often utilized in various facilities is group interactions with the therapy dog. The activities department schedules regular visits for a therapy dog team or teams to come and visit with a group of residents. This works best in a very large room with residents positioned in a circle. The handler and animal then go around the circle interacting with the residents. This type of intervention offers many social benefits while the residents share stories of their previous pets and engage with the visiting animal and handler.

AAA can also take the form of entertainment via dogs who can demonstrate various obedience skills, perform tricks or engage with the residents in games. One game the authors have modified for use with clients is Jenga. Each wooden block has a number written on it that corresponds to a question about animals. For example, share a story about a previous pet you had, who is your favorite TV animal or ask the therapy dog to "sit." When a client pulls a block from the tower, they answer the question that corresponds to that number. This game engages the residents in a fun way to discuss animals while interacting with the visiting dog. If stacking and pulling blocks from the tower is difficult, one can just lay the blocks on the table and clients can select one.

A more formalized group intervention can be facilitated by the Social Worker. This AAT group would be provided to individuals with similar

concerns. For example, a group for individuals who have anxiety may benefit from learning deep breathing. Grover (2010) has several fun activities to integrate the dog into these AAT groups; she suggests using flavored bubbles for dogs to teach the clients how to engage in deep breathing. Clients enjoy blowing bubbles and watching the dog attempt to catch these bubbles which invariably leads to a lot of laughter as well as skill development.

Although most of these strategies are focused on clients, one must also take measures to care for the valuable human service professionals. Job burnout is a severe consequence that can cause workers to feel dissatisfied, uncommitted or ready to leave the job (Beheshtifar & Omidvar, 2013; Jourdain & Chenevert, 2010). Implementing simple strategies to demonstrate concern for the staff will go a long way to diminishing the likelihood of burnout. Therapy animals can be invited to staff meetings for general support or fun, engaging team building activities. Professionals who are working with older adults are not invincible to the grief and loss experienced when a client dies. Offering small group interventions with a therapy dog present to help them process and share their feelings demonstrates that the organization cares for their staff.

Fortunately significant crises and disasters, such as fires or tornadoes, rarely happen within a facility. Following crises, however, many clients and staff are impacted. HOPE AACR, a national, non-profit organization can be called in to provide animal-assisted comfort and support to individuals following disasters (HOPE AACR, 2019). No cost for this service makes it especially feasible for facilities serving older adults. These crisis "comfort" dogs can be utilized to work with groups or individuals and provide a calming presence following a disruptive incident.

Conclusion

As the aging generation continues to grow, it is essential that social work practitioners utilize the most effective and evidence-based interventions to enhance the quality of life for these seniors. Research on AAI documents several benefits which are especially relevant for the seniors with neurocognitive impairments. Developing and using innovative animal-assisted interventions in micro and meso practice will certainly contribute to improving outcomes for older adults and their families.

Social workers experienced with AAI are in a unique position to increase the awareness of AAI as a therapeutic modality which can be used in different environments. It is essential for social workers to educate professionals and paraprofessionals on the advantages of AAI as an intervention which ultimately assists in improving the quality of life for older adults with dementia. Social workers will need to work closely with the administration of different environments to achieve their support towards the integration of AAI into their living facilities. They will also work with the administration to develop policies and procedures to ensure the safety of residents, staff, and the animals they encounter, as well as the certification of the dogs and their handlers. As a therapeutic intervention there exist documented studies which illustrate the potential of AAI in decreasing symptoms associated with dementia, however additional studies are needed. Practical recommendations have been identified for social workers interested in incorporating animals into the therapeutic process; however additional research is clearly indicated to advance AAI as modality which can be used with various populations. There are many resources[1] to assist practitioners in locating qualified canines to assist in the provision of services.

Unfortunately, there are limited research studies that target the aging population with neurocognitive impairments and animal-assisted intervention. Searching research titles for "animal-assisted" and "dementia" using SAGE premier, yields only five studies. Much of the research on animal-assisted interventions and the aging population continue to utilize smaller sample sizes and anecdotal evidence. Utilization of formalized

1 National resources are available on the journal websites https://www.petpartners.org, https://www.therapydogs.com, and https://www.hopeaacr.org

assessment measures to demonstrate change will enhance the validity of this intervention. Extending these assessment measures to include all symptoms of dementia, such as psychotic symptoms, will further evaluate how AAI may be useful in the management and treatment of dementia and specific symptoms.

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GENERAL COMMENTARY

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C.A.R.E.: A Model for Improving the Process of Assessment

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Abstract

Assumptions, perceptions, and expectations (APEs) determine how individuals view the social world and the people who live within, especially if persons do not share the same cultural experiences or beliefs of other individuals. Health care workers serve a variety of individuals from a multitude of cultural and ethnic backgrounds. Although workers are charged with developing individualized plans of care to address the multiple disadvantages and unique needs experienced by persons who admit for healthcare service, APEs held by the worker moderate the clustering of disadvantage experienced by clients within the social environment, further separating them from those who make determinations of, and decisions about, care. Although factors connected to vulnerability or disadvantage may affect the well-being and outcomes of clients, the process of othering, either implicit or explicit, creates and maintains a state of inequity, documented through assessments, care plans, and other formal artifacts of service. This paper uses a critical lens to review how APEs intersect with the existing processes and procedures of assessment, affirming and enhancing clusterings of disadvantage and social injustices experienced by clients, creating corrosive and reified states of chronic disadvantage that lead to poor and pervasive patterns of outcomes for vulnerable persons relegated to the category of the other and proposes a model of C.A.R.E. to improve outcomes during the assessment process.

Keywords: Admission process, APEs, assumptions, disadvantage, expectations, othering, perceptions, stigma, long-term care

Key Practitioners Message:

- *Attitudes, perceptions, and expectations of human service professionals influence the process of assessment, which influences documents of care.*
- *The bias of human service workers can be explicit or implicit, malevolent or benevolent. Regardless of intent, all bias skews the accuracy of assessments for older persons admitting for services, including Long Term Care.*
- *Inaccurate assessments can influence plans of care for long periods of time, within and across systems.*
- *Personalizing the process of assessment improves the accuracy of assessment for older persons admitting for services.*
- *Incorporating clients into initial and on-going assessment by Connecting through Active engagement, Relationship building, and Empathetic response creates better, and more accurate, assessments.*

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Othering may be defined as an intentional and structured process, which separates persons into groups of *them and us*. Hatzenbueler, Phelan, and Link (2013) examined such intentional acts as functions of social control that create a stigma to *keep people down*, *keep people out*, and *keep people away*. The division is apparent in commonly alienating subjects such as politics, religion, and migration; yet, *othering* is also present in ways persons assess, evaluate, and document the needs of human beings.

Othering can take place on a large group basis; however, it also occurs in smaller and more intimate ways that separate and marginalize individuals. Though the intent of this process may not be nefarious, it creates and maintains separations between people. *Benevolent othering* was defined by Grey (2016) as a tendency of offering concern and equality that preserves barriers of individuality and equity, maintaining "subordination of (mental health) care users" (p. 241). This *benevolent othering* is seen in helping professions, such as social work, where workers are charged with evaluating and triaging multiple needs, separating and categorizing individuals, often through a superficially benevolent process of *doing to* (Grey, 2016).

To examine the role of social work and conceptualize procedures and practices of *benevolent othering,* this paper will identify factors that contribute to *benevolent othering* within social work assessment procedures.

Background

Human service professionals, such as social workers, provide services to vulnerable persons by identifying the needs of individuals seeking services, optimally working with these individuals to identify and develop strengths, linking individuals to appropriate and available services, and advocating for issues of social justice, improving and sustaining the lives of persons within the social environment (IFSW [International Federation of Social Workers], 2016).

Multiple factors create and maintain marginalization, contributing to what Wolff and de-Shalit (2007) described as clustering of disadvantage, impacting one's ability to thrive within the social environment, with clients seeking assistance, or coming into care, experiencing risk, vulnerabilities, and situational stressors. Because these factors are bounded by time, space, and place, human service workers use assessment tools to triage specific needs, target interventions, and develop plans of care; yet, the assessment process is influenced by the attitudes, perceptions, and experiences (APEs) of social workers and other helping individuals (Werner & Araten-Bergman, 2017). Though such bias may be implicit, it explicitly affects decisions and delivery of care for those who seek assistance from professionals ethically obligated to respect "the inherent dignity and worth of the person" (NASW [National Association of Social Workers], 2017, para 9).

Assessments

Persons seeking assistance from human service organizations are initially assessed to evaluate current and anticipated needs for services related to the identified problem, including identification of the underlying diagnosis or other factors supporting the identified problem(s) (SAMHSA [Substance Abuse and Mental Health Services Administration], 2009). The intake process is usually the first formal contact between the client and an organization, providing opportunities to create shared knowledge between the individual and the organization. These assessments inform decisions for plans of care that attempt to match services with needs, driving the delivery of services (SAMHSA, 2009).

Standardized forms have long been employed during the assessment process to create an accurate evaluation of need. In 1917, Mary Richmond published assessment forms, establishing a standard of practice for social workers who develop interventions and plans of care to address the needs of vulnerable individuals. Indeed, Tomberlin, Eggart, and Callister (1984) described the importance of standardized forms for "consistent and efficient patient evaluations in a short period

of time" (p. 348). Assessment forms are employed as tools to help individualize care; however, the standardized nature of these tools, limits the identification and individualization of the presenting client.

The accuracy of assessments is dependent upon the questions asked and answered, the purpose of the organization, and the engagement between the worker and client. Although classic literature finds that professional assessments judge clients with accuracy (Schrauger & Osberg, 1981), multiple factors can influence the assessment process, including time allotted for the assessment, the skill, and experience of the worker, and the APEs of workers. This process is prevalent in the way older persons are assessed upon entering residential or long-term care (LTC).

Othering as a Product of Assessment in Long-Term Care

Multiple disciplinary assessments are conducted upon, or shortly after, admission to residential or LTC. Initial assessments are completed to create a holistic assessment of the resident's unique needs. Additionally, many assessments are standardized and involve the process of checking boxes and determining categories of care, based upon the current evaluation of persons who have recently experienced trauma and/or continued states of delirium, brought on by changes of condition, acute injury or illness, or side-effects of drugs. Kosar and his colleagues (2017) noted the problem of misdiagnosis due to delirium contributing to poorer short-term and long-term outcomes.

Additionally, the social history of the new resident may be unknown or unshared. As a result, data informing these assessments are often not an accurate reflection of the resident's normal state. Though assessments are updated, they may merely add to the initial assessment.

Once initial assessments are entered into electronic medical records, ticked boxes from inaccurate assessments may continue to identify goals and objectives of care, regarding these baseline assessments. Although social workers and other providers are charged with accurately assessing and individualizing plans of care, standardized forms and electronic medical records promote what Grey (2016) described as the continued separation and categorization of individuals, often based upon an inaccurate assessment of the initial presentation of the resident.

Additionally, rapid assessments of newly admitted residents are mandated by regulation, contributing to what Schnelle et al. (2004) called "the culture of inaccurate documentation" (p. 1378), with deadlines for assessments having greater magnitude, than accuracy.

APEs

Health care workers' attitudes, perceptions, and expectations may further contribute to inaccuracies, which align with Goffman's concept of stigma as a perception of "blemishes of character" (Goffman, 1963, p.4), echoing historical views of deservingness, dating to the Old Poor Laws of 1601. Historical views of deservingness separated clients into two arbitrary categories the "worthy" and "unworthy."

Though the helping professions, including social work, advocate for value-free practice, which maintains the dignity and worth of individuals (National Association of Social Workers, 2017), the beliefs, values, and experiences of workers, coupled with increased scarcity of available resources, influence decision making regarding care (Banaji & Greenwald, 2013). These discrediting influences contribute to inaccurate and unfair assessment practices for vulnerable persons. Additionally, Banaji and Greenwald (2013) declared that APEs provide a default of decision, especially when judging persons belonging to other social groups, creating and maintaining barriers to understanding and empathy for persons seen as *other*.

Assumptions

Assumptions are what persons believe to be true (VIU [Vancouver Island University], 2018). One's assumptions reify, over time, and create meaning.

Although assumptions are made by everyone, they create "a flawed foundation for our understanding" (VIU, 2018, para. 4).

For persons seeking assistance, assumptions held by the health care worker result in inaccurate and skewed assessments, which drive plans of care and delivery of services. Inaccurate assessments prove even more problematic when considering how written information and electronic medical records remain accessible for years, cementing perceptions of clients across, and within, agencies and organizations.

Perceptions

Perceptions are how person regard, understand, and interpret one another (VCI, 2018).

Perceptions are unique to the person holding them, arising from personal values and beliefs, informing positions of explicit and implicit bias (Banaji & Greenwald, 2013; VCI, 2018).

For persons seeking assistance, perceptions of health care workers create and maintain stereotypes and discrimination, limiting the individualization of care.

Expectations

Expectations are assertions that something will happen and is inevitable. Expectations are based on personal experience(s) and generalize future events (VCI, 2018).

For persons seeking care, expectations of staff influence plans of care, creating barriers to meaningful relationships and limiting positive outcomes.

Othering

Persons who seek assistance are often confronted with bureaucratic and compulsory procedures that categorize individuals into groups defined by the presence and intensity of need, formalizing positions of power (Johnson et al., 2004). This differentiation was described by Lister (2004) as othering - the division people make between persons defined as persons, and us defined as them. Powell and Menendian (2017) defined othering as "a set of dynamics, processes, and structures that engender marginality and persistent inequality…" (para. 12). Standardized forms are an alternative to long-hand assessments, and though they serve as an important information-gathering tool, they fail to capture the unique needs of the whole person, and often support labeling practices that continue to oppress vulnerable persons.

Benevolent Othering

Grey (2016) explained that persons receiving services commonly experience a benevolent type of *othering* where they are treated kindly, but held at a distance, seen as less able to control life circumstances, dependent upon assistance from others. The process of assessment may be impersonal, but it is not necessarily intentional; regardless, documents of assessments often reduce persons to checked boxes and filled blanks, supporting disparity and disadvantage (Wolff and de-Shalit, 2007), and supporting what Freire (1968/1970) described as a process that "dehumanizes the oppressed" (p. 44).

The assessment process frames the interaction, informed by the attitudes, perceptions, and experiences of social workers and others, who view vulnerable persons as unable to make good decisions and life choices. Though *benevolent othering* is employed, ostensibly, to help others, it patronizes and infantilizes those seeking care, creating and maintaining dependency through the imbalance of power between those who help provide access to care and those who receive it (Sakamoto & Pitner, 2005). Whether the act of *othering* is motivated by exclusion or inclusion – intentional or not - it dilutes and depersonalizes individuals, limiting opportunities for success (Johnson et al., 2004).

Assessment as Process

The assessment has long been defined as a top-down systematic process, designed to identify the needs of the presenting individual as accurately as possible (Wright, Williamson, & Wilkin-

son, 1998). Despite efforts to personalize plans of care, the process of assessment is frequently a time-limited experience that fails to holistically evaluate individuals, reducing persons to demographic statistics and quantitative measurement, limiting outcomes for those dependent upon the decisions of others (Freire, 1968/1970; Schnelle et al., 2004).

Persons seeking assistance from social service organizations live and operate within social contexts. So too, do health care workers. The likelihood of *othering* practices increases according to organizational culture, with a greater number of institutional characteristics associated with a greater prevalence of *othering*, creating higher degrees of vulnerability for persons seeking formal assistance through organizations and institutions of care (Goffman, 1961) and influencing significant consequences to health and well-being (Johnson et al., 2004).

Though assessments are intended to personalize the response to individualized need, the process of assessment is often a route taking of name, address, age, gender, and status, with demographics serving as determinants of response, often collected by persons holding clipboards or staring at screens, which differentiates persons sitting on opposite sides of desks.

Johnson et al. (2004) determined othering as organizational discrimination, which "can reinforce and reproduce positions of domination and subordination" (p. 253). When formulating answers to formulated questions are used to create documents of assessment, processes of care and caring become mere responses to objective data, influenced by workers whose conceptions and perceptions influence drivers of care (Johnson et al., 1998).

Conceptual Model

The conceptual model depicted in *Figure 1* assumes that disparities exist in the process of assessment and illustrates the mediating influence of workers' APEs upon the creation of documents of care. These disparities create threats to well-being for persons seeking assistance, limiting opportunities and outcomes for persons who have less power (Prasad, 2018).

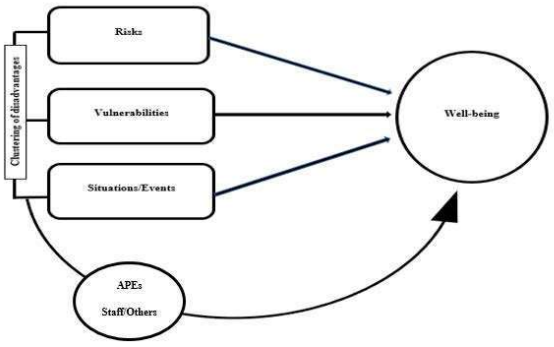

Figure 1. Authors' conceptual model of the relationship of clustered disadvantage; attitudes, perceptions, and expectations of staff/others; and well-being for persons seeking assistance through social service organizations.

It may be hypothesized that multiple disadvantages faced by persons entering care are further complicated by the APEs of workers. Although any factor of vulnerability or disadvantage may affect well-being, Wolff and de-Shalit (2007) argued that multiple factors often intersect with multiple vulnerabilities, clustering together and creating corrosive disadvantage that leads to persistent patterns and poor outcomes.

Although the definition of well-being is subjective, the Centers for Disease Control and Prevention (CDC, 2016) noted the role of relationships and social ties in the promotion of well-being. Health care professionals should interpersonally engage with clients to develop plans of care, adopting qualitative measures to assessment procedures and intentionally engaging with clients, establishing a personalized partnership of care. Engaging clients in the assessment process is not a substitute for documentation of standardized needs; rather, it provides an enhancement for evaluation, and an invitation for clients to engage in the reflection of the current situation(s) and action to address them, with the praxis of engagement serving as a catalyst for better outcomes.

Assessment as Praxis

Critical consciousness compels social workers and other helping professionals to see beyond answers obtained from standardized forms. Intentional engagement of those seeking services creates a space for holistic assessments, which engage clients in the assessment process, providing a path for workers to *do with*, rather than *do to*, minimizing oppression created by imbalances of power (Sakamoto & Pitner, 2005). Tylee and his colleagues (2012) described the importance of collaboration, between providers and patients, on positive outcomes for health and wellness.

C.A.R.E.

We propose the integration of a model of C.A.R.E. into the process of assessment, especially initial assessments. This model augments existing processes of assessment and utilizes relationships to enhance client well-being by "Connecting through", "*A*ctive engagement", "*R*elationship building", and "*E*mpathetic response". C.A.R.E. incorporates the process of *working with* clients to develop plans of care that best meet identified needs. C.A.R.E. establishes clients as their experts, and affirms the right to make the decisions that they determine are best. Establishing clients as their own best experts helps workers develop more accurate assessments through engagement practices, involving removing desks and other physical barriers during assessment. Additionally, the active incorporation of interpersonal skills, such as, addressing the client by name throughout the process of assessment; gathering information through open-ended questions and active listening (defined as summaries and reflections); appropriate use of affirmations, including maintaining a non-judgmental disposition, including the use of person-first language and avoiding pejoratives such as *habits*. Further, including the client in the development of goal setting, including the asking of *the miracle question*, incorporates a person-centered vision of the client's best self, in the best situation, at the best time.

Actively and authentically engaging clients takes time. Collaborative processes are more time intensive than standardized assessments; however, while the C.A.R.E. process would add time to initial assessments, the investment may provide a more accurate measure of where the client is, and where the client would like to be going. Such accuracy will help practitioners to be collaborative create interventions and responses that better address the needs of the clients and, more importantly, invite clients into a process that focuses on active engagement with the assessment process, creating a praxis of care, which builds on the capacity of all engaged stakeholders. The mediating influence of care upon well-being is depicted in *Figure 2*.

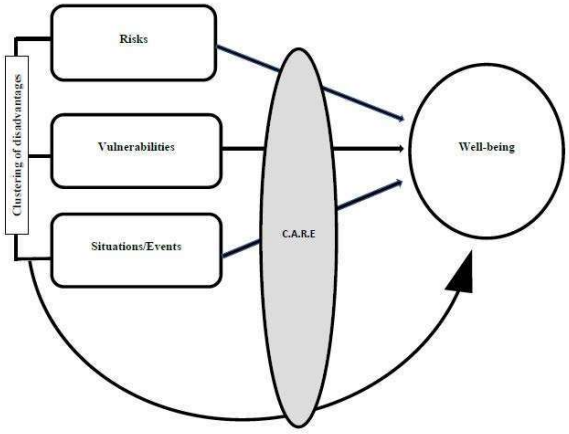

Figure 2. Authors' conceptual model of the relationship of clustered disadvantage; attitudes, perceptions, and expectations of staff/others; and well-being for persons seeking assistance through social service organizations, with C.A.R.E. as a moderating factor.

Conclusion

Evaluating the needs of new clients and residents is not intended to be a one-size-fits-all model of practice. Needs vary from person to person and place to place, as does the perception of well-being, defined as satisfaction regarding access and opportunities for mental, physical, and social health (Centers for Disease Control and Prevention, 2016). The C.A.R.E. model respects this variance and conforms to current recommendations of resident assessment as a personalized, evolving, and on-going process (Toney-Butler & Unison-Pace, 2019).

Care matters. It affects how we relate to others and how others relate to us. "Unequal" treatment is the manifestation of a lack of empathy, created through the process of *othering* those who are different. Incorporating C.A.R.E. will allow social workers and other health care workers to "approach questions of social reality and knowledge production from a more problematized vantage point, emphasizing the constructed nature of social reality" (Prasad, 2018, P.7) to assess: How is the client affected by the social environment? How can the client be supported? How can client well-being be enhanced? How can we recognize well-being for the client? How can we recognize what works for the client? How can we come to know how to do better? How can we move beyond the forms and make meaningful connections that not only identify the individual needs but the individual, as well? This study hopes to personalize care, by **C**onnecting through **A**ctive engagement, **R**elationship building, and **E**mpathetic response, with the ethical tenet of respecting the dignity and worth of the person as the core of C.A.R.E.

As Perlman (1979) reminded us:

> …our lifetime relationship experiences, especially those that drove deep into us at times of our helplessness, need, dependency upon the caring of others, condition us to want not only whatever material or psychological aid we need but also another human being to resonate to our distress. (p. 53)

Meeting people *where they are*, looking people in the eye, calling them by name, actively listening to their troubles and triumphs show people that they are not just cared *for*, but cared *about*, as well.

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Mostly White, Christian, and Straight: Informational and Institutional Erasure of LGBTQ and Ethnoculturally Diverse Older Adults on Long-Term Care Homes Websites

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Abstract

The website of a long-term care home is the face of the organization, providing not only a snapshot view of the home's programs and services but also an insight into the organization's vision, mission, policies, and culture. The website provides information—either purposefully or inadvertently—about the manner in which the organization responds to diversity among its residents. Guided by an intersectional analysis, this study uses content analysis to examine websites of long-term care homes run by companies, municipalities, and not-for-profit organizations in two provinces in Canada to understand how these websites demonstrate inclusion towards ethnoculturally diverse and LGBTQ older adults. Findings of the study indicate that these long-term care home websites showed very little inclusion of LGBTQ and ethnoculturally diverse older adults in the information provided on their website.

Keywords: Older adult, long-term care home (LTCH), website, race and racialization, LGBTQ, diversity, inclusion

Key Practitioners Message:

- *Practitioners in long-term care homes (LTCHs) need to engage in a process of reflection, organizational change, and training to improve inclusion and support of ethnoculturally diverse and LGBTQ older residents.*
- *There is a need to provide culturally and linguistically relevant services for diverse LTCH residents.*
- *Residents' councils should aim to include and represent the needs of diverse older adults.*
- *LTCHs need to evaluate the communication material on their websites to see if it adequately reflects the functioning of the home. Websites should reflect the inclusion of diverse older adult populations through attention to language, images, and messaging.*

There were almost six million older adults in Canada in 2016, and approximately 23 percent of Canadians are estimated to be over the age of 65 by 2031 (Grenier, 2017). These older adults are increasingly likely to be diverse due to their ethnicity, skin color, religion, language, or accent. This ethnocultural diversity brings a unique challenge to long-term care homes (LTCHs) in Canada (Sue Cragg Consulting and the CLRI Program, 2017a, 2017b). Older adults are also likely to be diverse on the basis of their sexual orientation and gender identity. Canadian laws that recognize same-sex relationships and gender nonconformity may make it likely that aging adults are more open

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about their sexual orientation, gender identity, and relationship status than ever before. Yet research has shown that LGBTQ[1] older adults can fear the treatment they will receive as they age and enter long-term care; they may feel forced to go back into the closet out of concern for experiencing homo-bi-transphobia (Brotman, Ryan, Collins, et al., 2007; Wilson, Kortes-Miller, & Stinchcombe, 2018). Past research has observed the importance of seniors' services recognizing ethnocultural diversity (Koehn, Mahmood, et al., 2016; Laher, 2017; Um, 2016) and LGBTQ populations (Wilson et al., 2018; Witten, 2014). However, the means and measure by which LTCHs have been able to adapt to this demographic shift so as to be inclusive of ethnoculturally diverse and LGBTQ populations have not been well studied.

Guided by the theory of intersectionality (Crenshaw, 1991), the researchers use content analysis to explore the websites of LTCHs in two provinces in Canada in order to understand how these websites demonstrate the inclusion of ethnoculturally diverse and LGBTQ older adults. While past research points to the need for LTCHs to be more inclusive, no existing study provides empirical evidence for this need. This study fills that gap. It is important to know how responsive LTCHs are to differences in race/ethnicity, sexual orientation, and gender identity.

Ontario is one of the most diverse provinces in Canada. In Newfoundland and Labrador, a strong push exists to welcome new immigrants and refugees to help build the economic infrastructure of the province. However, this effort has been plagued by the exodus of many immigrants and refugees from Newfoundland and Labrador for other provinces (Cooke, 2017).

This study will help to provide an understanding of how institutions in Newfoundland and Labrador can appear welcoming towards the diverse populations they are seeking to attract and retain. The website of an LTCH is an important tool by which the organization communicates with its viewers (Ingenhoff & Koelling, 2009). Such a tool offers not only a snapshot of the home's programs and services but also an insight into the organization's vision, mission, policies, and governance structure. A website also provides information—either purposefully or inadvertently—about how the organization responds to diversity among its residents.

This paper is divided into five sections. Following this introduction, the researchers review the literature to provide an overview of the LTCH system in Ontario and Newfoundland and Labrador, and of the unique needs of two diverse groups of older adults in relation to LTCHs—ethnoculturally diverse older adults and the LGBTQ older adult population. In the next section, the theoretical framework and methodology of the study are presented.

In the following two sections, the researchers delineate the findings of the study and discuss the implications of the findings for LTCH services with diverse older adults. The researchers conclude by making recommendations for LTCHs working with ethnoculturally diverse and LGBTQ older adults.

Literature Review

An overview of the LTCH system in Ontario and Newfoundland and Labrador

In Canada, LTCHs typically provide 24-hour nursing and dietary care, personal support, and social and recreational programming for high-needs older adults. In Ontario, 14 regional health care authorities, Local Health Integration Networks (LHINS), coordinate LTCHs and determine eligibility for admission to them. LTCHs in Ontario are run by companies, not-for-profit organizations, and municipalities.

The *Ontario Long-Term Care Homes Act, 2007,* guides and regulates LTCHs across Ontario. The Act is based on the principle that . . . a long-term care home is primarily the home of its residents and is to be operated so that it is a place where they may

1 The researchers use the common acronym LGBTQ to describe the lesbian, gay, bisexual, transgender, and queer populations encompassed within the term, while recognizing the heterogeneity within this population and their very diverse needs and experiences. LGB is used to refer to someone's sexual orientation, and the umbrella term transgender is used to refer to someone whose gender identity is opposite to their assigned sex at birth.

live with dignity and in security, safety and comfort and have their physical, psychological, social, spiritual and cultural needs adequately met (*Ontario Long-Term Care Homes Act, 2007*, Section 1). The Residents' Bill of Rights within the Act protects the residents' right to pursue their distinct social, cultural, and religious interests. The Act also mandates the establishment of a residents' council to advise residents of their rights and responsibilities and to provide input into the functioning of the home. In Newfoundland and Labrador, eligibility to LTCHs is determined by one of four Regional Health Authorities (Government of Newfoundland and Labrador, 2018). Operational standards describe the Newfoundland and Labrador government's commitment to provide older adults with "a high quality of holistic, resident-centered care in a homelike environment .. with emphasis on providing for the spiritual, psychosocial, cultural and physical needs of residents" (Government of Newfoundland and Labrador, 2005, p. 4). While these operational standards guide how LTCHs are run (Government of Newfoundland and Labrador, 2005), no law exists to regulate the homes (Barker, 2018).

In Ontario, older adults are allowed to select up to five homes into which they are willing to move once they have been deemed eligible for long-term care. Newfoundland and Labrador allows older adults to indicate their choice of home (Government of Newfoundland and Labrador, 2018). The information contained on the websites of these homes provides an important first impression for potential residents and their families. The inclusivity towards diverse communities shown on the LTCH website will go a long way in assuring older adults that the LTCH they are considering is a good fit for them.

Ethnoculturally Diverse Older Adults

Canada's population is becoming increasingly diverse in terms of ethnicity, race, language, and religion, largely due to changes in immigration policy over the past few decades (Satzewich & Liodakis, 2007; Statistics Canada, 2016). Linguistic diversity is also seen in the Aboriginal population; the 2016 Canadian census revealed that 228,770 Indigenous peoples spoke over 70 Aboriginal languages at home (Statistics Canada, 2017b).

Ethnic minority groups are likely to have faced many disadvantages over their lifetime in Canada. Research has identified the economic disadvantages experienced by ethnic minorities, including immigrants and Aboriginal persons (George, Chaze, Fuller-Thomson, & Brennenstuhl, 2012; Human Resources and Skills Development Canada [HRSDC], 2013). Immigrants' inability to communicate effectively in English or French has been associated with income disadvantages (Boyd & Cao, 2009), poorer health outcomes (Ng, Pottie, & Spitzer, 2011), and limited access to services (Guruge et al., 2009). Additionally, research with ethnic minority groups describes experiences of discrimination and racism in Canada (Currie, Wild, Schopflocher, & Laing, 2015). Ethnoculturally diverse older adults have been known to face barriers in accessing services in Western societies (Lai & Chau, 2007; Periyakoil, 2019; Liu, Cook & Cattan, 2017; Drummond, Mizan, Brocx & Wright, 2011).

Many factors, including systemic discrimination, contribute to immigrants underusing mental health services compared to native-born persons (Thomson, Chaze, George, & Guruge, 2015). Barriers to older immigrants accessing health services have been known to include cultural and language incompatibility between immigrants and health care providers; personal attitudes, such as discomfort with asking for help; and circumstantial challenges, such as not knowing about health services (Lai & Chau, 2007; Periyakoil, 2019). Aboriginal older adults are similarly disadvantaged in relation to health care services. A history of colonization and ongoing racism and discrimination make many Aboriginal peoples reluctant to trust Western medicine or mainstream programs (Sue Cragg Consulting and the CLRI Program, 2017b).

There is an urgent need to recognize the growing cultural diversity within the Canadian population and to examine its impacts on services for older adults (Laher, 2017). Many LTCHs continue to be "run in accordance with Anglocentric norms and values" (Koehn, Baumbusch, et al., 2018, p.157)

that are reflected in food choices, decor, staff, and recreational programming. These norms and values can be alienating and isolating for ethnocultural minority older adults. Koehn, Mahmood, and Stott-Eveneshen (2016) suggested that most LTCHs are not equipped to meet the needs of racialized, non-English speaking immigrants.

LGBTQ Older Adults

Although Canada has progressive legislation that protects the LGBTQ community from discrimination, that population continues to experience discrimination and health disparities due to their sexual orientation or gender identity (Sinding, Barnoff, McGillicuddy, Grassau, & Odette, 2010; Steelman, 2018). A majority of LGBTQ older adults have been victimized due to sexual orientation or gender identity at least once in their lives (CARP, 2015). This population continues to face many challenges in accessing health care at the end of life (Stinchcombe, Smallbone, Wilson & Kortes-Miller, 2017; Cartwright, Hughes, Lienert, 2012), and research has noted the lack of accessible care for LGBTQ older adults (Daley et al., 2017). Based on their past experiences in health care and social service settings, LGBTQ older adults fear discrimination (Knochel, Quam, & Croghan, 2011). They may be apprehensive about having to seek out services from homo-bi-transphobic service providers (Stinchcombe, Kortes-Miller, & Wilson, 2016).

LGBTQ older adults may withhold "coming out" and identifying as gay or trans in professional environments due to fear of discrimination and mistreatment on account of homo-bi-transphobia in the LTCH setting (Brotman, Ryan, & Cormier, 2003; Furlotte, Gladstone, Cosby, & Fitzgerald, 2016; Ottawa Senior Pride Network, 2015; Steelman, 2018; Wilson et al., 2018; Serafin, Smith, & Keltz, 2013).

LGBTQ older adults face unique challenges in relation to long-term care. Such adults are more likely to be living alone or estranged from their families prior to admission into the LTCH. This situation might make them more vulnerable to premature institutionalization (Maddux, 2010). The sexual and intimacy needs of older LGBTQ adults may be overlooked in LTCHs because of dominant heteronormative and cisgendered assumptions and practices (Stinchcombe, Smallbone, et al., 2017).

Fearing discrimination from staff, LGBTQ older adults may choose not to disclose their sexuality or gender identity, which might be a barrier to receiving proper care. This strategy of nondisclosure, however, may not be possible to maintain as the person ages and requires increased health care. Transpersons, whose gender expression may not align with their sex, may be inadvertently outed in LTCH settings (Sussman et al., 2018); they may be victims of ridicule or hostility by staff and residents (Brotman et al., in Daley et al., 2017), which would increase the risk of alienation and discrimination. Sexual orientation and gender identity are important aspects of social identity for LGBTQ older adults (Wilson et al., 2018). Recognizing LGBTQ older adults' sexual orientation and gender identity can help them feel validated and accepted (Steelman, 2018). Consequently, LTCHs and their websites displaying inclusiveness towards LGBTQ older adults are crucial.

This research reviewed literature focused on the unique needs and vulnerabilities of ethnoculturally diverse and LGBTQ older adults. However, very little empirical research existed on older adults for whom these identities overlap.

Theoretical Framework and Methodology

Intersectionality

This study is guided by the theory of intersectionality (Crenshaw, 1991), which recognizes the unique vulnerability of people caught at the intersection(s) of more than one identity marker such as race, class, gender, and ability. According to this theory, oppressions are overlapping, interconnected, simultaneous, and multiple. It is important for researchers to focus not only on one aspect of identity and its associated vulnerabilities but also on the points where multiple identity markers intersect, as those are spaces where the individual becomes even more vulnerable. Intersectionality

asks us to consider how different components of identity such as gender, age, class, and race intersect to create unique challenges and vulnerabilities for people.

By their very nature, LTCHs are geared towards the needs of the older population with diminished physical and mental ability, a majority of whom are women (Hudon & Milan, 2016). Women constitute up to two-thirds of the residential care population, and almost three-quarters of residents who are 85 years or older (Jansen & Murphy, 2009). Nine out of ten residents in LTCHs have a form of cognitive impairment, and residents require care and support with activities of daily living; these factors, therefore, place a higher demand for staff members and specialized care for more people with complex health needs (Ontario Long-Term Care Association, 2018).

This study focuses on intersecting diversity markers other than gender and ability, such as ethnicity and culture, and sexual orientation and gender identity, since these are underexplored yet crucial identity categories that intersect with age to create unique vulnerabilities. Focusing on these underrepresented groups could help LTCHs avoid creating experiences of "social invisibility" (Purdie-Vaughns & Eibach, 2008, p. 380) for these residents. Consequently, the current study is unique in its aim of understanding how LTCHs demonstrate on their websites diversity and inclusion of LGBTQ and ethnoculturally diverse older adults. The question that guided this exploratory study was: How inclusive of LGBTQ and ethnoculturally diverse older adults are LTCHs websites in Ontario and Newfoundland and Labrador?

The website of an organization is a window into the organization, and a content analysis of LTCH websites was considered a suitable technique for finding answers to the research question. Content analysis is a nonreactive technique that uses structured observation to gather and analyze text (words, images, symbols, or messages). Content analysis is useful "to reveal messages in a text that can be difficult to see with casual observation" (Newman & Robson, 2009, p. 208).

Method

The researchers began by creating a comprehensive list of all LTCHs in Ontario and Newfoundland and Labrador. For the province of Ontario, they identified 621 such facilities through the information provided on the LHIN subregion websites. The researchers drew their sample from three diverse pools: LTCHs run by large companies, municipalities, and other randomly selected LTCHs (which included LTCHs run by smaller companies, religious organizations, and not-for-profits). From the list of 621 homes, the researchers identified and selected large companies that ran over 10 LTCHs each in Ontario. They found eight such large companies in Ontario. Together, these companies ran between 15 to 48 LTCHs each, representing a total of 208 LTCHs in Ontario.

The researchers also identified and selected for review LTCHs run by 40 municipalities in Ontario. This selection was made by identifying LTCHs with the municipality name in its web address. One municipality LTCH website was under construction for a continued period of time, so it was removed from the sample. While websites for smaller companies and not-for-profit organizations may showcase their individuality, websites of homes run by larger companies or municipalities have messaging that is often standardized for all the homes under their jurisdiction. When a municipality had more than one home, the researchers looked for any variation between those homes in relation to the dimensions that were being explored. For the most part, almost no differences in terms of inclusion of diversity were found on the websites of the different homes run by municipalities. When differences were found, they were noted. Although the research focused on one LTCH in each municipality, this LTCH often, therefore, represented all the other homes in the same municipality. The one exception was a municipality referred to as Municipality A in this study. While this municipality had some common elements that ran through all its ten homes, there were significant differences in the way the websites of these homes demonstrated inclusion of LGBTQ and ethnoculturally diverse older adults. Municipality A stood out as an outlier in terms of its inclusion of LGBTQ and ethnocul-

turally diverse older adults. For this reason, Municipality A and its 10 LTCHs have been discussed separately from the other 38 municipality homes. The researchers also selected ten additional LTCHs in Ontario, hereafter referred to as Randomly Selected Long-Term Care Homes (RSLTCHs), which did not belong to either big companies or municipalities using a random number generator. This selection was made in order to capture the diversity of services within the LTCH, which were not run by either municipalities or large companies.

To identify homes in Newfoundland and Labrador, the researchers started from a list of LTCHs provided by the Government of Newfoundland and Labrador. According to this list, the 37 LTCHs in Newfoundland and Labrador were organized under four different regional health authorities: Eastern, Western, Central, and Labrador-Grenfell. As this pool of LTCHs was much smaller than what was found in Ontario, all 37 LTCHs were included in the sample. The final sample for this study comprises 103 LTCH websites (66 LTCH websites in Ontario and another 37 websites in Newfoundland and Labrador).

A coding sheet was created based on one used by the first two authors in a previous content analysis study (Giwa & Chaze, 2018). The coding sheet for the current study was modified and pilot tested based on a few LTCH websites. The researchers each independently coded information from three websites from the list of LTCHs to compare their coding. Coding categories were finalized based on this exercise (see Table 1 for a template of the individual coding sheet). The student researcher was provided training on coding the website data. All the LTCH websites were independently coded by at least two researchers to ensure interrater reliability.

Table 1: Individual LTCH Coding Sheet

Name of the LTCH: _____

LTCH type (Company/Municipality/Municipality A/RSLTCH/NL Home): _____	Yes/No	Elaboration/Explanations/ Examples
Website content in languages other than English and French		
LGBTQ friendly symbols		
Messaging that directly address LGBTQ persons		
Services specific for LGBTQ community		
Diversity/inclusion statement that recognizes differences in religion/race/ethnicity/culture/language		
Diversity/inclusion policy/mission/vision statement that specifically mentions LGBTQ + persons		
The website has images of ethnoculturally diverse people		
The website has images of LGBTQ + people? If yes, specify if they were White or racially diverse		
Was there specific heteronormative language used on the website		
The website has messaging (including activities/services/ symbols) that recognize and respect cultural differences		
The website mentions ways in which the residents can provide feedback/input into the functioning of the home		
Videos on the website represent diverse resident groups		
Other observations/comments:		

In completing the coding sheet, the researchers reviewed the programs, services offered, food menus, daily activities, and monthly/activity calendar available for each home. Additionally, information related to the vision and mission of the organization, its policies related to inclusion and diversity, and images and videos posted on the website were assessed. The home page "About" and "Services" sections on each website were examined thoroughly to capture words that conveyed the vision/mission of the organization. The words LGBTQ were added in the search tab of each website to look for material that might have been otherwise missed in a search of webpages.

Table 2: Overview of Findings

	Large company homes (n=8)	Municipal homes (n=38)	Municipality A homes (n=10)	RSLTCHs (n=10)	NL homes (n=37)	Total number (n=103)	Total (%)
Website provided the option for languages other than English and French	1	12	10	2	0	25	24.27%
Images of inclusion of LGBTQ populations by symbols	1	0	0	0	0	1	0.97%
Images of LGBTQ populations	0	0	0	0	0	0	0.00%
Images of ethnoculturally diverse residents	5	3	4	1	0	13	12.62%
Video of ethnoculturally diverse persons	1	2	3	1	0	7	6.79%
Messaging for LGBTQ persons	0	0	3	0	0	3	2.91%
Recognizing diversity	4	15	5	5	3	32	31.06%
Services that reflect underlying values of heteronormativity and gender binaries	1	13	0	0	0	14	13.59%
Mechanism for resident and family feedback	3	29	3	5	8	48	46.60%
Services for ethnoculturally diverse residents	1	8	5	3	2	19	18.45%
Services for LGBTQ residents	0	0	2	0	0	2	1.94%

Results

Website Languages

As can be seen in Table 2, 24.27% (n = 25) of all homes provided the option to view website content in languages other than French or English. Only one company provided the option to view the website content in a language other than English. 31.57% (n = 12) of municipal websites (n = 12), 100 percent (n = 10) of Municipality A's LTCH

websites, and 20% (n = 2) of RSLTCHs provided the option of translating the website content into multiple languages. Five municipal homes provided the option to view the website information in French or English. Two RSLTCHs provided the option of viewing the content in English and one other ethnic language. All LTCHs in Newfoundland and Labrador had the option to view the website information only in English.

Images of Inclusion of LGBTQ Populations by Symbols

The researchers looked for images of symbols that represented the inclusion of the LGBTQ population, such as a pink triangle or a positive-space sign. 99.23% (n = 102) of the LTCHs did not display such images. The only LGBTQ positive image found was on the website of one company. Here a resident was wearing a multicolored lei in support of an LGBTQ community parade.

Images of Diverse Populations

The researchers also looked for images that represented residents of diverse backgrounds. No images that depicted LGBTQ residents (for example, two older adults of the same sex holding hands, hugging, or kissing) were found on any of the 103 websites.

Only 12.62% (n = 13) of all websites provided images of ethnoculturally diverse residents. The websites that provided such images included five company websites, one RSLTCH website, four LTCH websites in Municipality A, and three other municipal websites. Of the three municipal websites, one municipality had images of ethnoculturally diverse persons in three out of five of its LTCH videos. In Newfoundland and Labrador, only one image was found that represented diverse residents indirectly, in an image that showed hands of different skin colors layered together.

On some websites, ethnoculturally diverse staff were the only visible people of color. This was the case in three companies, three municipalities, and five of the RSLTCHs. No staff of color were visible on the Newfoundland and Labrador LTCH websites. When videos of the homes were available, the researchers looked to see if they featured residents and whether those residents represented diverse groups. Only one of the eight company websites had video footage that included one or more ethnoculturally diverse residents. Another home had video images only of an ethnoculturally diverse staff. Only two municipal homes and one RSLTCH featured ethnoculturally diverse residents in their videos. One other municipal home featured only ethnoculturally diverse staff. Three LTCH websites in Municipality A featured ethnoculturally diverse residents.

Images of Inclusion of Ethnoculturally Diverse Populations by Symbols

One of the LTCH websites in Municipality A had images of Chinese wall-hangings and decorations in the lounge area. Another home in the same municipality had Chinese television programming in the background, possibly indicating the presence of Chinese-origin residents.

Messaging Addressing LGBTQ Persons

No messages that directly addressed LGBTQ persons were found on the websites of company homes, municipal homes, RSLTCHs, or homes in Newfoundland and Labrador. Three of the 10 LTCHs in Municipality A were exceptions. One home described itself as a "lesbian, gay, bi and transgender (LGBT) friendly home accepting all residents regardless of religion, language, and cultural, ethnic background." Another home described itself as a leader in the "City's creation of inclusive and affirming long-term care and services for lesbian, gay, bisexual, trans, queer and two-spirit persons." A third home mentioned supporting "a welcoming LGBT environment" in partnership with local organizations serving the LGBTQ community.

Messaging recognizing Diversity

Of the 103 LTCH websites, 31.06% (n = 32) recognized the diversity of residents in their homes. Fifty percent of the company websites (n = 4) acknowledged diversity among their residents and used words such as "honor," "recognize," "value," and

"respect" to describe the LTCH's approach towards diversity. One home mentioned that residents could "form friendships and enjoy relationships with persons of one's choosing." The same home spoke of providing care "without discrimination." Diversity and individuality were spoken about in very generic terms by these four organizations. No mention was made of the specific diversities that the LTCHs were recognizing or appreciating. Fifteen of the 38 municipal homes stated they acknowledged, recognized, or valued the diversity of their residents. Of these, seven homes specifically mentioned cultural/ethnic/language diversity in residents and staff and spoke of their LTCH meeting such needs.

One of the municipal homes mentioned encouraging residents to "maintain their unique identities and lifestyles." Three of these LTCHs used rights-based terminology in reference to diversity, such as working in an environment that was "free from discrimination" and being "committed to upholding the rights for all residents." One of these municipal homes talked about how all residents had a "right to be treated with respect and courtesy" and that they lived this value by "providing education for all, acknowledging individuals needs and embracing differences." None of the 38 municipal homes acknowledged diversity in terms of sexual orientation or gender identity.

Fifty percent of RSLTCHs (n = 5) acknowledged residents' cultural diversity. Two homes mentioned meeting the needs of one specific ethnic group while acknowledging the needs of other diverse ethnic groups. A third home met the needs of only one specific ethnic group. Three LTCH websites in Newfoundland and Labrador acknowledged diversity among its residents. One home mentioned "embracing diversity and multiculturalism," while two other homes talked about how service in the LTCHs "reflects the diverse physical, cultural, social, emotional, spiritual, recreational, and economic needs of the residents." Two other homes specifically discussed providing care according to Christian values, ethics, and principles.

Municipality A highlighted its commitment to diversity in numerous ways. The website mentioned a five-year LTCH service plan that was aligned with the service principles of "equity, respect, inclusion, and quality of life" as specified in the Municipality's senior strategy. The plan promised service provision that was respectful of cultural and sexual diversity. The plan further delineated steps that LTCHs would take to provide residents with opportunities to observe their own religious and spiritual beliefs.

Three individual LTCHs on Municipality A's website displayed their own messages of inclusion. One stated that they were a "lesbian, gay, bi, and transgender (LGBT) friendly home accepting all residents regardless of religion, language, and cultural, ethnic background."

A second website mentioned that their LTCH strove to

> encourage residents to be themselves, take pride in who they are, and enjoy life in an open, dignified, [and] respectful place. The home believes that everyone has the right to quality care that respects their culture, ethnoracial background, family tradition, community, language, all sexual orientations and gender identities, spiritual beliefs and traditions.

A third home stated that it worked in partnership with a prominent organization that worked for the LGBT community to "support a welcoming LGBT environment." Fifty percent of the LTCHs (n = 5) in Municipality A mentioned specific ethnocultural groups to which they catered either by naming the communities (French, Ismaili, Chinese, Jewish, Korean, Japanese-Canadian, Armenian, and Tamil) or by saying their LTCH had a "multicultural population with residents from 12 countries speaking 14 different languages."

Services That Reflect Underlying Values of Heteronormativity and Gender Binaries

13.59% (n = 14) of all websites mentioned services that reflected the underlying values of heteronormativity or gender binaries. The expectation of residents being either only male or female was most visible in the calendar of events and recreational programs offered by the LTCHs. Ten municipal homes had services such as "Men's

Club," "Women's Club," "Ladies' Auxiliary Yard & Bake Sale," "Men's Program," "Women's Devotional Hour," "Men's Recreational Group," "Men's Group," "Men's Coffee," and "It's a Guy Thing." Gender binary language was found in one RSLTCH and two municipal homes. One company website mentioned that they try to "bring people of the same gender with lots in common together, so that you and your new friend can enjoy your time here." One other municipal website had similar messaging. An assumption of asexuality or heterosexuality among older adults also seemed implied. Except for one image of a man and a woman sitting in the same private room that had two separate beds, the researchers did not find any images representing intimacy or sexuality among the older adults.

The Mechanism for Resident and Family Feedback

46.60% (n = 48) of all websites mentioned mechanisms by which residents could provide feedback into the running of the home. Two company websites mentioned having residents' councils and family councils. Another mentioned only residents' councils. LTCHs run by municipalities highlighted their family councils and residents' councils more prominently. Two municipal and company homes encouraged residents to talk to the staff. They also provided feedback mechanisms such as surveys for residents to provide comments to the staff. Forty percent (n = 4) of RSLTCHs mentioned both residents' and family councils, while one mentioned only a residents' council. 21.62% (n = 8) of LTCHs in Newfoundland and Labrador mentioned residents' and family councils. Two of Municipality A's LTCH websites mentioned residents' councils and family councils. One of these homes also elicited information by way of satisfaction surveys. A third home mentioned two residents' councils for two ethnic groups.

Services for Diverse Residents

18.45% of all websites (n = 19) reviewed mentioned services that kept in mind ethnoculturally diverse older adults. Only one of the eight company websites mentioned services that accounted for the residents' ethnic diversity, including "community and cultural events" and "multifaith spiritual services." Eight municipal homes mentioned one or more services for diverse residents, which included celebrations of diverse cultural/religious events and multifaith spiritual services.

One municipality had two homes that offered French-language service. Another municipal home offered cultural and language-specific spiritual services. A third municipal home spoke of scheduling "menu theme days to acknowledge traditional holidays." A fourth municipal LTCH spoke of offering programs "to promote and fulfill the residents' intellectual and cultural needs."

Another LTCH mentioned that their calendar reflected "the diverse and changing interests and abilities of the residents as well as current cultural trends and community participation."

For the most part, spiritual services involved services related to the Christian faith. For example, 55.26% (n = 21) of municipal homes mentioned chapels, pastors, and church services on their websites. Two municipal LTCHs referred to multidenominational services, and one mentioned nondenominational services.

Thirty percent of the RSLTCHs (n = 3) mentioned services for multicultural populations. These included the following:

- A social worker that provided culturally sensitive support (one home)
- Multicultural events (two homes)
- Culturally and linguistically appropriate services (three homes)
- A food menu that was diverse and incorporated ethnic foods consistently (one home)
- Language-specific recreational and religious services for one ethnic community (one home)

Five percent of LTCHs in Newfoundland and Labrador (n = 2) mentioned services such as "multipurpose room for multi worship," "multifaith services," and menus that "suit all preferences and cultural needs." Like Ontario, Christian prayer

services seemed to be the norm. Pastoral or chapel services were mentioned by 45.94% (*n* = 17) of homes. When videos of the LTCHs showed rooms around the home and mentioned a chapel, the accompanying image was almost always of a room with a cross prominently displayed in it, indicating that Christianity was the dominant and normalized religion in the LTCHs.

In Municipality A, five LTCH websites listed specific services their homes provided for ethnocultural residents. These included the following:

- Providing activities and events and care in the language-specific environment (three homes)
- Involving volunteers and partnerships with local ethno-specific communities so that residents could continue their connections with their cultural community (three homes)
- Providing culturally appropriate meal choices (one home)
- Providing culturally appropriate services (one home)
- Providing ethno-specific cultural activities geared towards specific ethnic communities (one home)
- Involving the resident and "their family/friends in the care to ensure it is consistent and based on resident's values, beliefs, and wishes" (one home)

Only 1.94% (n = 2) of all websites mentioned services specifically for the LGBTQ community within the home. Both websites belonged to LTCHs in Municipality A. The home page of Municipality A's LTCHs stated: "lesbian, gay, bi, and transgender (LGBT) supports, community outreach and extensive volunteer programs are available in every home." However, this information was not available on the individual LTCH pages. One Municipality A home page mentioned "creating a welcoming community" for LGBTQ residents in partnership with two local organizations/networks. Another LTCH described how LGBTQ organizations and community members provided a "vital community link" for residents.

Discussion

Culture—including food, dress, customs, habits, and rituals—influences many aspects of people's lives. If older adults do not feel that their culture is supported or respected in the LTCH they are entering or the culture of the LTCH is very different from their own, these older adults are likely to experience social isolation, negative health consequences, spiritual isolation, and distress (Sue Cragg Consulting and the CLRI Program, 2017a). When services account for older adults' language and culture, positive impacts on their physical and mental health are known to occur (Um, 2016). Recognizing and supporting the cultural diversity of older adults would mean that LTCHs "seek input regarding their needs, concerns, practices and desires when designing ethnically appropriate programs and activities" (Sue Cragg Consulting and the CLRI Program, 2017a, p. 13). The researchers found in this exploratory study little recognition of support for cultural diversity on the websites of LTCHs reviewed in Ontario and Newfoundland and Labrador.

Only one-quarter of the 103 websites reviewed had options to view the website content in languages other than English or French. This situation is far from ideal given the increasing ethnic diversity of Canada, where 7.3 million people speak a mother tongue other than English or French (Statistics Canada, 2017b). Older adults entering LTCHs are at one of the most vulnerable periods in their lives. Language incompatibilities have been identified as a barrier in service utilization (Lai & Chau, 2007). Ethnoculturally diverse older adults need the information to decide on the homes where they will be spending the rest of their lives, and it is imperative that they have equal access to information in languages with which they are most familiar.

In a recent study on the perceptions of LGBTQ older adults entering long-term care (Kortes-Miller, Boule, Wilson, & Stinchcombe, 2018), participants shared their observations about heterosexist assumptions and their perception of being invisible in LTCHs. The current study found evidence of such invisibility, with no images of

older adults from the LGBTQ community on any of the websites. This lack of visibility of any physical signs of inclusion from 102 out of the 103 homes, including those in Municipality A having clearly articulated policies related to the inclusion of LGBTQ older adults, is problematic. LTCHs without appropriate staff training and organizational orientation inclusive of LGBTQ persons are not advised to display images that would suggest otherwise (Giwa & Chaze, 2018). However, organizations that do support LGBTQ older adults need to consider such imagery as they come at an almost negligible cost to the organization and communicate important indications of support for this group. The lack of inclusion and representation of older LGBTQ adults can be described as covert or elusive discrimination (Furlotte et al., 2016).

Except for one image of a man and a woman sitting in the same private room that had two separate beds, the study did not find any images that represented intimacy among the older adults. Older adults are often desexualized in general, and LTCHs have struggled with dealing with sexuality among their residents. This discomfort can become amplified when the older adults expressing their sexuality are not heterosexual. The lack of representation of such intimacy is possibly a way of adhering to the sensitivities of the residents. Yet heterosexual intimacy is often depicted in public imagery in Canada, and the absence of imagery depicting intimacy in LTCHs is more likely an outcome of the intersection of ageism and heterosexism.

Given the growing diversity of Canada, there is a need to consciously include images that visually represent the diversity of residents to create a more welcoming and inclusive environment. The images of residents shown on LTCH websites were overwhelmingly of White older adults. None of the 103 homes had any visual representation of Aboriginal people or symbols representing these cultures; this factor is problematic considering that Aboriginal people comprise 4.9% of the Canadian population (Statistics Canada, 2017a) and their history of forced assimilation in Canadian culture (Sue Cragg Consulting and the CLRI Program, 2017b). Viewing websites with little or no representation of people of color is likely to be alienating for ethnoculturally diverse older adults who are increasingly expected to be the resident population of these LTCHs in the very near future.

While a fair number of LTCHs had messaging that acknowledged the diversity of their residents in some form, only 18.45% (n = 19) percent of the websites reviewed translated written recognition of diversity into services of some kind. When provided, services that kept in mind diverse residents mostly included celebrations of events or provisions of multifaith spiritual services. Koehn and her colleagues (2018) have discussed the alienation and isolation that ethnocultural minority groups can encounter when they live in homes that are run in accordance with dominant Anglocentric norms and values.

For the most part, information available on the websites of LTCHs reviewed in this study suggested that the homes seemed to provide primarily Christian spiritual services. Older adults of other faiths or those with negative experiences with Christianity may feel marginalized or uncomfortable by this. In a study by Kortes-Miller and her colleagues. (2018), LGBTQ older participants shared how visual religious symbols like crucifixes on the walls of LTCHs made some participants feel uncomfortable and insecure. Older adults of faiths other than Christianity may experience "spiritual isolation" (Sue Cragg Consulting and the CLRI Program, 2017b, p. 3); they may feel invisible or feel the need to hide their faith in order to assimilate with other residents of exclusively Christian spiritual practices. These messages can also be re-victimizing for older adults who might have experienced faith- and race-based discrimination in their lifetime.

Providing services in their own language (Montayre, Montayre & Thaggard, 2018), familiar foods and appropriate programs are important for older adults, particularly for those with dementia (Sue Cragg Consulting and the CLRI Program, 2017a; 2017b). A minuscule number of the homes in this study provided menu choices or programming

that reflected the diversity of their residents. The menus reviewed displayed a noticeable lack of diversity in food choices.

While they often offered a choice of two meal options, very few menus offered ethnic foods or considered a vegetarian meal choice consistently for each meal. The need for linguistically accessible services for ethno-specific populations has been reiterated in the literature (Guruge et al., 2009; Koehn, Baumbusch, et al., 2018). Only nine LTCHs provided services in languages other than English. As Laher (2017) noted, linguistic barriers may make communication with LTCH staff difficult for these older adults.

Only two homes in the study sample mentioned services that catered to LGBTQ residents. In both cases, the services involved collaborating with local LGBTQ-specific organizations. No details were available about what these collaborations would provide the older adult. LTCH websites need to have more details of specific services available to support older adults from the LGBTQ community. Such details would allow older adults and their families to understand exactly how potential residents would be supported, understood, and respected. Past research indicates that LGBTQ older adults worry about discrimination and mistreatment in LTCHs (Brotman, Ryan & Cormier, 2003; Wilson et al., 2018; Ottawa Senior Pride Network, 2015). Being explicit about services that LTCHs provide for LGBTQ individuals can provide recognition of their sexual orientation and gender identity, which can make them feel validated and accepted (Steelman, 2018). 13.59% (n = 14) of all the homes sampled had services that reflected the underlying values of heteronormativity and gender binaries. With one exception, all these homes were in municipalities in Ontario. This was disturbing, given the values and protections promised by the Ontario Human Rights Commission on the grounds of sexual orientation and gender identity.

The *Ontario Long-Term Care Homes Act* mandates LTCHs to have residents' councils and allows for family councils. In Newfoundland and Labrador, the rights of residents to participate in decisions affecting them are acknowledged as a standard of care for LTCHs. Not surprisingly, 60.61% (n = 40) of LTCHs in Ontario and 21.62% (n = 8) of LTCHs in Newfoundland and Labrador mentioned mechanisms for resident and family feedback. Since resident involvement can be empowering to older adults in LTCHs, this effort is promising, though not ideal (Boelsma, Baur, Woelder, & Abma, 2014). This kind of involvement makes it possible for residents to propose changes to the functioning of the home more in keeping with their individual preferences or lifestyles. However, cognitive and language limitations may limit the diversity of residents who participate in these councils (Koehn, Baumbusch, et al., 2018). Additionally, residents' councils are often chaired by a staff member or a director of care, which may increase the likelihood that residents feel a power imbalance when raising issues in these forums.

Conclusion

There are limitations to this study. The first relates to the kind of data that can be generated by content analysis. It is possible that the websites reviewed do not adequately reflect the functioning of the home in reality. Research by Sussman and her colleagues (2018) has shown that anticipated negative resident/family reactions can play a role in the visibility of an LTCH in its inclusivity practices. The content analysis does not allow for such verification of accuracy. Dominant power dynamics in society are reinforced when LTCH websites reflect mostly White, Christian, and heterosexual identities. This sends a message to minority groups (i.e., LGBTQ and ethnoculturally diverse older adults) that they would need to assimilate into the dominant values of the LTCH in order to fit in.

LTCHs need to engage in a process of organizational change to serve LGBTQ and ethnoculturally diverse communities better. As institutions crucial to the care of vulnerable older adults, LTCHs need to reflect the values of Canada as a country that prides itself on being multicultural.

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Vision and Mission

The major goal of the ***Journal of Aging and Long-Term Care (JALTC)*** is to advance the scholarly contributions that address the theoretical, clinical and practical issues related to aging and long-term care. The ***JALTC***, while making efforts to create care services for older people at the best quality available that are more humane, that pay special attention to people's dignity, aims from the perspective of the whole aging process- to discuss Social Care Insurance as a human right, to contribute care for older people to be transformed into an interdisciplinary field, to integrate care services for older people and gerontological concepts and to create more effective collaboration between them, to enhance the quality of care services for older people and the quality of life of caregivers from medical, psychological and sociological perspectives, to highlight the cultural factors in care for older people, to increase the potential of formal and informal care services, to provide wide and reachable gerontological education and training opportunities for caregivers, families and the older people.

Aims and Scope

"National Association of Social and Applied Gerontology (NASAG)"has recently assumed responsibility for the planning and introduction of a new international journal, namely, the **Journal of Aging and Long-Term Care (JALTC)**. With world societies facing rapid increases in their respective older populations, there is a need for new 21st century visions, practices, cultural sensitivities and evidenced-based policies that assist in balancing the tensions between informal and formal long-term care support and services as well as examining topics about aging.

The **JALTC** is being launched as the official journal of the **NASAG**. The preceding journal aims to foster new scholarship contributions that address theoretical, clinical and practical issues related to aging and long-term care. It is intended that the **JALTC** will be the first and foremost a multidisciplinary and interdisciplinary journal seeking to use research to build quality-based public policies for long-term health care for older people.

It is accepted that aging and long-term care is open to a diverse range of interpretations which in turn creates a differential set of implications for research, policy, and practice. As a consequence, the focus of the journal will be to include the full gamut of health, family, and social services that are available in the home and the wider community to assist those older people who have or are losing the capacity to fully care for themselves. The adoption of a broader view of aging and long-term care allows for a continuum of care support and service systems that include home base family and nursing care, respite day care centers, hospital and hospice care, residential care, and rehabilitation services. It is also crucial to be aware that life circumstances can change suddenly and dramatically resulting in the need for transitional care arrangements requiring responsive, available, accessible, affordable and flexible health care service provision.

For further assistance and more detailed information about the JALTC and the publishing process, please do not hesitate to contact Editor-in-Chief of the JALTC via sending an e-mail: editor-in-chief@jaltc.net
Editor-in-Chief: Emre SENOL-DURAK

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