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# **Using the Community Readiness Model to Guide Services for LGBT Elders**

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## **Setting the Stage: Our Community**

Today there is an estimated 1 to 3 million lesbian, gay, bisexual, and transgendered (LGBT) individuals over the age of 65 in America (National Gay and Lesbian Task Force, 2000). This number is expected to reach 4 million by the year 2030 (National Gay

and Lesbian Task Force) and it seems that our social institutions might be ill-prepared to provide the necessary services to this aging population. Many of these elders spent their young adulthood prior to the Stonewall years and carry with them internalized shame and fear because during their formative years homosexuality was highly criminalized, pathologized, and stigmatized (Hollibaugh, 2004). Because of these factors LGBT elders are much less likely than their heterosexual peers to have the self-advocacy skills necessary for successfully navigating the system as an aging adult.

In addition, LGBT elders are also less likely to have others available to assist in advocacy because of diminished social networks (Brookdale Center on Aging and SAGE, 1999). Lesbian, gay, and bisexual elders are twice as likely to face aging as a single person, four and one half times more likely to have no children to call upon in a time of need, and are two and one half times more likely to live alone than are their heterosexual peers (Hollibaugh). This lack of formal and informal social support leads to a myriad of problems for these elders including depression, substance abuse, unnecessary institutionalization, and premature death (Hollibaugh). This disconnection from a social network introduces a conundrum where LGBT elders are forced to rely more heavily on historically heterosexual institutions; those institutions that they fear because of discrimination and bias (National Gay and Lesbian Task Force).

Gay and lesbian elders are five times less likely to access services than their heterosexual peers (Hollibaugh, 2004; National Gay and Lesbian Task Force, 2000), albeit this underutilization of services is not likely to continue as the “Stonewall LGBT baby-boomer generation,” who have acquired significant advocacy skills, emerges (Hollibaugh). Even though the landscape of service access is changing, the needs of elders, including LGBT individuals, remain rather constant. The eight primary areas of need as identified by LGBT elders include 1) services to maintain physical and mental health, 2) economic and financial security, 3) legal and civil rights, 4) social and community involvement, 5) familial and partner support, 6) spiritual well-being, 7) support with care-giving, and 8) intervention when abused and neglected (Butler, 2004; Orel, 2004).

### **What We Know About Service Provision and Service Providers**

Current literature indicates that LGBT elders desire services to support them as they age and at the same time they fear the intolerance, ridicule, neglect, and sometimes even violence of the professionals and social institutions that provide those services (Boulder County Aging Services Division, 2004). Other barriers to service access include institutionalized heterosexism, oppressive legislation and public policy, and the residual effects of growing up in a “different social climate” (Butler, 2004).

The GLBT Health Access Project ([www.glbthealth.org](http://www.glbthealth.org)) outlines ten standards with corresponding indicators regarding appropriate health care services to LGBT individuals (Clark, Landers, Linde, & Sperber, 2001). In short, these standards are categorized into a)

personnel, b) clients' rights, c) intake and assessment, d) service planning and delivery, and e) confidentiality. According to the Boulder County Aging Services (2004), an organization can take solid steps towards meeting these standards by creating an inclusive infrastructure (policies), establishing a welcoming environment, developing effective communication skills, asking open-ended questions, and using gender-neutral language.

Institutions that serve the elderly historically have a one-dimensional view of older adults and aren't comfortable with client sexuality much less client sexual orientation (Boulder County Aging Services Division, 2004). Considering this and the social-political nature of the issue of sexual orientation, systemic change such as that indicated above might be very difficult. What we do know is that unless a community is aware of the issue or problem and "ready" for change, innovation will not be attainable and sustainable (Edwards, Jumper-Thurman, Plested, Oetting, & Swanson, 2000; Plested, Edwards, & Jumper-Thurman, 2006). The challenges that inhibit forward movement include the reality of institutional discrimination, the varied context of service providers, the diverse needs of the LGBT community being served, and the lack of formal structures for examining existent characteristics and implementing appropriate change strategies. Facilitating improvement of service provision to LGBT elders calls upon a sound theoretical model that has been used in a variety of applications and has been adequately tested.

### **The Community Readiness Model**

The Community Readiness Model (CRM), developed by the Tri-Ethnic Center for Prevention Research at Colorado State University, integrates an assessment of the community's culture and readiness for change as well as resources to more effectively implement change strategies (Edwards, Jumper-Thurman, Plested, Oetting, & Swanson, 2000; Plested, Edwards, & Jumper-Thurman, 2006). Considering the sensitive nature of service to and advocacy for lesbian, gay, bisexual, and transgendered individuals, it is particularly salient to utilize a model that explores and is sensitive to the readiness of the organization when trying to enhance such services. The CRM explores "readiness" within six dimensions: 1) Community Efforts, 2) Community Knowledge of the Efforts, 3) Leadership, 4) Community Climate, 5) Community Knowledge about the Issue, and 6) Resources Related to the Issue; as well as nine stages: 1) No Awareness, 2) Denial/Resistance, 3) Vague Awareness, 4) Preplanning, 5) Preparation, 6) Initiation, 7) Stabilization, 8) Confirmation/Expansion, and 9) High Level of Community Ownership (Plested, Edwards, & Jumper-Thurman, 2006, pp. 10-11).

The CRM utilizes seven steps in implementation: 1) Identify your issue, 2) Identify your "community", 3) Conduct a Community Readiness Assessment, 4) Analyze the results of the assessment, 5) Develop strategies to pursue that are stage-appropriate, 6) Evaluate the effectiveness of your effort, 7) Utilize what you have learned to apply the model to another issue (Plested, Edwards, & Jumper-Thurman, 2006). For the sake of demonstration, we are concerned with the provision of service to LGBT elders (the issue)

in a long-term care facility (the community). This statement encapsulates step 1 and step 2 of the model. Step 3 (the readiness assessment) needs further clarification.

The community readiness assessment tool is a 36 item structured interview with an anchored rating scale that is scored independently by two raters who then reference their individual scores to arrive at a consensus score for each item. The interview takes between 30 to 60 minutes to complete and participant responses are typically recorded in the moment through transcription. Since this protocol quantifies the content of responses and does not rely on “in vivo” quotes or rich narrative description like more traditional qualitative research, there is little need to actually audio tape participant responses. In addition, this protocol helps to limit recorder interpretation or elaboration (Plested, Edwards, & Jumper-Thurman, 2006). Interviewees should be chosen based upon their connection to the issue and should represent different segments of the community. Generally only four to six interviewees are necessary to accurately score the community readiness. The specific questions that have been constructed by the authors of the CRM are closely tied to the scoring process so applying them must be done carefully to retain the core meaning of the question (Plested, Edwards, & Jumper-Thurman, 2006). The interview questions as modified appropriately for the purposes of assessing readiness of a long-term care facility to meet the needs of the elderly LGBT population are attached as Appendix A.

Steps four and five of the process are also relevant to this manuscript and the presentation from which it is drawn, but steps six and seven are procedures that are rather self-explanatory and follow much later. Step four involves scoring and analyzing the interview responses. Ideally, at least two people should be involved in the scoring process to increase the validity of the results (Plested, Edwards, & Jumper-Thurman). The scoring of the interview follows an eight step process that includes 1) each scorer independently reading through each interview in its entirety before scoring any of the dimensions, 2) each scorer independently reads the anchored rating scale for the dimension being scored and highlights in each interview statements that refer to the anchored rating statements, 3) each scorer records his or her independent scores on the form for individual scores, 4) the two scorers discuss their independent scores and when consensus is reached they fill in the table for combined scores then add rows to yield a total for each dimension, 5) the team then determines the calculated score for each dimension and divides it by the number of interviews, 6) the team calculates the overall stage of readiness, 7) overall stage of readiness scores are rounded down, 8) finally, any impressions or comments are recorded. Specific details and forms regarding the scoring process are available in the CRM manual that can be downloaded for free from the Tri-Ethnic Center for Prevention Research at Colorado State University at [www.TriEthnicCenter.ColoState.edu](http://www.TriEthnicCenter.ColoState.edu) (Plested, Edwards, & Jumper-Thurman, 2006).

The final stage of the process that will be introduced in this manuscript is the development of strategies or interventions based upon the assessed community readiness level. The strategies as introduced in the CRM manual, and those articulated by the

researchers are not intended to be answers for the community, but examples of different approaches that might be used by that community to address the issue or need in question (Plested, Edwards, & Jumper-Thurman, 2006). When working with a community, be it a long-term care facility or a social service agency, it is important to be sensitive to the expressed concerns and needs of that organization. Even if the CRM assessment indicates that an organization is at a certain level of readiness, organizational representatives always have the ability to give input regarding the accuracy of the assessment results.

### **Conclusion**

Service provision to LGBT elders is a dynamic and sensitive area. Examining the readiness and resources of organizations serving such individuals requires not only heart and sensitivity, but also resources and a clear vision. The community readiness model as developed by the Tri-Ethnic Center at Colorado State University is one tool that can help service providers critically examine their practices and culture with the ultimate goal of enhancing service to LGBT elders.

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## Appendix A

### Interview Question Set: Items in bold are essential for scoring

#### A. COMMUNITY EFFORTS (Programs, Activities, Policies, etc.)

AND

#### B. COMMUNITY KNOWLEDGE OF EFFORTS.

First, how would you define LGBT (Lesbian, Gay, Bisexual, and Transgender) elders?

1. **Using a scale from 1 to 10, how much of a concern are the needs of LGBT elders in your long-term care facility community \*(community throughout this interview refers to residents, employees and stakeholders in the facility)? (with 1 being “not at all” and 10 being “a very great concern”) Please explain your answer. (D)** (NOTE: this figure between one and ten is NOT figured into your scoring of this dimension in any way – it is to only provide a reference point.)
2. **Please describe the efforts/activities that are available at your facility to address the needs of LGBT elders? (A)**
3. **How long have these efforts been going on in your facility? (A)**
4. Using a scale from 1-10, how aware are people in your community of these efforts (with 1 being “no awareness” and 10 being “very aware”)? Please explain. (B) (NOTE: this figure between one and ten is NOT figured into your scoring of this dimension in any way – it is only to provide a reference point.)
5. **What does the community know about these efforts/activities? (B)**
6. **What are the strengths of these efforts/activities? (B)**
7. **What are the weaknesses of these efforts/activities? (B)**
8. Who do these efforts/activities serve? (For instance: residents, families, administrators, employees, etc.) (A)
9. Would there be any segments of your community for which these efforts/activities

- may appear inaccessible? (A)
10. Is there a need to expand these programs/services? Why or why not? (A)
  11. Is there any planning for more efforts/activities, going on in your facility surrounding the needs of LGBT elders? If yes, please explain. (A)
  12. What formal or informal policies and practices related to LGBT elders are in place in your facility, and for how long? (PROMPT: An example of formal policy/practice would be a non-discrimination code in place that addresses LGBT, LGBT Safe Zone stickers on aides, nurses, and administrators office doors; and an example of informal policy would be a nurse not responding to hate speech regarding LGBT residents, etc.) (A)
  13. Are there segments of your community for which these policies and practices may not apply? (PROMPT: For example, ethnicity, age, being “out” etc...) (A)
  14. Is there a need to expand these policies and practices? If yes, are there plans to expand these policies and practices? Please explain. (A)
  15. How does your facility view these policies and practices? (A)

### C. LEADERSHIP

16. Who are the leaders specific to LGBT elders in your facility? (If different from the leaders mentioned above.)
17. **Using a scale from 1 to 10, how much of a concern is the issue of service provision to LGBT elders to the leadership in your facility community? Please explain. (with 1 being “not at all” and 10 being “of great concern”)? Please explain. (NOTE: this figure between one and ten is NOT figured into your scoring of this dimension in any way – it is only to provide a reference point.)**
18. **What “leaders” in your facility are involved in efforts regarding the needs of LGBT elders? Please list. How are these leaders involved? If involved in a committee, task force, club, etc., how often do they meet?**
19. **Would the leadership support additional efforts designed to meet the needs of LGBT elders in your facility community? Please explain.**

### D. COMMUNITY CLIMATE

20. Describe \_\_\_\_\_. (name of the facility)
21. Are there ever any circumstances in which members of your community might think that lack of service provision to LGBT elders should be tolerated? Please explain.
22. **How does your facility support the efforts addressing LGBT elders?**
23. **What are the primary obstacles to efforts addressing LGBT elder issues in your community?**
24. Based on the answers that you have provided so far, what do you think is the overall feeling among community members regarding LGBT elders?

## **E. KNOWLEDGE ABOUT THE ISSUE**

25. **In general, what does the facility community know about issues facing LGBT? (Prompt: For example, barriers to access of services, legal issues, medical concerns, family issues).**
26. **What type of information is available about LGBT elders at your facility?**
27. **Is local data available about LGBT elders in your facility?**
28. **How do people obtain this information in your facility?**

## **F. RESOURCES FOR PREVENTION EFFORTS**

29. **Who would a LGBT identified elder or ally first turn to for help in your facility? Why?**
30. **On a scale from 1-10, what is the level of expertise and training among those working to address LGBT issues in your facility (with 1 being “very low” and 10 being “very high”)? Please explain. (NOTE: this figure between one and ten is NOT figured into your scoring of this dimension in any way – it is only to provide a reference point.)**
31. **Do efforts that address issues related to LGBT elders have a broad base of volunteers?**
32. **Does local business and/or industry support the facility’s efforts with such things as time, money, and/or space for LGBT elders?**
33. **Are you aware of the funding sources for the current efforts that address LGBT elders in your facility? Please explain.**
34. **Are you aware of any proposals or action plans that have been submitted for funding that address the needs of LGBT elders in your facility community? If yes, explain.**
35. **Are you aware of any strategies to evaluate the efforts or policies that are in place? If yes, on a scale of 1 to 10, how sophisticated is the evaluation effort (with 1 being “not at all” and 10 being “very sophisticated”)? (NOTE: this figure between one and ten is NOT figured into your scoring of this dimension in any way – it is only to provide a reference point.)**
36. **Are the evaluation results being used to make changes in programs, activities, or policies or to start new ones?**

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## **VISTAS 2008 Online**

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