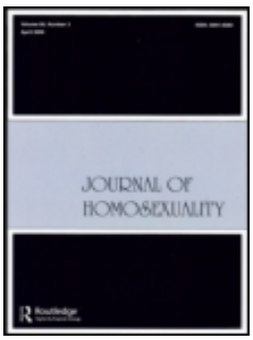

Routledge
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Journal of Homosexuality

ISSN: 0091-8369 (Print) 1540-3602 (Online) Journal homepage: https://www.tandfonline.com/loi/wjhm20

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To cite this article: Mark Brennan-Ing PhD , Liz Seidel MSW , Britta Larson MNA & Stephen E. Karpiak PhD (2014) Social Care Networks and Older LGBT Adults: Challenges for the Future, Journal of Homosexuality, 61:1, 21-52, DOI: 10.1080/00918369.2013.835235

To link to this article: https://doi.org/10.1080/00918369.2013.835235

Journal of Homosexuality, 61:21–52, 2014

ISSN: 0091-8369 print/1540-3602 online
DOI: 10.1080/00918369.2013.835235

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Social Care Networks and Older LGBT Adults: Challenges for the Future

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Research on service needs among older adults rarely addresses the special circumstances of lesbian, gay, bisexual, and transgender (LGBT) individuals, such as their reliance on friend-centered social networks or the experience of discrimination from service providers. Limited data suggests that older LGBT adults underutilize health and social services that are important in maintaining independence and quality of life. This study explored the social care networks of this population using a mixed-methods approach. Data were obtained from 210 LGBT older adults. The average age was 60 years, and 71% were men, 24% were women, and 5% were transgender or intersex. One-third was Black, and 62% were Caucasian. Quantitative assessments found high levels of morbidity and friend-centered support networks. Need for and use of services

We thank Betty Akins, Hope Barrett, Philonise Keithley, and Zach Zimmerman for their assistance in conducting the field effort for the study in Chicago. We also thank Sheila Massinde for her help with data preparation, cleaning, and data entry. Last, but not least, we are truly grateful to the over 200 lesbian, gay, bisexual, and transgender older adults who took the time to share their lives with us.

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was frequently reported. Content analysis revealed unmet needs for basic supports, including housing, economic supports, and help with entitlements. Limited opportunities for socialization were strongly expressed, particularly among older lesbians. Implications for senior programs and policies are discussed.

KEYWORDS caregiving, homosexual, LGBT, services, social support

Although the National Institutes of Health and the National Institute on Aging have identified the need to reduce health disparities in disadvantaged and minority populations, a dearth of knowledge on issues affecting lesbian, gay, bisexual, and transgender (LGBT) adults, and especially older adults, persists (Fredriksen-Goldsen, Kim, Emlet, Muraco, & Erosheva, 2011; Knochel, Quam, & Croghan, 2011). Recognizing this need to include older LGBT adults has begun to be directly addressed by the federal government. The Department of Health and Human Services (HHS) has recently partnered with SAGE (Services and Advocacy for GLBT Elders) to create the National Resource Center on LGBT Aging (SAGE, 2013a). In addition, the U.S. HHS Secretary announced that the agency will integrate questions on sexual orientation into data collection efforts by 2013 (U.S. HHS, 2011), building on the recommendations of the Institute of Medicine (IOM; 2011) report. Thus, there is a growing consensus that additional research is needed on LGBT older adults to better meet the needs of this population.

SOCIAL CARE NEEDS OF OLDER LGBT ADULTS

Given our existing albeit limited knowledge of LGBT aging, one area of concern is their ability to access adequate social care in as they age. As defined by Cantor and Brennan (2000), social care includes the broad-based system of informal social network resources (i.e., family and friends) and the network of community-based formal services (e.g., senior centers, home health care). The social care network is considered to be a vital component of helping people to age independently and maintain quality of life, and is the focus of this article on older LGBT adults.

The dynamics of the social care network are illustrated by the *Hierarchical Compensatory Theory* of social supports (Cantor & Mayer, 1978). This theory posits that when older people need assistance, they turn first to close family members such as spouses or children. If these individuals are not available, they will then turn to more distant relatives, then friends and neighbors, and, finally, to formal community-based supports in a hierarchical manner. Formal services are increasingly accessed when

informal caregivers are unable to meet the needs of the older adults (Cantor & Brennan, 2000). Support for the Hierarchical Compensatory Theory is evidenced in findings that older adults using formal services were more likely than their peers to live alone (i.e., not have a partner or spouse) and to be disadvantaged in health and economic resources (Cantor & Brennan, 1993). Other studies report that socially isolated older adults often use community-based supports, such as religious congregations for their needs, viewing them as "surrogate families" (Sheehan, Wilson, & Marella, 1988; Tirrito & Choi, 2005).

Research suggests that the LGBT population may have different health needs when compared with their heterosexual counterparts. Such differences can affect the social care needs of this population. For example, LGBT individuals report poorer health than the general population (Wallace, Cochran, Durazo, & Ford, 2011). Higher disability rates have also been reported, with one study reporting 47% of older LGBT adults having at least one disability (Fredriksen-Goldsen et al., 2011; Wallace et al., 2011). HIV infection is also a dominant health issue within the LGBT community. Data from the Centers for Disease Control and Prevention (CDC; 2010) show that 55% of all new HIV infections occur among men who have sex with men, and 17% occur among people age 50 and older. As a result of effective antiretroviral treatments, it is estimated that the majority of people living with HIV will be 50 and older by 2015 (Effros et al., 2008). Significantly, older adults with HIV are evidencing the early onset of age-related illnesses, such as cardiovascular disease and osteoporosis, that are typically associated with the very old (Havlik, Brennan, & Karpiak, 2011).

Older lesbians have higher rates of obesity compared to heterosexual women, which negatively affects their health by increasing the risk for condition such as diabetes, cardiac disease, and certain cancers (Fredriksen-Goldsen et al., 2011; IOM, 2011). The problem of obesity among African American lesbians is worse, and this condition is exacerbated among those who live in either urban or rural areas, and are of lower socioeconomic status (Substance Abuse and Mental Health Services Administration [SAMSA], 2012). Lower rates of pregnancy and underutilization of PAP smears and mammograms puts lesbians at higher risk for reproductive cancers (U.S. HHS, 2010; SAMSA, 2012). Care for lesbian and bisexual women is often compromised because they are reluctant to disclose their sexual identities to health care providers, fearing poor treatment or negative reactions (Stein & Bonuck, 2001).

According to the American Lung Association (2010), tobacco smokers are at greatest risk for lung cancer, and gay and bisexual men are more likely to smoke than their peers in the general population. Lesbians are more likely to smoke than heterosexual women. Among older LGBT adults, one study found a 50% lifetime smoking rate with 10% currently smoking (Fredriksen-Goldsen et al., 2011). Smoking tobacco accounts for the vast majority of

lung cancers (87%) and is linked to other serious conditions such as heart disease, stroke, and emphysema. Those living with HIV may be at further risk as research finds that HIV makes the lungs less able to recover from smoking damage. Given that smoking is commonplace in bars and clubs that are frequent social venues for older LGBT adults, exposure to secondhand smoke may also increase health risks in this population (American Lung Association, 2010).

Poor mental health has been identified as an issue in LGBT populations (IOM, 2011) and is also linked to poorer health outcomes (Havlik et al., 2011). Fredriksen-Goldsen et al. (2011) found that one-third of their participants met the clinical threshold for depression. In addition nearly 10% of older LGBT adults in this study used alcohol excessively and consumed drugs that were not prescribed to them. These high rates of morbidity and prevalence of mental health and substance use issues suggest that many LGBT adults will face health challenges as they age and will require assistance from their social care networks to maintain independence and a decent quality of life in the coming decades.

THE INFORMAL SOCIAL NETWORKS OF OLDER LGBT ADULTS

As aging LGBT adults increasingly require social care, their informal social networks are a cause for concern. Research finds that LGBT older adults typically do not have the robust informal social resources that characterize those from heterosexual communities. Among heterosexual older adults, it is the spouse and children who are the most likely to provide needed assistance and support (Cantor & Brennan, 2000). Among community-dwelling older adults, 43% report a spouse, whereas 77% have at least one living child (Cantor & Brennan, 1993). However, among older LGBT adults, approximately 40% have a partner or spouse, and only 20% to 25% report at least one living child (Cantor, Brennan, & Shippy, 2004; Fredriksen-Goldsen et al., 2011). Thus, the social networks of older LGBT adults are characterized by reliance on the "family of choice" comprising close friends and neighbors, in contrast to the biological family or "family of origin" that is the foundation for most heterosexual older adults (de Vries & Hoctel, 2007; Dorfman, Walters, Burke, Hardin, & Karanik, 1995; Grossman, D'Augelli, & Hershberger, 2000; Shippy, Cantor, & Brennan, 2004).

While the importance of friends in the lives of LGBT older adults is well documented, there may be limits in their ability to provide care to them over the long term, especially if decision making is required (Fredriksen-Goldsen et al., 2011). The absence of blood ties between friends who comprise the family of choice and the older LGBT adult can result in negative interactions with the biological family. In addition, the lack of legal recognition of

same-sex partners in most jurisdictions excludes these individuals from making caregiving decisions concerning their significant others (Cantor et al., 2004).

SERVICE UTILIZATION BY LGBT OLDER ADULTS

Given the limited social networks of older LGBT adults, many will need to rely on formal community-based supports to meet their needs as they grow older. LGBT adults, including older adults, face barriers when accessing care including assumption of heterosexuality, lack of same-sex partner recognition, and disparate treatment by providers manifested by discrimination springing from negative attitudes toward the LGBT population (Brotman, Ryan, & Cormier, 2003; Cantor et al., 2004; M. Hughes, 2007; Tan, 2005). Tjepkema (2008) found that such barriers result in reduced access to services and increased unmet needs. An IOM (2011) report concluded that LGBT adults face barriers due to a lack of culturally competent providers and fear of discrimination, both of which promote health disparities in this population. Fredriksen-Goldsen et al. (2011) found that over 10% of LGBT older adults reported receiving sub-par care or being denied care. Clover (2006), in a qualitative study of gay men between the ages of 60 and 70, found many hesitated to receive aging services because they anticipated being discriminated against and not receiving optimal care. Overt discrimination aside, research shows that many mental health, substance use, aging and health services organizations do not have enough information or training about LGBT individuals to serve them in a culturally competent manner (A. K. Hughes, Harold, & Boyer, 2011; Israel, Walther, Gortcheva, & Perry, 2011; Knochel et al., 2011).

PURPOSE AND RATIONALE

LGBT older adults face numerous challenges as they age, including high levels of physical and mental health morbidity, limited social networks that may be not be able to meet their needs, and continued barriers to service such as discrimination, heterosexist attitudes, and a lack of cultural competence on the part of providers. Many of these older adults will have a greater need to access formal community-based supports as they grow older. In 2010, the older adult program at the Center on Halsted (COH) in Chicago was awarded a generous grant from the Human Resources Services Administration to enhance the live of LGBT older adults. COH recognized that there was a dearth of research addressing the needs of older adults that would be useful for policy, advocacy and program planning, and set aside a

significant portion of these funds to conduct a comprehensive study of the health and psychosocial needs of older LGBT adults in Chicago. Drawing from these data, the purpose of this article is to examine the social care network of older LGBT adults, with a focus on the viability of the social support network, formal service utilization, and unmet needs for assistance. After providing a demographic and health profile of a sample of these older LGBT adults, we then describe their informal social networks, service utilization patterns, and services needs based on quantitative measures. This is followed by a qualitative examination of unmet service needs that provides more comprehensive insight of the issues faced by these older adults as they access social care resources.

METHOD

Samples and Procedures

Data were obtained in 2010 and 2011 from a convenience sample of older LGBT adults recruited through the COH, the most comprehensive LGBT community center in the Midwest. COH offers diverse public programs and social services, including mental health counseling, HIV testing and prevention, community and cultural programs, technology classes, youth programs, and a vibrant older adult program for those 55 and older. Participants were also recruited at and at various AIDS service organizations (ASOs), health fairs, and community events in Chicago, IL. To qualify for participation an individual had to identify as LGBT and be 50 years of age or older and sufficiently fluent in English to complete the survey. Two hundred thirty-three participants were recruited resulting in 210 usable surveys. Twenty-three surveys were not usable due to incomplete data or from participants who failed to meet the inclusion criteria (most often for not being LGBT). Informed consent was obtained prior to data collection. The survey instrument was self-administered and took, on average, 45 to 60 min to complete. After completion participants were debriefed, thanked, and given a $25 gift card. Research methods and materials were evaluated and approved by the Copernicus Group Independent Review Board.

Quantitative Measures

Whenever possible standardized measures with known psychometric properties were used to insure validity and allow for comparison with published data. Questions were developed based on items in Research on Older Adults with HIV study (Brennan et al., 2009), National Social Life, Health and Aging Project (Lindau et al., 2007), and the Caregiving among Older Lesbian, Gay, Bisexual and Transgender New Yorkers study (Cantor et al., 2004).

Demographic profile. Single items obtained information on a*ge, gender identity* (i.e., male, female, male-to-female transgender, female-to-male transgender, or intersex), *sexual identity* (i.e., heterosexual, homosexual, bisexual, queer, or questioning)*, race, Hispanic origin, level of education, income adequacy, work status, HIV status, veteran's status,* and *marital or partnership status* (see Table 1).

TABLE 1 Sociodemographic Characteristics of Older Lesbian, Gay, Bisexual, and Transgender Adults (Valid Percentages)

	Total		Men		Women	
Variable	*n*	%	*n*	%	*n*	%
Age						
M	59.6		59.9		58.4	
SD	8.00		8.41		6.57	
Age group						
50–54	67	32.4	48	32.7	17	35.4
55–59	51	24.6	32	21.8	13	27.1
60–64	34	16.4	27	18.4	7	14.6
65–69	30	14.5	19	12.9	9	18.8
70+	25	12.1	21	14.3	2	4.2
Gender						
Male	148	70.5	148	100.0		
Female	50	23.7			50	23.7
Transgender male	1	0.5				
Transgender female	10	4.8				
Intersex	1	0.5				
Sexual identity						
Gay/lesbian	165	80.1	116	80.0	44	88.0
Bisexual	28	13.6	23	15.9	3	6.0
Queer	7	3.4	5	3.4	1	2.0
Questioning	3	1.5	1	0.7	2	4.0
Heterosexual	3	1.5				
Race/ethnicity						
Black/African American	66	32.0	47	32.0	14	29.8
White/Caucasian	127	61.7	92	62.6	30	63.8
Hispanic	8	3.9	6	4.1	2	4.3
Asian/Pacific Islander	1	0.5	1	0.7	0	0.0
American Indian/Alaskan Native	1	0.5	0	0.0	1	2.1
Other	3	1.5	1	0.7	0	0.0
Education						
Less than high school	10	4.9	6	4.2	2	4.1
High school graduate/GED	31	15.2	24	16.7	4	8.2
Some college	50	24.5	33	22.9	12	24.5
College graduate/postgraduate	113	55.4	81	56.2	31	63.3
Income adequacy						
Not enough for expenses	32	15.5	23	15.9	6	12.0
Just manage to get by	94	45.6	68	46.9	20	40.0
Enough with a little extra	46	22.3	31	21.4	14	28.0
Money not a problem	34	16.5	23	15.9	10	20.0

(*Continued*)

TABLE 1 (Continued)

	Total		Men		Women	
Variable	*n*	%	*n*	%	*n*	%
Work status**						
Working	58	27.9	32	21.9	25	50.0
Unemployed	26	12.5	21	14.4	4	8.0
Disability	62	29.8	46	31.5	9	18.0
Retired	58	27.9	45	30.8	10	20.0
Volunteer	2	1.0	1	0.7	1	2.0
Other	2	1.0	1	0.7	1	2.0
Military veteran**	28	13.4	26	17.6	1	2.0
Marital/partnership status*						
Married	8	3.9	5	3.5	2	4.1
Civil union	2	1.0	2	1.4	0	0.0
Registered domestic partner	10	4.9	3	2.1	7	14.3
Life partner	50	24.4	35	24.3	15	30.6
Common law	1	0.5	0	0.0	0	0.0
Widowed/partner deceased	8	3.9	8	5.6	0	0.0
Divorced/separated	19	9.3	12	8.3	4	8.2
Single/not married	107	52.2	79	54.9	21	42.9

Note. $N = 210$ (men, $n = 148$; women, $n = 50$). GED = general equivalency diploma.
*$p < .05$. **$p < .01$.

Morbidity. Participants were asked if they had experienced any of 27 physical and mental health conditions in the previous year, including HIV-related conditions (e.g., neuropathy), age-related conditions (e.g., sensory loss), chronic and terminal illnesses (e.g., diabetes or cancer), and mental or neurological disorders (e.g., depression). The number of health comorbidities was calculated by summing the positive responses to these items.

Self-rated health. Participants rated their current health status on a 4-point Likert scale (i.e., from *excellent* to *poor*).

Depression. The 10-item version of the Center for Epidemiological Studies Depression Scale (CES–D; Radloff, 1977) was used to assess depressive symptoms (Andersen, Malmgren, Carter, & Patrick, 1994). Participants were asked about the frequency of depressive symptoms experienced over the past week, with four responses (i.e., none, a little, some, or most days). Responses were summed with higher scores indicating greater levels of depressive symptoms. Inter-item reliability for the CES–D was high (Cronbach's = .84). CES–D scores were then categorized (i.e., not depressed = 0 to 9, moderately depressed = 10 to 13, or severe depression = 14 to 30; Andersen et al., 1994).

Functional ability was measured using the Older Americans Resources and Services assessment (Fillenbaum, 1988). Respondents were asked about any difficulty they encountered with seven instrumental activities of daily living (IADLs) and six personal care activities of daily living (PADLs), with

TABLE 2 Physical and Mental Health Status of Older Lesbian, Gay, Bisexual, and Transgender Adults (Valid Percentages)

	Total		Men		Women	
Variable	*M*	*SD*	*M*	*SD*	*M*	*SD*
Number of health conditions	2.98	2.42	3.05	2.47	2.33	1.91
CES–D	8.25	5.89	8.04	6.16	8.42	5.19
Number of difficult IADLs	0.98	1.57	1.01	1.62	0.80	1.44
Number of difficult PADLs	0.41	1.15	0.39	1.10	0.42	1.31
	n	%	*n*	%	*n*	%
Self-rated health						
Excellent	57	27.1	43	29.5	11	22.0
Good	100	47.6	73	50.0	23	46.0
Fair	43	20.5	28	19.2	12	24.0
Poor	8	3.8	2	1.4	4	8.0
CES–D categories**						
Not depressed	135	64.3	101	68.2	28	56.0
Moderately depressed	33	15.7	15	10.1	15	30.0
Severely depressed	42	20.0	32	21.6	7	14.0
At least 1 IADL impairment	78	37.1	56	37.8	16	32.0
At least 1 ADL impairment	36	17.1	24	16.2	7	14.0
Insurance and benefits[a]						
Medicare*	93	44.7	72	48.6	16	32.0
Medicaid	56	26.9	39	26.4	9	18.0
Private health insurance*	88	42.3	59	39.9	29	58.0
Long-term care insurance	19	9.1	13	8.8	6	12.0
VA health coverage	14	6.7	13	8.8	1	2.0
Private disability policy	6	2.9	4	2.7	2	4.0
Supplemental security income	45	21.6	31	20.9	8	16.0
Social Security Disability Income	44	21.2	34	14.0	7	20.7
General assistance	5	2.4	5	3.4	0	0.0
Supplemental nutrition Assistance program	54	26.0	37	25.0	10	20.0

Note. $N = 210$ (men, $n = 148$; women, $n = 50$). CES–D = Center for Epidemiological Studies Depression Scale; IADLs = instrumental activities of daily living; PADLs = personal care activities of daily living; VA = Veterans' Administration.

[a]Multiple response categories. Totals do not equal 100%.

*$p < .05$. **$p < .01$.

higher scores indicating more difficulty. For these analyses, the number of activities with any difficulty reported was summed in both IADL and PADL domains. The proportion of respondents with at least one impairment in each domain was also calculated (see Table 2).

Insurance and benefits were assessed by asking about government health insurance (e.g., Medicaid), private insurance, long-term care and disability coverage, and various entitlement programs (e.g., Supplemental Security Income [SSI]; see Table 2).

Living arrangement was assessed by asking respondents if they lived alone or with others, and if living with others, the nature of that relationship.

Informal social network. Detailed information was collected on informal networks based on previous large-scale studies of older adults (Cantor & Brennan, 1993, 2000). Participants indicate if they have any living members of five groups (e.g., parents, children, sibling, other relatives, and friends) that typically compromise informal networks, and the number of those network elements present. Two additional items assessed frequency of contact (e.g., in-person visits or telephone conversations). Assessments of contact frequency was necessary to calculate the functional status of each network element, based on criteria established by Cantor (Cantor, 1979)—namely, monthly in-person visits or weekly telephone conversations. The proportion of respondents having at least one functional network element in each of the five categories was then calculated. Respondents were also asked the number of neighbors known well and the number of their friends who had HIV/AIDS.

Type and frequency of assistance from family and friends. Participants indicated the frequency of eight types of instrumental and emotional assistance provided by family members and friends, respectively (e.g., shop or run errands, help with housekeeping, advice, and talk about personal problems). Respondents were also asked about negative support received from either family or friends (e.g., upset you or hurt your feelings). These responses were summed to create indexes of family/friend help and negative support (see Table 3).

Formal service utilization. Questions on services accessed in the previous year in addition to those received at the COH were adapted from previous studies of service utilization among older adults (Cantor & Brennan, 1993, 2000). The time frame of the previous year was retained so as to facilitate comparisons between the study sample and other data. Four categories were assessed: (a) government agencies and offices (e.g., Medicaid), (b) HIV/AIDS-related services (e.g., HIV day program), (c) health and long-term care services (e.g., emergency room), and (d) other older adult services (e.g., senior center). The number of services used within each of the four categories and overall was summed to create variables indicating the total number of services used the number used in each domain (see Table 4).

Service needs in the previous year. Respondents were asked about 11 service needs in the previous year in four domains: *socialization* (e.g., someone to call or visit), *social services* (e.g., help with entitlements), *household tasks* (e.g., home repairs), and *health-related* (e.g., care after a hospital stay). Positive responses to these items were summed to create an index of service needs in the previous year (see Table 5).

Open-ended questions on service needs. The narrative data used for the qualitative examination of service needs in the previous year was taken from two questions. The first item asked, "We are interested in knowing more about why people did not get all the help they needed. If you did not receive all of the help you needed, please tell us in your own words about

TABLE 3 Social Network Characteristics (Valid Percentages)

	Total		Men		Women	
Variable	*n*	%	*n*	%	*n*	%
Living arrangements***						
Live alone	131	63.3	105	70.5	18	39.1
Live with spouse or partner	44	21.3	25	16.8	18	39.1
Live with other	32	15.5	19	12.8	10	21.7
Social network members						
Parent	86	41.7	65	44.5	18	36.7
Functional parent	55	26.1	41	27.5	13	26.0
Child**	64	30.9	36	24.5	23	47.9
Functional child***	48	22.7	23	15.4	21	42.0
Grandchild*	43	20.8	25	17.2	16	32.0
Functional grandchild**	20	9.5	9	6.0	10	20.0
Sibling	174	84.1	121	82.9	44	88.0
Functional sibling*	81	38.4	53	35.6	27	54.0
Other relative in contact	100	50.3	72	50.7	25	54.3
Friend	179	86.1	127	86.4	43	86.0
Functional friend	162	76.8	114	76.5	39	78.0
	M	*SD*	*M*	*SD*	*M*	*SD*
No. of friends with HIV**	0.81	1.63	1.05	1.84	0.18	0.51
No. of neighbors known well	1.49	2.80	1.42	2.66	1.60	2.10
Size of social network**	10.58	7.37	9.87	6.80	12.98	8.51
No. of ways family helps**	1.94	2.05	1.72	1.92	2.64	2.15
No. of ways friends help	2.20	2.06	2.06	1.96	2.40	2.05
Family negative support**	0.68	0.99	0.54	0.90	1.02	1.07
Friend negative support	0.46	0.87	0.46	0.80	0.44	1.01

Note. $N = 210$ (men, $n = 148$; women, $n = 50$).
*$p < .05$. **$p < .01$. ***$p < .001$.

the situation." The second question asked, "Are there any other programs or services that could be helpful to you from Center on Halsted or other service providers?"

Design and Analysis

This study used a mixed methods approach incorporating both quantitative and qualitative data analyses. The quantitative portion used a correlational design to assess how demographic factors, health status, informal network characteristics, formal service utilization, and service needs were associated with gender. Due to the small number of transgender and intersex respondents (i.e., $n = 12$; see Table 1), it was not possible to include these individuals in significance testing by gender identity, but they were included in reporting the total descriptive information for the sample reported in Tables 1 through 5. Differences in study variables by gender identity were assessed using chi-square analyses for nominal and ordinal data and analyses of variance for continuous data. When noted in the text, "significant" refers to statistically significant differences at the $p < .05$ level or greater. For the

TABLE 4 Services Used by Older Lesbian, Gay, Bisexual, and Transgender Adults in the Past Year (Valid Percentages)

	Total		Men		Women	
Variable	*n*	%	*n*	%	*n*	%
Government offices/agencies						
Social Security office	90	42.7	65	43.6	17	34.0
Medicare office	43	20.5	33	22.3	7	14.0
Medicaid office	42	19.9	28	18.8	8	16.0
VA hospital	16	7.6	14	9.4	2	4.0
HRA	42	20.0	32	21.6	5	10.0
Chicago Housing Authority	43	20.5	32	21.6	6	12.0
Police	25	11.9	15	10.1	8	16.0
Department on Aging	57	27.1	41	27.7	10	20.0
ASOs						
AIDS Foundation of Chicago***	43	26.2	40	33.1	1	3.1
BEHIV*	18	11.0	18	15.0	0	0.0
COH HIV services	49	30.2	39	32.5	7	21.9
Chicago House and Social Services	20	12.3	18	15.0	2	6.2
Howard Brown Health Services	41	25.5	34	28.6	5	15.6
Test Positive Aware Network**	30	18.4	29	24.2	0	0.0
South Side Help Center	11	6.7	9	7.5	2	6.2
CORE Center*	21	13.0	19	16.0	1	3.1
Chicago Women's AIDS Project	9	5.6	8	6.7	0	0.0
Health and LTC						
Private medical clinic	68	33.0	46	31.5	21	42.9
Health maintenance organization	23	11.1	18	12.2	4	8.2
Dentist/dental clinic	101	48.8	68	46.6	30	60.0
Mental health services	56	27.2	36	24.7	15	30.6
Drug/alcohol treatment	23	11.3	19	13.2	4	8.2
Emergency room	56	27.1	37	25.2	17	34.7
Inpatient hospital	39	18.9	25	17.1	12	24.5
Outpatient hospital	77	37.6	56	38.6	20	40.8
Case management*	59	28.5	48	32.7	8	16.3
Homecare services	36	17.4	24	16.3	8	16.3
Assisted living	10	4.8	5	3.4	5	10.2
Hospice	6	3.0	3	2.1	1	2.1
CBOs						
Senior center	52	25.2	32	21.9	14	28.6
Meal/nutrition program	41	19.8	27	18.4	10	20.4
Self-help group	30	14.5	22	15.0	6	12.2
Clergy**	47	22.7	40	27.2	4	8.2
Legal services	43	20.8	31	21.1	9	18.4
COH senior services						
Mental health support	21	10.5	15	10.5	3	6.5
HIV support group**	20	10.3	20	14.4	0	0.0
Congregate meals	69	35.6	48	34.8	14	31.1
Legal assistance*	21	10.8	18	12.9	1	2.3
Computer technology center	52	26.4	38	27.1	8	17.4
Social/education programs	54	27.8	34	24.8	15	31.9

(Continued)

TABLE 4 (Continued)

	M	*SD*	*M*	*SD*	*M*	*SD*
Government services used	1.70	1.95	1.75	1.95	1.26	1.76
ASOs used***	1.20	1.79	1.50	1.93	0.36	0.78
Health/LTC services used	2.63	2.27	2.58	2.19	2.90	2.54
CBOs used	1.01	1.18	1.02	1.16	0.86	1.23
COH services	1.12	1.29	1.16	1.25	0.82	1.26
Total no. of services[a]	6.48	5.14	6.85	5.19	5.38	4.94

Note. $N = 210$ (men, $n = 148$; women, $n = 50$). VA = Veterans' Administration; HRA = Human Resources Administration; ASOs = AIDS service organizations; COH = Center on Halsted; BEHIV = Better Existence with HIV; LTC = long-term care; CBOs = community-based organizations.
[a]Does not include Center on Halsted Services due to overlap with other items.
$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$.

TABLE 5 Need for Services in the Past Year Among Older Lesbian, Gay, Bisexual, and Transgender Adults (Valid Percentages)

	Total		Men		Women	
Variable	*n*	%	*n*	%	*n*	%
Number services needed						
M	2.48		2.44		2.54	
SD	2.25		2.26		2.23	
Socialization						
Someplace to socialize	105	51.0	76	52.1	23	47.9
Someone to call or visit	52	25.4	35	23.8	13	27.7
Social Services						
Personal/family counseling	59	28.6	40	27.4	14	29.2
Help with entitlements*	47	22.7	39	26.7	6	12.2
Finding a job*	37	18.0	31	21.2	4	8.3
Household						
Home repairs**	45	23.0	28	18.9	17	35.4
Housekeeping/personal care	37	18.2	22	15.5	12	24.5
Home-delivered meals	8	3.8	4	2.7	4	8.2
Health-related						
Escort to doctor or clinic	65	31.6	41	27.7	19	39.6
Care after hospital stay	42	20.5	29	20.1	10	20.4
Visiting nurse/home health care	25	12.3	18	12.3	5	10.6

Note. $N = 210$ (men, $n = 148$; women, $n = 50$).
$^{*}p < .05$. $^{**}p < .01$.

sake of brevity, only significant differences based on gender are described in the results.

The qualitative portion of the study used a grounded-theory approach (Glaser & Strauss, 1967)—namely, codes and themes were not identified *a priori,* but were developed through a process of open coding. Narrative data from the two open-ended questions were imported into the qualitative analysis program *ATLAS.ti* (Muhr, 1997). Mark Brennan-Ing conducted the open-coding process in an iterative process by identifying content and

themes and corresponding coding, refining the coding system by making several passes through the data using the method of constant comparisons. Following this phase, Liz Seidel independently reviewed the initial coding and themes and noted any disagreement both with regard to the passages that were coded, as well as the codes themselves. The proportion of agreements and disagreements between Mark Brennan-Ing and Liz Seidel were calculated and disagreements were resolved through discussion. Interrater agreement for the open-coding phase was 94%. Because the interrater agreement for the open-coding phase was very high, a focused coding phase was not deemed necessary and the initial coding was corrected to reflect the consensus of Mark Brennan-Ing and Liz Seidel.

RESULTS

Sociodemographic and Socioeconomic Characteristics

The average age of this sample of older LGBT adults was 59.5 years, and ranged from 50 to 92 years of age. The median age was 58 years. The majority identified as male (71%), with 24% identifying as female, and 5% as transgender female. One individual identified as a transgender male (0.5%) and one identified as intersex (0.5%). Due to the small numbers of transgender and intersex individuals, they were not included in the bivariate comparisons by gender of the quantitative data that follow, but were included in the qualitative analysis of service needs (see Table 1). Eighty percent identified as gay or lesbian, 14% as bisexual, 1% as queer, and 3 transgender individuals (1%) identified as heterosexual. The majority of the sample was White (62%), followed by Black (32%). The remaining race/ethnicities ranged from 4.0% (Hispanic) to 0.5% (Asian/Pacific Islander and American Indian/Alaskan Native).

Educational attainment in this sample was high, with 55% having graduated from college or attended graduate school. Twenty-five percent had attended some college but not received a degree, and 15% had obtained a high school diploma or general equivalency diploma. Only 5% had less than high school educations. However, over one-half reported income inadequacy of either not having enough money for expenses (16%) or just managing to get by financially (46%). Nearly one-fourth said that they had enough money with a bit extra (22%), whereas 17% indicated that money was not a problem (see Table 1). With regard to current work status, comparable proportions were either working full time (28%), were retired (28%), or were disabled (30%). Twelve percent reported being unemployed. Work status differed significantly by gender with older women being significantly more likely than men to be working (50% vs. 22%), and less likely to report being retired (20% vs. 31%) or on disability (18% vs. 32%). The higher likelihood of disability among older men compared to lesbian and bisexual women is

likely a reflection of the much higher prevalence of HIV in the former group compared with the latter (46% vs. 2%; $p < .001$). Thirteen percent reported having served in the military (see Table 1), and older gay and bisexual men were significantly more likely to be veterans as compared to lesbian and bisexual women (18% and 2%, respectively).

In terms of current marital/partnership status, 52% reported being single. The next largest group (35%) was those with a partner or spouse (life partners 24%, registered domestic partners 5%, married 4%, civil unions 1%, and common law 1%). Nine percent were divorced or separated and 4% reported being widowed or that their partner was deceased. Older lesbian and bisexual women were much more likely to say they had a partner (31% life partner and 14% domestic partner) as compared to their male peers (24% life partner and 2% domestic partner; see Table 1).

Health, Health Care, and Insurance

Physical and mental health. Respondents were asked if they had experienced any of 27 health conditions in the previous year, including age-related conditions (e.g., arthritis, cardiac conditions, cancer, depression, hepatitis, and HIV). As seen in Table 2, on average, older LGBT adults reported having three health conditions, and this did not differ significantly by gender. Despite this level of comorbidity, three-fourths self-rated their health as either excellent (27%) or good (48%). Twenty-one percent responded that they were in fair health, and only 4% rated their health as poor. The number of health conditions and self-rated health were not significantly related to gender.

Data on depressive symptomatology showed the study group had an average CES–D score of 8.3. Using the classification system developed by Andersen et al. (1994), 16% reported moderate levels of depressive symptoms, whereas one out of five had severe levels of depressive symptoms. Average CES–D scores did not differ significantly by gender. However, in terms of severity of symptoms, older gay and bisexual men were significantly more likely to have severe symptoms (22%) and less likely to have moderate symptoms (10%) as compared with older lesbian and bisexual women (14% and 30%, respectively; see Table 2).

Regarding functional ability, the IADL task with the most frequent reported difficulty was housework (25%). Difficulty getting to places out of walking distance (21%) and shopping (18%) were the next most difficult IADL, whereas 16% reported difficulty with meal preparation. Less than one 1 of 10 reported difficulty with using the telephone (5%), taking medications (5%) or handling money (8%). Thirty-seven percent reported difficulty with at least one IADL task (see Table 2), and reported 1.0 difficult IADL tasks, on average. Older LGBT adults were less likely to report difficulties with PADLs as compared with IADLs. The greatest reported difficulty was for getting in

and out of bed (12%) and dressing/undressing (9%). Seven percent or less reported difficulty with the remaining PADLs; walking across a small room (7%), bathing (6%), grooming (5%), and feeding oneself (3%). Seventeen percent reported difficulty with at least one PADL task, and the average number of PADL difficulties was 0.4.

Health insurance and entitlement benefits. Medicare was the most frequently reported health insurance program (45%). Men were significantly more likely than women to report Medicare coverage (49% and 32%, respectively). This was followed by private health insurance (42%); however, women were more likely than men to report such coverage (58% and 40%, respectively). Slightly more than one-fourth of the sample was on Medicaid (27%), whereas relatively few reported long-term care insurance (9%), coverage through the Veterans' Administration (VA; 7%), or a private disability policy (3%). With regard to entitlements, about one-fifth reported either SSI or Social Security Disability Income (SSDI; see Table 2). Twenty-six percent reported being enrolled in the Supplemental Nutrition Program. Less than 2% were receiving welfare in the form of general assistance.

Social Network Composition and Social Support

Nearly two-thirds of the sample lived alone (63%), whereas 21% lived with a partner or spouse, and 16% lived with some other person (see Table 3). Men were significantly more likely to live alone compared to women (71% and 39%, respectively), and concomitantly less likely to live with a partner or spouse (17% and 39%, respectively). With regard to social network elements and functional elements, 42% reported the presence of a living parent. However, the proportion having a functional parent declined to 26%. (Note that a functional network member is in at least monthly face-to-face or weekly telephone contact.) Less than one-third (31%) reported the presence of a living child, whereas 23% reported having at least one functional child. Older gay and bisexual men were significantly less likely than their female counterparts to report a living child (25% and 48%, respectively). A similar picture emerged regarding functional children with women more likely than men to report a functional child (42% and 15%, respectively). Given their greater likelihood of having children, it was not surprising that women were significantly more likely to report both living grandchildren (32%) and functional grandchildren (20%) as compared with men (17% and 6%, respectively). Eighty-four percent reported a living sibling, but less than one-half of these could be categorized as functional (38%). One-half of the sample reported having other, more distant relative with whom they are in frequent contact.

The well-documented friend-centered nature of LGBT social networks, or so-called families of choice, was evident among the older adults in our sample. Eighty-six percent reported having a close friend, and 77% reported

having a functional friend (see Table 3). On average, older LGBT adults reported 4.1 friends in their social networks, and approximately one out of four was HIV-positive ($M = 0.80$). Older gay and bisexual men had a significantly higher average number of friends with HIV as compared with women ($M = 1.05$ and $M = 0.18$, respectively). An additional source of non-kin support is from neighbors. Respondents reported knowing 1.5 neighbors well, on average (see Table 3). Older LGBT adults reported a mean of 10.6 individuals in their social networks. Women had significantly larger networks, on average ($M = 13$), as compared with men ($M = 10$). The larger size of social networks among women is due to their greater likelihood of having both children and grandchildren compared to men.

Support assistance and negative support. We asked older LGBT adults about the amount of assistance they received from family and friends in terms of instrumental help (i.e., shop/run errands, keep house/prepare meals, someone to take them to the doctor/clinic, help with mail/correspondence, and managing money) and emotional support (i.e., advice, need cheering up, and talk about personal matters). Respondents reported receiving 1.9 types of help, on average, from family. Women reported significantly greater help from family as compared to men ($M = 2.6$ and $M = 1.7$, respectively). With regard to help from friends, older LGBT adults reported 2.2 types of help from their families of choice, on average, and this did not differ significantly by gender. More important, the amount of support from friends was not significantly lower than that received from family, $t(210) = -1.63$, $p = .10$, underscoring the crucial role of non-kin support among older LGBT adults.

We also assessed negative social support from family and friends in terms of refusing to help when asked, being reluctant to talk, or upsetting/hurting the feelings of the respondent. On average, respondents reported 0.7 types of negative support from family. While older lesbian and bisexual women have larger family networks who provide greater levels of assistance, they are also significantly more likely than men to report higher levels of negative family support ($M = 1.0$ and $M = 0.5$, respectively). Respondents reported 0.5 types of negative support from friends, on average, and this was significantly less than negative support received from family, $t(210) = 2.89$, $p < .005$.

Service Utilization in the Previous Year

Government offices and agencies. The most frequently utilized service in this group was the Social Security Office (43%), followed by the Department for Family and Support Services, Senior Division/Department on Aging (27%). Next were the Chicago Housing Authority (21%) and Medicare and Medicaid Offices (21% and 20%, respectively). Twenty percent had also used the Department of Human Resources Administration in the previous year (see Table 4). Use of the VA (8%) and police (12%) were the least

frequently reported services. On average, older LGBT adults used 1.7 services in this category.

HIV-related services and ASOs. The most frequently used services in this group were HIV services from the COH (23%), AIDS Foundation of Chicago (20%), Howard Brown Health Services (19%). Smaller proportions used the Test Positive Aware Network (14%) and the CORE center (10%) or Chicago House and Social Services (10%), whereas use of Better Existence with HIV (BEHIV) was reported by 9% of the sample. Five percent or fewer reported using the South Side Help Center of the Chicago Women's AIDS Project. Because nearly all the HIV-positive individuals in this sample were men, significantly greater proportions of men compared to women reported using the AIDS Foundation of Chicago, BEHIV, the Test Positive Aware Network, and the CORE Center (see Table 4). Use of services in this domain was significantly higher among men ($M = 1.5$) as compared with women ($M= 0.4$).

Health and long-term care services. The most frequently utilized service in this area was the dentist/dental clinic, with nearly one-half of older LGBT respondents reporting such use in the past year. Outpatient hospital care was reported by 38%, whereas 19% had received inpatient hospital care (see Table 4). Over one-fourth had used the hospital emergency room in the past year. One-third reported going to a private medical clinic and 1 out of 10 had utilized a Health Maintenance Organization. Behavioral health and substance use treatments were also utilized, with 27% having received mental health treatment and 11% utilizing drug or alcohol treatment and recovery programs. Case management, was reported by nearly one-third of participants (29%). Twice as many men had used case management (33%) as compared with women (16%). This is likely due to the proportion of HIV+ men in the sample as we also found that HIV+ older LGBT adults were significantly more likely to use case management (61%) as compared to their peers (12%). Few older LGBT adults had accessed homecare services (17%) or institutional long-term or continuing care (5%). Three percent used hospice during the previous year. On average, older LGBT adults used 2.6 health or long-term care services.

Other community-based organizations (CBOs). Senior centers were the most frequently used community-based service (25%). Clergy, meal and nutrition programs, and legal services were used by about one out of five older LGBT adults during the previous year (23%, 21% and 20%, respectively). Approximately 15% had attended a self-help group in the past year. In this group, only one significant gender difference emerged; older gay and bisexual men were significantly more likely to have turned to clergy (27%) as compared with lesbian and bisexual women (8%). Older LGBT adults used 1.0 of such CBO services, on average.

Use of services provided by the COH. Participants were asked about services provided by COH. The most frequently utilized service provided

by COH was the Senior Congregate Meal Program (36%). The COH's Senior Social and Education programs were the next most frequently used (28%), followed by the computer technology center (26%). Approximately 1 out of 10 had had used the COH HIV support group (10%), mental health supportive services (11%) and legal services (11%). The only significant gender differences observed werer that older men were more likely to have used the HIV support group (14%) and legal assistance (13%) as compared with women (0% and 2%, respectively). The average number of COH services used was 1.1.

Need for Services in the Previous Year

Older LGBT adults were asked about their service needs in the past year from a list of commonly utilized health and social services (see Table 5). The average number of services needed in the past year was 2.5. In terms of specific service needs, socialization opportunities were among the most frequently mentioned with 51% of older LGBT adults indicating needing someplace to socialize (see Table 5). The need for a regular contact, either by a visit in person or by phone, was indicated by one-fourth of older LGBT adults. Regarding social service needs, counseling assistance, either personal or family, was the third highest in terms of need in the previous year (29%). Help navigating the entitlement system was an expressed need for 23% of older LGBT adults in the past year. Eighteen percent of older LGBT adults reported that they had needed help finding a job in the past year. With regard to household-related services, the most frequently reported service need in this domain was help with home repairs, which was reported by 23% of older LGBT adults. Nearly one out of five older LGBT adults reported that they had needed help with housekeeping or personal care in the home over the previous year (18%). Four percent of older LGBT adults reported that they needed meals brought to them at home during the previous year ($n = 8$; see Table 5). In the final domain of health-care related services, the most frequently reported need was assistance in getting to the doctor's office or a medical clinic (32%). Approximately one out of five (21%) older LGBT adults reported needing help following a stay in the hospital in the previous year. The need for homecare services (i.e., visiting nurse, home health aide, or home attendant) was reported by 12% of older LGBT adults.

There were few gender differences with regard to service needs in the previous year (see Table 5). Older gay and bisexual men were significantly more likely than women to mention they needed help navigating the entitlement system (27% and 12%, respectively), likely due to the preponderance of HIV cases in the former group. In fact, those with an HIV diagnosis were significantly more likely than their peers to indicate a need for this type of assistance (40% and 14%, respectively). Men were more than twice as likely to indicate that they needed help finding a job (21%) compared

with women (8%). Finally, over one-third of lesbian and bisexual women indicated that they needed help with home repairs (35%), significantly higher as compared to men (19%).

Qualitative Analysis of Unmet Needs for Services

Using a grounded-theory approach (Glaser & Strauss, 1967), we identified 35 individual themes based on two open-ended questions concerning (a) unmet needs and (b) additional services desired at COH. Because of the extent of overlap in responses, we combined these data for the analyses reported in the following. Individual themes were grouped into four "families" (i.e., superordinate themes) that represented (a) needing help with basic support and instrumental tasks (b) education and recreation services, (c) health-related services, and (d) social services (see Table 6).

TABLE 6 List of Code Families and Codes From Qualitative Analysis of Unmet Service Needs

Needed Services			
Help With Support or Instrumental Tasks	Education or Recreation Programs	Health-Related	Social Services
Help with household tasks (1)	Computer or technology (3)	CAM (1)	Caregiving support (1)
Home repairs (3)	Culinary (2)	Dental care (5)	Case manager (1)
Nutrition program (6)	Cultural (1)	Health or medical care (2)	Employment or job placement (19)
	Education (2)	HIV/AIDS services at COH (2)	Entitlement or insurance help (5)
	LGBT discussion group (1)	Medication adherence and support (1)	Financial help/planning (10)
	Spanish language (1)	Mental health (3)	Friendly visiting (1)
	Spiritual or religious activities (3)	Non-HIV related LGBT services (1)	Gay parents group (1)
	Sports and recreation (6)	Substance abuse recovery (3)	Homeless services (3)
	Volunteer opportunities (1)	Vision care (1)	Housing/senior housing (21)
			Legal services (6)
			Lonely/isolated (5)
			Senior/senior programs at COH (1)
			Socialization opportunities (17)
			Support/education groups (2)

Note. Frequency of quotations (*n*). LGBT = lesbian, gay, bisexual, and transgender; CAM = complementary and alternative medicine; COH = Center on Halsted.

Help with basic support and instrumental tasks. Although relatively young (i.e., average age 60 years), many needed basic supports and help with instrumental tasks. Home repairs were a problem, as illustrated by a 66-year-old woman who shared that her son was too busy to help her with home maintenance. Others described more basic needs, such as the 59-year-old man who reported, "I have trouble getting around, getting food." Others said they were in need of nutrition programs or an increase in their food stamp benefits.

Education and recreation services. There was interest in a wide range of educational and recreational programs, including computer and technology classes, and culinary programs. A 60-year-old woman suggested that financial barriers exist in accessing culture and the arts wanting "more affordable cultural programs." Some wanted educational programs, or programs to assist with returning to school. A 63-year-old man was interested in a LGBT-identified discussion group, but was concerned about feeling shy and feared rejection. Spiritual and religious programs were wanted, specifically programs that did not discriminate based on sexual identity. General sports and recreation programs were mentioned, with interests ranging from sports, to yoga and exercise classes, and board and card games.

Health-related services. Some older LGBT adults were interested in complementary and alternative medicine, such as acupuncture. Others wanted adherence programs for HIV medication, but a 50-year-old woman wanted to see more non-HIV specific health services. Dental care was frequently reported, with many citing the lack of Medicare coverage for such services. Mental health and substance abuse recovery services were also mentioned frequently. A 56-year-old Black man described how the need for mental health services was related to cultural issues:

> For Afro-American [sic], it is in our culture not to seek help for depression or marital/family decisions. We need to learn that talking to a counselor or psychiatrist or taking meds for depression does not mean you are looney [sic] tunes (crazy).

Social services. Older LGBT respondents needed a wide range social services (see Table 6). Three areas stood out: employment assistance, housing, and socialization opportunities. Given the severe economic recession and high levels of unemployment during the time of data collection (i.e., 2010–2011), it was not surprising that help finding a job and employment counseling were needed. Some reported that they had been looking for work but were not successful. Many indicated that job-seeking efforts were hampered by ageism. A 60-year-old man related, "There are not jobs for people over 50 and no one is working to address that specific need!" Another 57-year-old woman said, " . . . for any leads I get, the employer is always looking for someone younger."

Given the high cost of living in urban areas like Chicago, it was not surprising that many were seeking affordable housing. A 73-year-old man told us, "Right now I need subsidized housing. My apartment had a fire and right now I'm kind of homeless and staying with friends." A number of individuals were interested in senior or supportive housing for older adults, many wanting a gay-friendly or a LGBT-focused facility. The third major area of unmet needs concerned opportunities for socialization, often motivated by feelings of loneliness and isolation. A 51-year-old transgender woman described how her substance abuse treatment created barriers to socialization that she wished to overcome:

> My social network outside of the [I]nternet has been limited to rehab, half-way house, sober living housing and respite shelter. I need a social life with regular people in the outside world.

Although the bar scene has been a social staple for the LGBT community, a common remark by the older respondents in this sample was a need for venues outside of this domain. One 54-year-old woman said, "Don't know where to go besides clubs to meet people. Want a girlfriend." Noting the ageism that persists in LGBT communities, a 67-year-old man told us, "I feel lonely and isolated a lot of the time (partly internalized ageism). I don't know where to go to meet other gay men my own age in a healthy setting, not bar, etc." Many lesbian and bisexual women related the difficulties they had on the social scene as they got older:

> Lesbians have limited social environments after age 50. Bar scene, limited at best, is for younger women. Fundraisers are too costly ($300 for date and me to go to Lesbian Community Care Project). Social events give 50+ women chance to meet other women, reconnect with friends, etc. (50-year-old woman).

Another important issue for older LGBT adults was needed assistance with either entitlement or insurance, or with regard to financial help/planning. A 56-year-old man told us, "I worry about surviving financially until I'm eligible for Social Security." Financial issues involved financial planning, as well as the need for financial assistance. A 50-year-old Black woman wanted "bankruptcy (or housing) help for those LGBTs affected by the economy." A number of respondents indicated a need for direct financial help and support. One man (age unknown) shared the difficulties he faced living on disability checks:

> Anybody on SSI or SSDI should be qualified for all services because that is not a living amount of money—it is only maintaining you. No money for trips or special places to go. Nothing left over. From month to month.

Summary of qualitative findings. The preceding qualitative analysis of the service needs of older LGBT adults has reinforced the quantitative information given by these respondents. But, more important, it has revealed additional areas of unmet need in this population. What was striking was the need for many of these respondents for basic human requirements such as food, shelter, or a viable occupation to provide economic security. Medical and dental care needs were mentioned by many, with lack of insurance coverage serving as a significant barrier. Isolation and socialization opportunities were also prominent. Socializing and finding romantic partners appeared to be a particular challenge for older lesbians, but the problem of ageism in the LGBT community was cited by both women and men. However, there was a significant amount of need expressed by these older adults for educational and recreational programs leading to self-improvement and enjoyment and highlighting positive aspects of LGBT aging.

DISCUSSION

This study of the social care networks of older LGBT adults in Chicago extends the limited research in this domain with regard to social support networks and exchanges of assistance, and contributes new findings in the areas of service utilization and the service needs of this population. Although this sample reported relatively high socioeconomic status in terms of education and income adequacy, it is important to recognize that many were struggling economically with nearly one out of six not having enough for expenses. Nearly one-half were just managing on their incomes, dispelling the myth of the "wealthy" gay demographic, echoing other research on income disparities in this population (Black, Makar, Sanders, & Taylor, 2003; Martell, 2010; Prokos & Keene, 2010). HIV has clearly had an impact on this community and contributed to the high rates of disability (30%) and the high prevalence of physical and mental health conditions. However, HIV is not the only health issue for this group. On average, the number of health conditions among those without HIV was 2.4 as compared to 2.6 for the entire sample (i.e., including those with HIV). Among those who are HIV-positive, an average of 3.1 comorbid conditions is reported, nearly identical to the findings on HIV-positive adults over 50 in New York (Havlik et al., 2011). Approximately one out of six reported at least one PADL difficulty, whereas over one-third had at least one IADL challenge. One-third had rates of depressive symptoms considered to be clinically significant. Smoking and substance use were also prevalent. These findings on the physical and mental health status of this population reflect data from other reports (Fredriksen-Goldsen et al., 2011; IOM, 2011).

Considering their relatively young average age of 60 years, the findings on health and disability rates in this sample suggest that many will

need to engage their social care networks now and in the future. Only one-third have spouses or partners, and nearly two-thirds live alone. Men were significantly more likely to report living alone than women and are likely at greatest risk for isolation, as has been documented in other studies (Fredriksen-Goldsen et al., 2011; Grossman et al., 2000; Shippy et al., 2004). Although the biological family is present, many family members are not connected with these LGBT older adults and cannot be classified as functional members of the social care system. Lesbian and bisexual women are significantly more likely to have children and grandchildren, and are also more likely to keep in contact with siblings compared with men. Consequently, women appeared to benefit from their greater likelihood of having offspring in terms of significantly larger social networks and receiving more types of help from family members compared to men. However, this greater involvement with family often translated into increased levels of negative social support.

Congruent with other research on LGBT populations, friends are the backbone of the social support networks, and were the most prevalent functional network element (77%). Research has found that older LGBT adults who report having friends available for needed assistance evidence better mental health compared to their counterparts without such support (Masini & Barrett, 2008; Shippy et al., 2004; Smith, McCaslin, Chang, Martinez, & McGrew, 2010). Indeed, we found that in this sample, having a functional friend was correlated with positive affect ($r = .16$, $p < .02$) and depression ($r = -.16$, $p < .02$). Older gay and bisexual men had significantly more friends with HIV when compared to women ($M = 1.1$ and $M = 0.2$, respectively). This may have consequences for these older men as they attempt to secure caregiving and other supports as they grow older. Because HIV-positive older adults have high rates of morbidity and resultant functional incapacity, these friends may not be in a position to provide support in times of need.

Reflecting Cantor's Hierarchical Compensatory Theory of social supports (see Cantor & Mayer, 1978) and their social network characteristics, older LGBT adults reported frequently turning to formal community-based services, using approximately six, on average, in the previous year. Gay and bisexual men, who were more likely to be HIV-positive and use HIV services, reported higher service use overall compared with women. This finding is explained by two factors; need and the use of case management. As noted earlier, those with HIV in this sample and a greater number of comorbid conditions, on average, compared to their peers, and thus likely have higher service needs. Other research has documented that higher levels of need tend to drive service utilization in older populations (Brennan-Ing, Seidel, London, Cahill, & Karpiak, 2014/this issue; Cantor & Brennan, 1993, 2000). In addition, the HIV-positive participants in this sample are also more likely to have used case management services compared to those without an

HIV diagnosis (61% and 12%, respectively; Brennan-Ing, Karpiak, & Seidel, 2011). Higher utilization of case management is also linked greater service utilization (Brennan-Ing et al., 2014/this issue; Cunningham, Wong, & Hays, 2008; London, LeBlanc, & Aneshensel, 1998). In terms of other services, older gay and bisexual men were almost 3 times as likely as women to have sought assistance from religious clergy in the past year. This may also be explained by the higher prevalence of HIV among men in this sample. HIV infection, although currently a treatable illness, remains life-altering and life-threatening and may lead one to seek religious and spiritual guidance in coping and adjusting to this diagnosis (Brennan, 2008; Vance, Brennan, Enah, Smith, & Kaur, 2011).

Older LGBT adults reported needing, on average, 2.5 services in the previous year. More men than women reported needing help with entitlements or finding a job, which is in line with the higher rates of disability and lower rates of employment in this sample among men as compared with women. Women were more likely to say they needed help with home repairs (35%), which was also an issue for one out of five men. This is congruent with the greater likelihood of lesbian and bisexual women in this sample to be co-op or condominium owners compared to gay and bisexual men (63% and 37%, respectively).

A majority of the sample reported the need for socialization opportunities. As noted earlier, nearly two-thirds of this sample lived alone, which fosters social isolation and feelings of loneliness. In addition, the qualitative findings revealed that, although gay and lesbian bars are often the public squares of the LGBT community, many of these older adults were looking for other venues to meet friends and romantic interests. Part of this was due to the perceived ageism in the bar scene, and part was not knowing what other options were available.

Many of these LGBT adults see aging as chance to grow, explore and make the most of life. Although our quantitative inquiry had focused on health and social service needs, a number of respondents used the open-ended items to express the need for educational, cultural, and recreational programs. Cost was clearly an issue for a number of individuals and financial help in accessing these resources was expressed. There was also unmet need expressed for spiritual and religious programs that would respect their sexual and gender identities.

Limitations

This study employed a convenience sample of older LGBT adults and the extent to which the findings are generalizable to the larger population are unknown. Due to small numbers, we were unable to perform statistical comparisons with transgender or intersex respondents, although they were included in the overall descriptive data and qualitative analysis. Future

research should specifically target these groups and recruit samples of a sufficient size to yield valid data. Finally, the bivariate comparisons made between men and women did not control for other factors on which these two groups differ. However, because our purpose was to provide information useful for policy and program planning, we felt the comparison by gender was both useful and appropriate.

Program Implications

Many aging LGBT adults will likely need to access community-based services given their high levels of need and often inadequate or unavailable informal social supports. How will the current network of aging service providers rise to meet this challenge? At present, LGBT older adults needing formal assistance may access services tailored to the LGBT community or seek mainstream aging services; both have challenges. LGBT-specific social services are unavailable in many communities. For example, Knochel et al. (2011) found that only 2% of aging service providers offered gay- and lesbian-specific services. Another study found that only a little more than 10% of substance abuse treatment centers had services tailored for the LGBT population (A. K. Hughes et al., 2011). Nationally, few older LGBT adults have access to services addressing their specific needs. In large metropolitan areas such as Chicago, there tends to be greater availability of programs such as the senior programs at the COH. Although it was only this year that SAGE was able to establish the first LGBT-dedicated senior center in New York City, despite the historically large sexual minority population in the area (SAGE, 2013b). However, even in large urban areas, services may not be available as one respondent in this study noted the dearth of LGBT providers on Chicago's South Side. Clearly we need to expand local programs and other opportunities that specifically target LGBT older adults in the communities where they reside.

Findings from this study underscore that some LGBT older adults do rely on LGBT-focused organizations to meet their needs, yet they tend to mainly rely on mainstream providers, such as government offices and agencies (1.7 services, on average), community-based social support, and health care providers (2.6 services, on average). However, challenges exist for older LGBT adults when trying to access mainstream services. Some fear doing so due to real and perceived discrimination (Knochel et al., 2011). Accessing mainstream providers also raises the issue of sexual identity disclosure to non-LGBT providers, which is exacerbated by fear of discrimination. This was supported by our qualitative data specifically around accessing religious and spiritual programs. For mainstream service providers, identifying and working with the older LGBT population, which can be "invisible" is a challenge. Disclosure to health care providers is critical to receiving appropriate care and it has been suggested that routine questions about

sexual identity could assist in this process. However, studies have demonstrated that non-disclosure to health providers is not uncommon (Clover, 2006; Steele, Tinmouth, & Lu, 2006; Wilging, Salvador, & Kano, 2006). In addition, disclosure appears to be more difficult for lesbians, as well as gay and bisexual men of color (Bernstein et al., 2008; Klitzman & Greenberg, 2002).

Without a concerted effort to address the unique issues of LGBT aging and to intentionally create a safe and welcoming space for LGBT older adults, it remains likely that LGBT older adults may be reluctant to access mainstream services. Thus, it is imperative that mainstream providers improve their LGBT cultural competency through training and capacity building efforts. Some interventions have focused on the creation of more culturally competent LGBT services by sensitizing health and aging providers through the use of education directed at staff and engaging the LGBT community; however, the effectiveness of these programs was mixed (Anetzberger, Ishler, Mustade, & Blair, 2004; Clark, Landers, Linde, & Sperber, 2001). On the positive side, many aging providers are open to receiving such training and better serving older LGBT adults (Knochel et al., 2011). Given the mixed-results to date, it is important that such programs be evaluated in terms of efficacy and best practices. LGBT cultural competency should be mandated for providers receiving local, state, or federal funding.

Finally, specific steps must be taken at the program level to address the socialization needs and pervasive isolation that too often characterize the aging LGBT adult. Isolation contributes to feelings of loneliness and depression, which, in turn, are related to poorer heath outcomes (Havlik et al., 2011). Moreover, isolation reduces the already frail support systems of these LGBT older adults because it mitigates against their ability to cultivate additional support resources as they grow older. There are many steps programs can take to reduce isolation. For example at COH, isolation is reduced by connecting individuals with their peers through a variety of social, recreational and educational programs specifically designed for LGBT older adults.

Policy Implications

Population-based LGBT research. Findings from this study underscore the challenges that older LGBT adults confront as they age with regard to financial difficulties and physical illness. More must be done to better document the health and economic disparities faced by LGBT adults as they age. At present, there is no representative national survey or database available to inform us on this topic (IOM, 2011). The inclusion of sexual orientation and gender identity questions on national surveys is crucial if we are to obtain sound population-based data on LGBT older adults, and the U.S. HHS (2011) is taking important steps in this direction.

Housing. The need for senior housing that addressed the unique needs of the LGBT community was frequently expressed in our qualitative data. This may reflect fear of discrimination and poor treatment in mainstream environs. Affordable housing was also a concern for the older LGBT adults in this study. Federal support for senior housing, such as Section 8, should in part focus on developing and identifying affordable LGBT senior housing. In addition, Title VIII of the *Civil Rights Act of 1968* (Fair Housing Act; U.S. Department of Housing and Urban Development, 2013) should be expanded to prohibit housing discrimination against LGBT adults.

Older Americans Act reauthorization. Declaring older LGBT adults a population of "greatest social need" would help to direct federal monies supporting state and local area agencies on aging to meet the health, housing, economic, and social service needs of this population. This would also assist in freeing funding for urgently needed cultural competency programs for aging providers.

CONCLUSION

Whereas aging is a time of personal growth for some, other older LGBT adults face considerable challenges in meeting basic human needs. Some had trouble being able to afford and secure food. Chronic health issues are common in this population and suggest that caregiving and other forms of assistance will be necessary to enable many of these individuals to continue to live independently. Although considerable support is received from friends, the majority live alone, and many lack the family supports that most older adults rely on in times of need. Unemployment in this group was higher than the national average (12%) and many had difficulties finding a job, often due to apparent ageism. Others had a need for affordable housing suitable to older adults, or were in fact homeless. Some of these older adults who identify these basic needs are utilizing government and community-based services and are likely receiving entitlements, but they perceive that the safety net is fraying and their quality of life has begun to decline. For those who are isolated due to illness, stigma or an absence of friends and family members, the risk is that these older LGBT adults will fall through the cracks if we are unable to better address their social care needs.

FUNDING

Funding for this study was obtained from a grant from Human Resources Services Administration to the Center on Halsted, Chicago, IL, who commissioned the work with AIDS Community Research Initiative of America.

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