FINAL REPORT

Health and Psychosocial Needs of LGBT Older Adults

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EXECUTIVE SUMMARY

This research study provides one of the most comprehensive descriptions of the health, well-being and social context of Lesbian, Gay, Bisexual, and Transgender (LGBT) older adults. This effort describes the characteristics of an aging LGBT population residing in Chicago, IL. These data should be used to facilitate policy-making and program decisions to address the current and future needs of these individuals. The study provides in-depth data on the health status of the aging LGBT community, including sexual health and concomitant risk behaviors, as well as the challenges of living with HIV. Detailed information was collected on social networks which are critical sources of support for an aging population, regardless of sexual identity. These older LGBT adults will also need to access community-based formal services as they age. Consequently, this study examines the service utilization patterns and the service needs of this older LGBT group, including unmet need in the past year.

The sample of just over 200 individuals had an average age of 60, 71% were men, 24% were women, and 5% were transgender or intersex. One-third reported being HIV-positive and 94% of this group were men. Those who were HIV-positive reported an average age of 55 years, whereas those who were HIV-negative were older, having an average age of 62.

- Eighty-percent of the sample identified as gay or lesbian, 14% as bisexual, and 5% as queer/questioning.
- One-third was Black or African American (32%), with the remaining 62% being primarily White.
- Over half of the sample had a college degree or post-graduate education.
- In terms of work status, 29% were currently working, 13% were unemployed, and 28% were retired. Nearly one-third were on disability.
- A sizeable minority were experiencing income inadequacy, with 15% reporting that they did not have enough money to cover expenses, and an additional 46% just managing to get by.
- Forty-two percent were home owners and 46% renters, comparable to the 44% home ownership rate in Chicago obtained from the 2010 Census.
- The majority (55%) indicated that they were not currently in a relationship and 62% reported living alone.
- Older LGBT adults reported primarily Protestant (23%) or Catholic (19%) religious affiliations, while 24% reported no affiliation. Nearly two-in-five older LGBT adults said that they turned to their religious congregations for support.

The majority (76%) of the sample rated their health as good or excellent. The older LGBT adults with HIV, though younger, reported significantly more health problems on average.

- Most (57 %) accessed care from a private doctor/clinic and almost 1/3 received heath services from a public clinic or hospital.
- Almost 60% indicated having at least a little trouble with vision and 37% reported having at least a little trouble with hearing.
- Almost half of the HIV+ group were presently smoking compared to 13% for those who were not positive.
- Current use of alcohol (63%) and pain killers (25%) did not differ significantly by HIV status.
- Twenty-percent of the sample reported that they were currently in recovery for a drug or alcohol problem.
- Over 1/3 evidenced having moderate levels of depressive symptoms and 20% had severe depressive symptomatology. Older LGBT adults with HIV were nearly twice as likely to report severe depressive symptoms compared to the non-infected (29% and 14%, respectively).

Among the 71 study participants who were HIV+, the average time since HIV diagnosis was 15 years. Almost 40% had been diagnosed with HIV in the last 10 years with the majority having been infected through unprotected anal intercourse.

- Half of this group had received an AIDS diagnosis.
- Nearly all (97%) were on antiretroviral therapy and the majority reported CD4 counts over 500 indicating their HIV infection was well controlled.

On average, older LGBT adults reported 11 people in their social networks, consisting of parents, family members, friends and neighbors. However, as documented in previous research, older LGBT adults tend to have friend-centered networks consisting of "families-of-choice" and have less involvement with biological family members compared to their heterosexual peers.

- Friends were the most likely to be able to provide assistance with day-to-day tasks as well as provide emotional support and advice.

- Older LGBT adults were much more likely to report receiving emotional support as compared to help with instrumental tasks (43% to 56%).
- Over one-quarter (27%) of older LGBT adults indicated that they and their neighbors helped each other on a regular basis.
- The older LGBT adults who were HIV+ were significantly less likely than those who were HIV- to perceive that emotional support was available all or most of the time. The HIV+ group was also significantly less likely to indicate having received all the emotional support they needed in the past year.
- Over 80% of the study sample said they did not currently need or use caregiving assistance. About 20% of the older adults with HIV indicated they could use caregiving support.
- Nearly one-quarter had provided caregiving assistance to someone during the past 5 years.

This study is one of the first to examine the sexual health of older LGBT adults. Sixty-nine percent were sexually active during the past year. Those under age 60 were more likely to report being sexually active compared to those who were older. Those living with HIV had significantly more sexual relationships when compared to those who were not HIV infected.

- Older LGBT adults tended to be involved with a partner who was younger (64%).
- Older adults with HIV were significantly more likely to indicate sex was extremely important as compared to those without HIV, but there were no differences between groups in terms of how often they thought about sex.
- About 1/3 said that their frequency of sexual activity was what they expected and 60% reported not having sex as often as desired.
- Forty-one percent of older LGBT adults indicated that they had avoided sexual activity, either because of lack of interest or physical problems (e.g., erectile dysfunction).
- In terms of safe sexual practices, approximately one-third never used condoms during either anal or vaginal intercourse.
- When asked why they would engage in unprotected sex, 14% of those with HIV said because they were depressed, while only 2% of those without HIV gave that as a reason.

The study examined the utilization and satisfaction with services at the Center on Halsted as well as those at local government offices and agencies, HIV-related services and AIDs Service Organizations (ASOs), health-related services, and other older adult community-based services.

- The most frequently used government services included the Social Security Office (43%), Department for Family and Support Services, Senior Division/Department on Aging (27%), Housing Authority (21%) and Medicare and Medicaid Offices (21% and 20%, respectively). Use of government offices and agencies was greater by the HIV+ older adult.
- The HIV+ older adults as expected used more services at AIDS service organizations and HIV-related CBO services.
- There were only two instances where HIV status was significantly related to use of health and long-term care services. Older HIV+ adults were significantly more likely to have used case management (61%) as compared to those without an HIV diagnosis (12%). Also, one-in-five HIV+ adults used drug and alcohol treatment/recovery in the past year as compared to 8% among non-HIV infected older LGBT adults.
- Senior centers were the most frequently mentioned other older adult community based service (25%). Clergy, meal/nutrition programs, and legal services were used by about one-in-five older LGBT adults during the previous year.
- Legal services were used by HIV+ people at a rate (32%) twice that of the HIV- group (15%).
- The most frequently utilized service provided by COH was the SAGE Congregate Meal Program (36%) followed by SAGE social and education programs (26%). Approximately one-in-ten used HIV support groups, mental health supportive services, or legal services (11%).
- The non-HIV infected older LGBT adults were more likely to use SAGE programming at COH, which may be related to the greater average age in this group.
- Overall, satisfaction with COH services was high with the most highly rated service being the computer technology center, followed by SAGE social and educational programs, and SAGE congregate meals.
- When asked what additional services they would like to see COH provide, the most frequently mentioned were assistance with housing and employment issues, more opportunities for socialization, and more programs aimed specifically at women.

Older LGBT adults were most likely to indicate using Medicare coverage (45%) followed by private health insurance (43%).

- Approximately one-quarter were enrolled in Medicaid and Food Stamps and about one-in-five reported income support either through Supplemental Security Income (SSI) or Social Security Disability (SSD).
- Only about one-in-ten had purchased long-term care insurance, and fewer (3%) had private disability coverage.
- Although 14% had served in the armed forces, only 7% received health care coverage through the Veterans Administration (VA).
- Older adults with HIV were more likely to access Medicaid and Food Stamps (49% and 41%, respectively) as compared to the non-HIV positive group (16% and 18%). A similar pattern was seen when receiving income support in the form of SSI (30% vs. 18%, respectively) or SSD (43% vs. 10%, respectively).

Fifty-eight percent of the sample reported at least one barrier to community-based services. Older LGBT adults with HIV reported significantly greater number of barriers to services, on average, as compared with their non-infected peers (3.9 vs. 2.2, respectively).

- Service barriers included: 1) they did not think they would be eligible to receive free services (43%); 2) worry about the cost of services (32%); and 3) knowledge of available services and their location (36% and 24%, respectively).
- Almost 30% thought getting services was confusing and/or difficult and a quarter thought that they would have to wait too long.
- The most frequently mentioned organizational barrier was that staff was unhelpful or seemed unmotivated (21%).
- Stigma and discrimination issues were mentioned by approximately one-in-ten, namely, feeling that staff did not like people like themselves or that they would not receive services if they tried.
- HIV stigma also appears to be an issue, with one-in-five HIV+ older LGBT adults feeling “staff didn’t like people like them” as compared with only 6% of the non-HIV diagnosed group.

- Older HIV+ LGBT adults were also more likely to cite contextual issues, such as disclosure of their HIV status (18%), difficulty in making or keeping appointments (13%) and childcare issues (9%) as barriers to care.

Older LGBT adults were asked about their need for services in the past year from a list of commonly utilized health and social services, whether their needs had been met, and if so, who provided the help (e.g., family, community-based organization).

- The average number of services needed in the past year was 2.5 (SD=2.2) and the average number of unmet needs was 0.6 (SD =0.9); this did not differ significantly by HIV status.
- Half the sample identified socialization as their highest unmet need followed by about 1/4 who noted one of the following; getting to medical appointments, post-hospital care, counseling and someone to call or visit regularly.

METHODOLOGY NOTES

Recruitment of this convenience sample took place in Chicago, primarily at the Center on Halsted but also at various AIDS Service Organizations, health fairs and community events throughout the city. To qualify for participation an individual had to identify as lesbian, gay, bisexual or transgender (LGBT), be 50 years of age or older and speak English as their primary language. Recruitment yielded 233 participants, resulting in 211 usable surveys. Participants provided informed consent prior to data collection. The survey instrument was self-administered by hand using a printed copy. On average, participants took 45 to 60 minutes to complete the survey. After completing the survey they were debriefed and thanked for their participation. As an incentive participants received a $25 gift card for taking part in this research project. Research methods and materials were evaluated and approved by the Copernicus Group Independent Review Board (IRB).

The survey instrument obtained information on the following areas: (1) demographic characteristics; (2) HIV/AIDS status; (3) physical conditions; (4) informal social supports; (5) caregiving (both receiving and providing care); (6) formal service utilization; (7) mental health; (8) substance use; (9) sexual behaviors; (10) health-related quality of life; and (11) religion/spirituality. Whenever possible standardized measures with known psychometric properties were used to insure validity and for comparison with other published data. Questions were developed based on items in *Research on Older Adults with HIV* (ROAH)[4] study, *National Social Life, Health and Aging Project* (NSHAP)[5], and the *Caregiving among Older Lesbian, Gay, Bisexual and Transgender New Yorkers* study[6]. When noted in the text, 'significant' refers to statistically significant differences at the $p < .05$ level or greater.

[4] Brennan, M., Karpiak, S.E., Shippy, R.A., & Cantor, M.H.(Eds.) (2009). *Research on Older Adults with HIV: An in-depth examination of an emerging population.* New York: Nova Science Publishers.

[5] Lindau, S. T., Schumm, L. P., Laumann, E. O., Levinson, W., O'Muircheartaigh, C. A., & Waite, L. J. (200&). A study of sexuality and health among older adults in the United States. *New England Journal of Medicine, 357*, 762-74.

[6] Cantor, M.H., Brennan, M., & Shippy, R.A. (2004). *Caregiving among Older Lesbian, Gay, Bisexual and Transgender New Yorkers*. Washington, DC: The National Gay and Lesbian Task Force Policy Institute.

INTRODUCTION

The health, well-being and social networks of the older Lesbian, Gay, Bisexual, and Transgender (LGBT) population are understudied. As people age they rely on the informal supports in their network for caregiving. In the United States most caregiving is provided by partners and children; LGBT older adults are more likely to live alone and less likely to have children than older heterosexuals. Although significant numbers of LGBT individuals give and receive caregiving from their family of origin some LGBT individuals have been ostracized by their family. Research suggests that LGBT persons are more likely to rely on friends, sometimes referred to as the *family of choice,* for caregiving and this may prove problematic as friends in the network age and also require assistance. One study of LGBT older adults found that a third of those without partners did not know who would care for them if they needed assistance.[7] Without traditional caregivers, these aging adults may rely increasingly on formal support services that may not be ready to meet the needs of LGBT older adults.

Older adult sexuality is often ignored in research despite significant rates of sexual activity in this population. In 2006 the National Health Social Life, Health and Aging Project provided comprehensive information on the sexual behaviors of older adults but did not specifically address LGBT older adults; leaving a need to look specifically at the sexual behavior, satisfaction, and barriers to sexual expression among LGBT older adults. As the rate of substance abuse in the LGBT community remains high, it is also important to further examine substance use, its relationship to sexual activity including sexual risk behaviors.

HIV still disproportionately affects the LGBT community. HIV is now a chronic and manageable disease that may be further complicated by the comorbidities associated with aging. But our research and that of others shows that today's older HIV population finds itself again disconnected from family and again facing the challenge of stigmatization. In order to age successfully they will need long-term caregivers. The combined management of HIV/AIDS and age-related comorbidities will have a profound impact on an already challenged health care delivery system. The need for caregiving and its critical role in health care management is evident. This is a population at risk. As HIV/AIDS affects greater numbers of older adults, their informal support networks will be challenged to provide needed instrumental assistance and emotional support as they adapt to life with multiple chronic illnesses (e.g., arthritics, diabetes, cardiac disease) that take their place alongside the life-threatening illness of HIV. Research data supports the conclusions that many in the growing ranks of older adults with HIV, who will be without informal caregivers, will find themselves wholly dependent on an already frayed formal care and services safety net. There is a clear need to better understand the existing social networks of these at risk older adults in order to preserve and expand that safety net to meet the needs as they age with HIV.

Lastly, given the inadequate informal social networks of many LGBT older adults and their expected reliance on the systems of formal, community-based organizations and supports, it is

[7] Met Life Mature Market Institute, Lesbian and Gay Aging Issues Network of the American Society on Aging, and Zogby International, (2006). *Out and aging: The MetLife study of lesbian and gay baby boomers.* Retrieved January 1, 2007 from: http://www.metlife.com/assets/cao/mmi/publications/studies/mmi-out-aging-lesbian-gay-retirment.pdf .

imperative that we have a better understanding of service utilization in this community. What services are used? What services are needed? And what are the perceived barriers to services in the community? These data will help policy makers, program planners and service providers meet the needs of LGBT older adults and facilitate their successful aging in the community.

Study Purpose

The purpose of this study is to better understand the health and psychosocial needs of the older LGBT population in Chicago as well as differences and similarities between LGBT older adults and LGBT older adults with HIV. Given what is known about the fragility of the informal networks of many of these older adults, it is imperative to gain an understanding of the integration of the systems of formal and informal social care. The goals of this cross-sectional survey are to provide data necessary for policy makers and program planners to best meet the real needs of this population as described below:

1. To assess the health status of LGBT older adults including physical and mental health problems, health-related quality-of-life, HIV status, and sexual health.
2. To assess in detail the informal social support networks and other caregiving resources that are available to the community of LGBT older adults in Chicago.
3. To determine what resources are accessed within a LGBT Community Center and which services are accessed in the larger community
4. To examine the extent of unmet need for formal services and barriers to service use among LGBT older adults.
5. To examine similarities and differences in use of services and barriers to service use of HIV-positive LGBT older adults and HIV-negative LGBT older adults.
6. To examine the sexual behaviors, sexual satisfaction and sexual difficulties among LGBT older adults.

DEMOGRAPHICS

The current sample included 211 lesbian, gay, bisexual or transgender (LGBT) older adults. Of these, 34% (n=71) reported being HIV-positive. Of the remaining 66%, most (49%) reported being HIV-negative and the remaining 17% were of unknown HIV status (i.e., had not had an HIV test). For this report, those who reported being HIV-negative or were of unknown status were grouped together for comparison with the HIV+ group, and are hereafter referred to as non-HIV infected/HIV-negative. The three individuals who were missing on the HIV testing variable were excluded from these comparisons based on HIV status.

The average age of participants was 60 years, and ranged from 48 to 92. Older adults with HIV were significantly younger compared to their peers on average (55.4 vs. 61.5 years). As illustrated in Figure 1, the majority of HIV-positive individuals were less than 55 years of age, while the largest group of HIV-negative respondents was 65 years or older (37%).

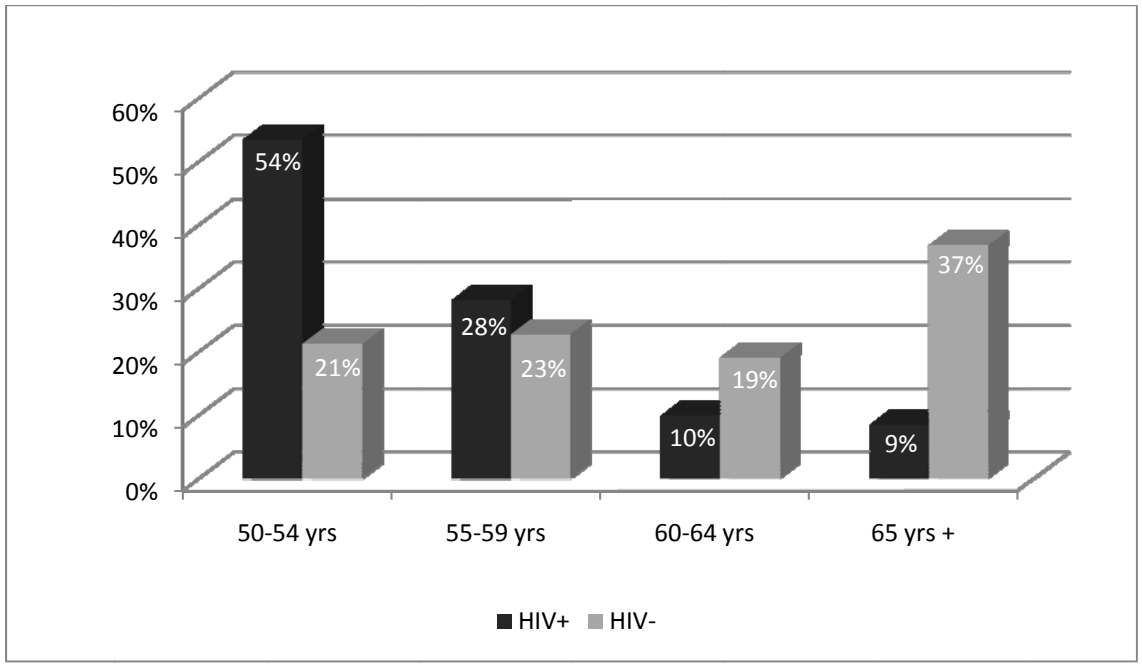

Figure 1: Age Distribution of the Sample

In terms of gender identity, 71% of the sample identified as male, and 24% identified as female. There were 10 transgender participants (1 female-to-male [0.5%], 9 male-to-female [4.3%]), and one person identified as intersex (0.5%). Gender identity varied significantly by HIV-status, with nearly all HIV+ individuals identifying as male (94%), 4% were transgender, and one female (1.4%). Among those who were not HIV-positive, there were a higher proportion of women (36%) and fewer men (58%).

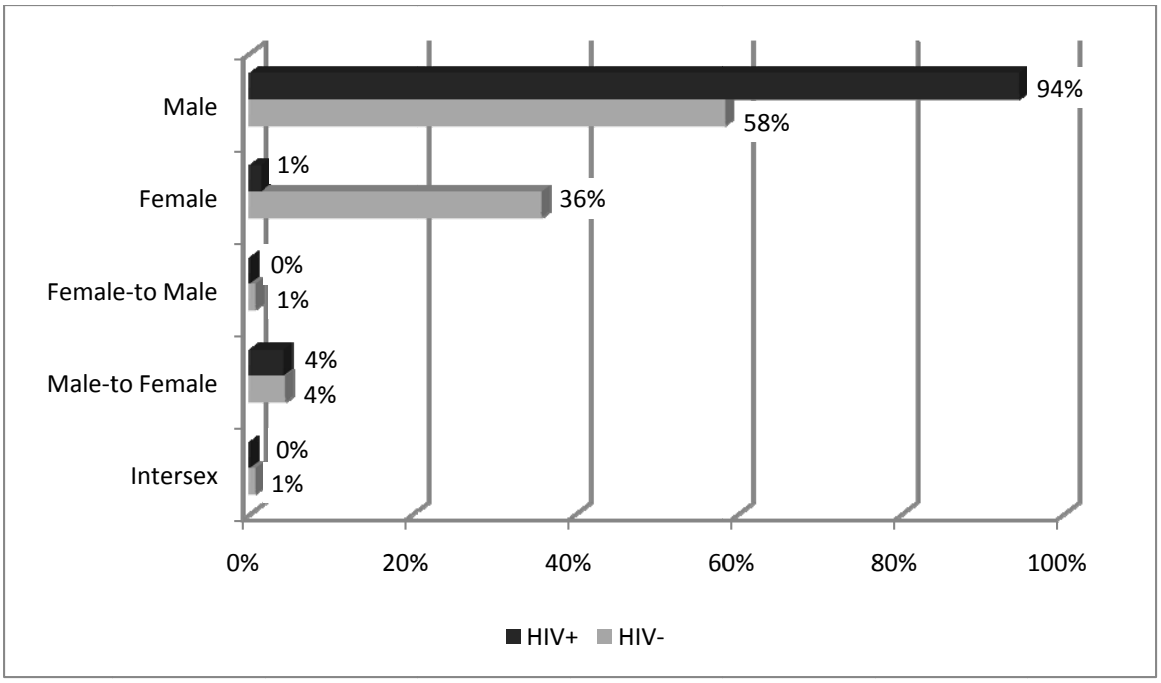

Figure 2: Gender Identity by HIV Status

Sexual identity did not differ significantly by HIV-status. Eighty-percent of the sample identified as gay or lesbian, 14% as bisexual, 3% as queer, and 2% as questioning. Three transgender individuals (2%) identified as heterosexual.

With regard to race/ethnicity, approximately one-third of older LGBT older adults in the present sample were Black or African American (32%), with the remainder being primarily White or Caucasian (62%). Hispanics comprised 4% of the sample, with Asians/Asian Americans, American Indians and Native Alaskans and "other" races making up 1% or fewer of participants. Race/ethnicity varied significantly by HIV-status, reflecting the disproportionate impact of HIV in communities of color as shown in Figure 3. Blacks or African Americans were the majority in the HIV-positive group (56%), followed by Whites (35%). In the non-HIV infected group, the majority were White (76%), followed by Blacks/African Americans (19%).

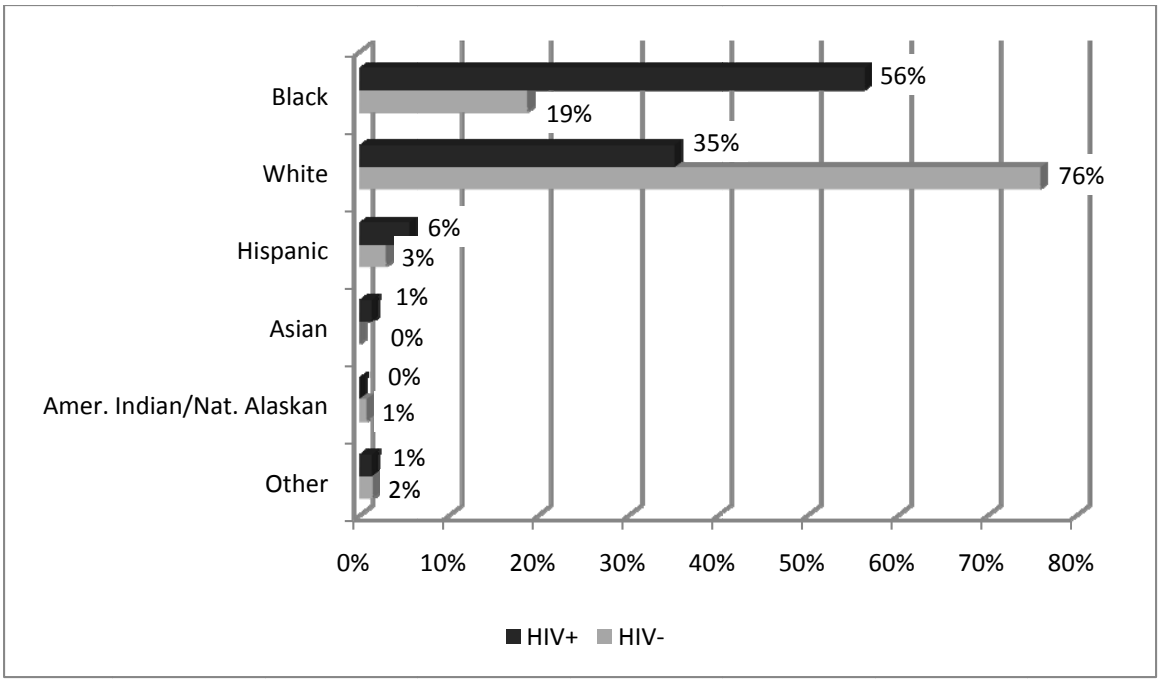

Figure 3: Race/Ethnicity and HIV Status

Nearly all older LGBT adults in the current sample reported being born in the United States (95%) and 99% reported speaking English at home. Nativity and language spoken at home did not vary by HIV status.

When asked if they had ever served in the armed forces, 14% of the sample indicated that they were military veterans, and this did not differ significantly by HIV status.

A similar proportion (13%) reported that they had been incarcerated (in prison) at some point in their lives, with HIV+ respondents significantly more likely to report a history of incarceration (23%) as compared with their peers (7%).

EDUCATION, WORK STATUS, & INCOME

Overall, educational attainment of the sample was high, with 56% having a college degree or post-graduate education, 24% attending vocational school or having some college experience, and 15% having graduated high school. Only 5% of the sample did not have a high school diploma or GED. Educational attainment was significantly lower in the HIV+ group compared with their peers, with 36% having college degrees or post-graduate educations as compared with 66% in the non-HIV infected group (see Figure 4).

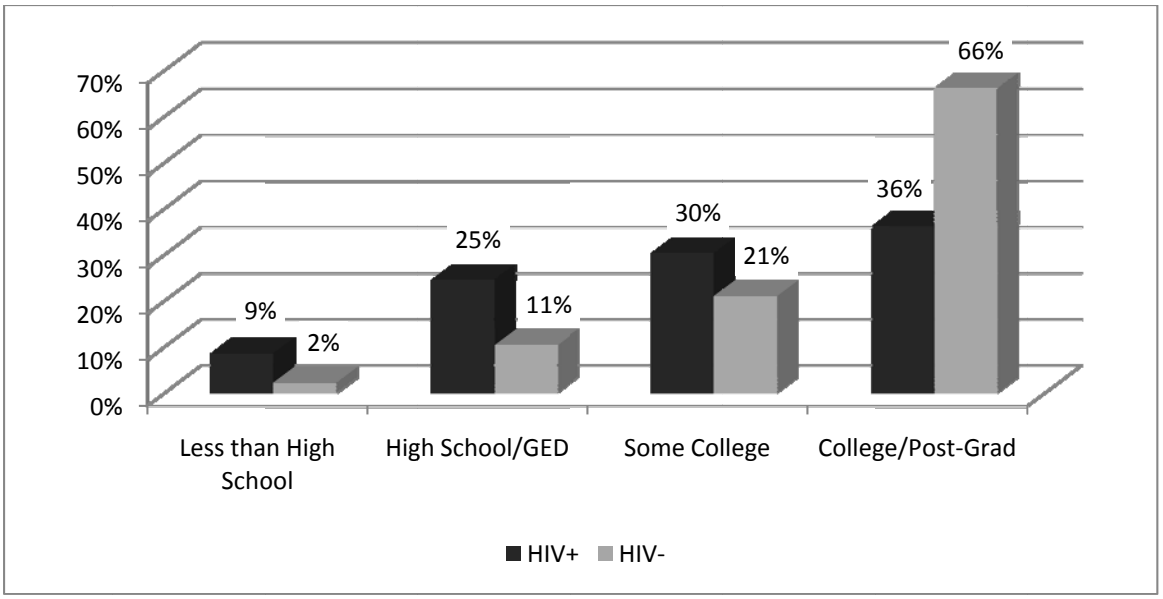

Figure 4: Differences in Level of Education by HIV Status

In the current sample of older LGBT adults, 29% were currently working either full- or part-time, 13% reported being unemployed, and 28% were retired. Nearly one-third (29%) reported being on disability. Work status differed significantly between the HIV+ group and their peers, with 57% of those living with HIV being on disability as compared with 13% in the non-infected group (see Figure 5). Older LGBT adults with HIV were also significantly less likely to be currently working, despite their younger average age, than their peers (20% and 33%, respectively), or to report being retired (9% and 38%, respectively).

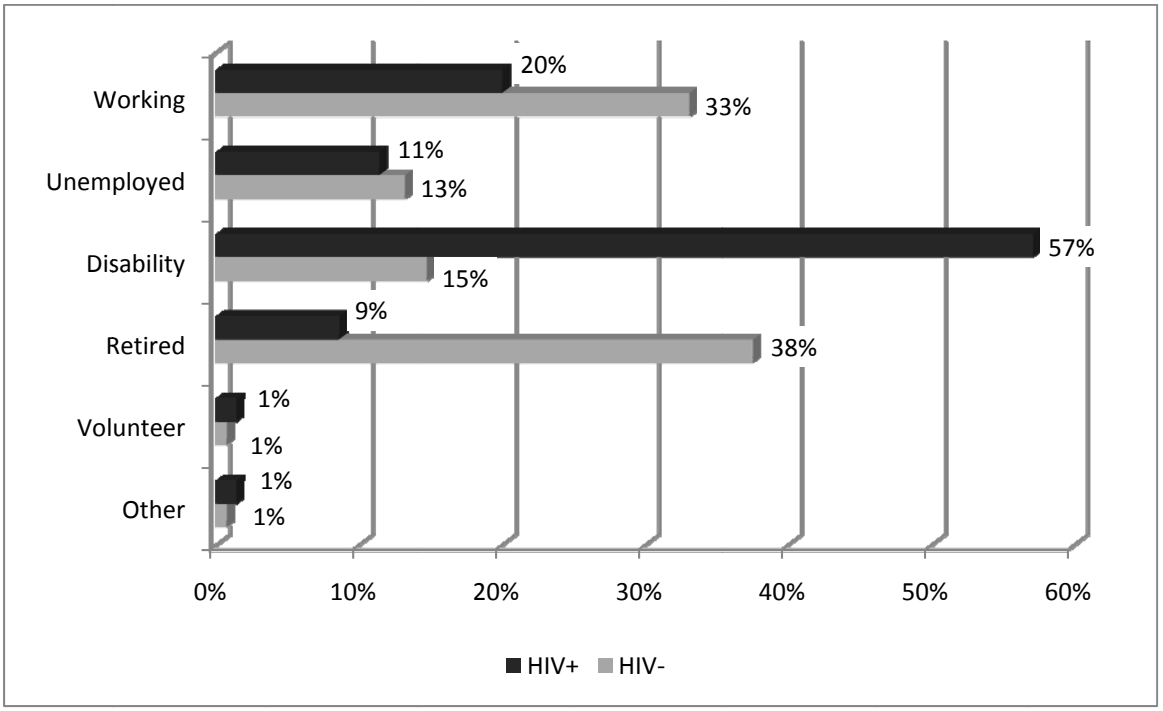

Figure 5: Employment by HIV Status

There were high levels of income inadequacy in the current sample of older LGBT adults, with 15% reporting that they did not have enough money to cover expenses, and 46% indicating that they just managed to get by on their income. About one-quarter (23%) said they had enough money with a little extra, and 16% reporting that money was not a problem. Income inadequacy was significantly worse in the HIV+ group compared to their peers, with over 80% reporting either that they did not have enough money (22%) or were just managing to get by (59%) (see Figure 6).

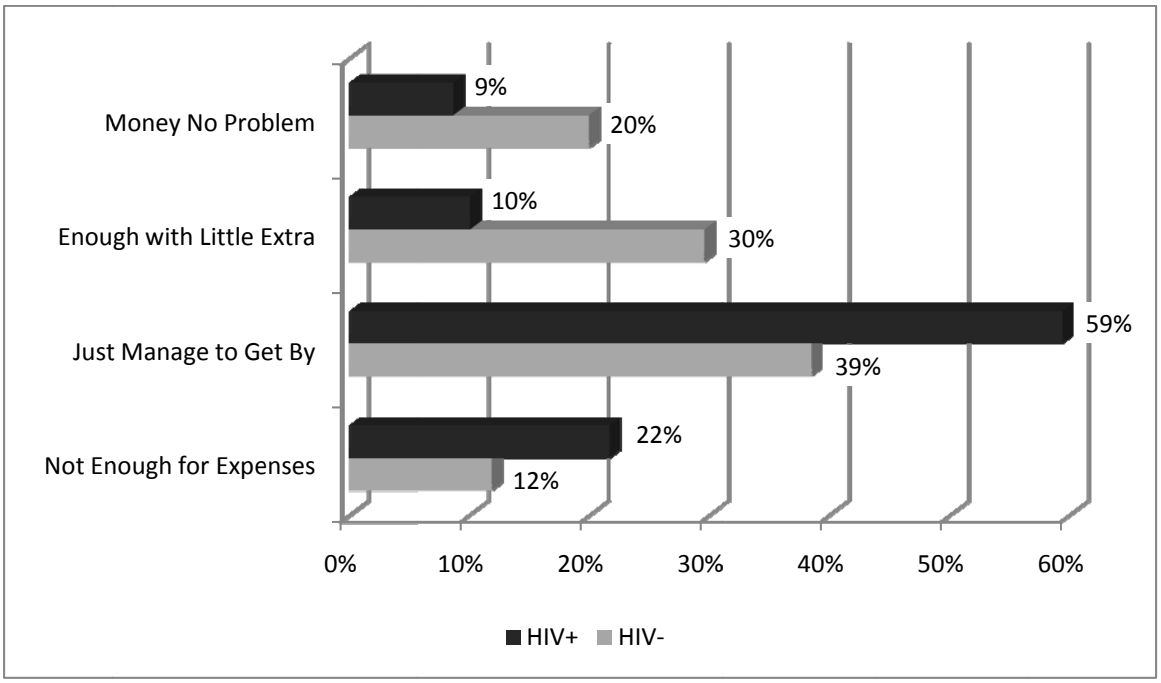

Figure 6: Income Adequacy by HIV Status

RELATIONSHIPS, PARTNER STATUS & LIVING ARRANGEMENTS

Forty-four percent of older LGBT adults reported that they were currently in a same-sex relationship, with 2% reporting that they were in an opposite-relationship. However, the majority (55%) indicated that they were not currently in a relationship. Over their lifetimes, 79% said that they had been in a long-term relationship with most reporting two or three such relationships (see Figure 7). While there were no significant differences in these relationship variables based on HIV status, older LGBT adults who were not HIV-infected reported that they had been in their current relationships significantly longer on average as compared with HIV+ adults (14.3 years and 8.9 years, respectively), and reported being more happy on average in their current relationship (5.9 and 5.4, respectively on a scale of 1 to 7).

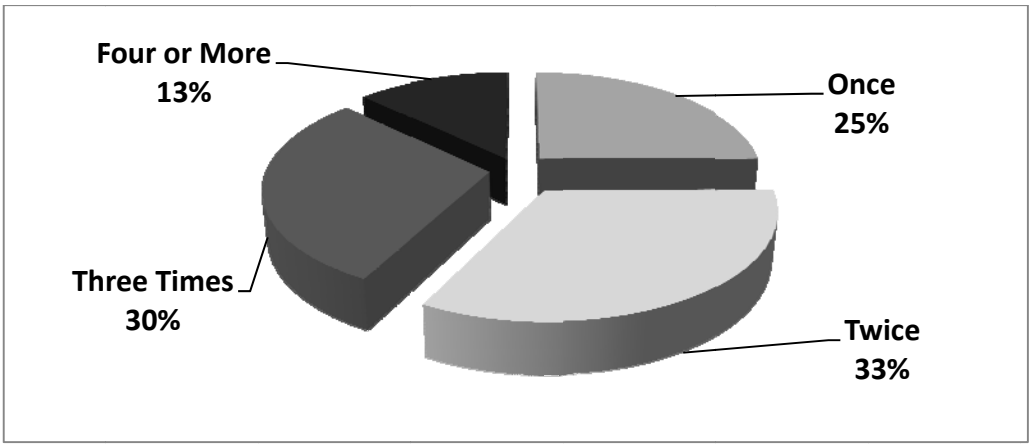

Figure 7: Number of Long-term Relationships

In terms of their legal partnership status, the majority of older LGBT adults reported being single/unmarried (53%), and only 4% reported being in a legally-recognized marriage and 1% in a civil union. While nearly one-third reported having a partner, only 5% were registered as domestic partners (see Figure 8). HIV status was not significantly related to legal partnerships.

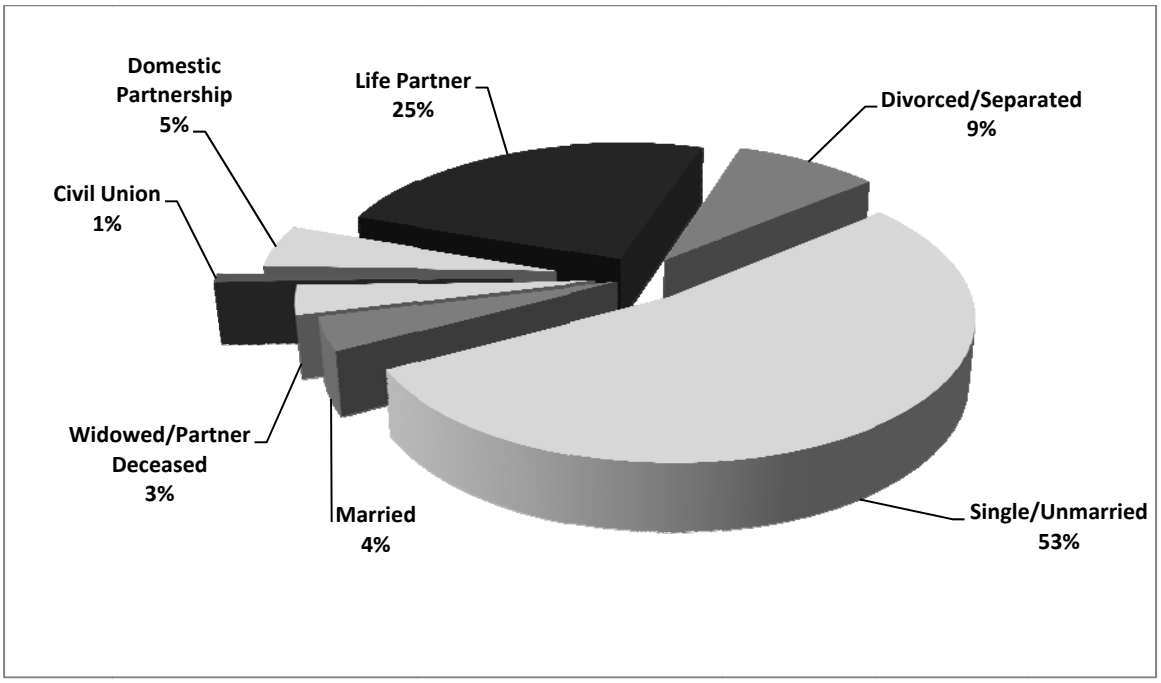

Figure 8: Legal Partnership Status of Older LGBT Adults

A majority of the older LGBT adults reported living alone (62%). While a higher proportion of older LGBT adults reported living alone compared to their HIV-positive peers (70% and 57%, respectively), this difference was not statistically significant. Among those living with others, most lived with a partner (58%) or spouse (11%). Eleven-percent lived with a child, while one-fifth lived with a friend (13%) or roommate (8%).

Older LGBT adults appeared to be in stable housing situations. Nearly equal proportions reported being home owners (42%) or renters (46%) of apartments, rooms, single-room occupancy housing (SROs), or scatter-site apartments. However, 12% indicated that they had not had stable or permanent housing in the past six months. Type of housing differed significantly by HIV status, with HIV+ older LGBT adults more likely to be renters, and their non-infected peers more likely to be home owners (see Figure 9). Furthermore, HIV+ adults were more likely to indicate no permanent housing in the past six months compared to their peers (16% and 11%, respectively).

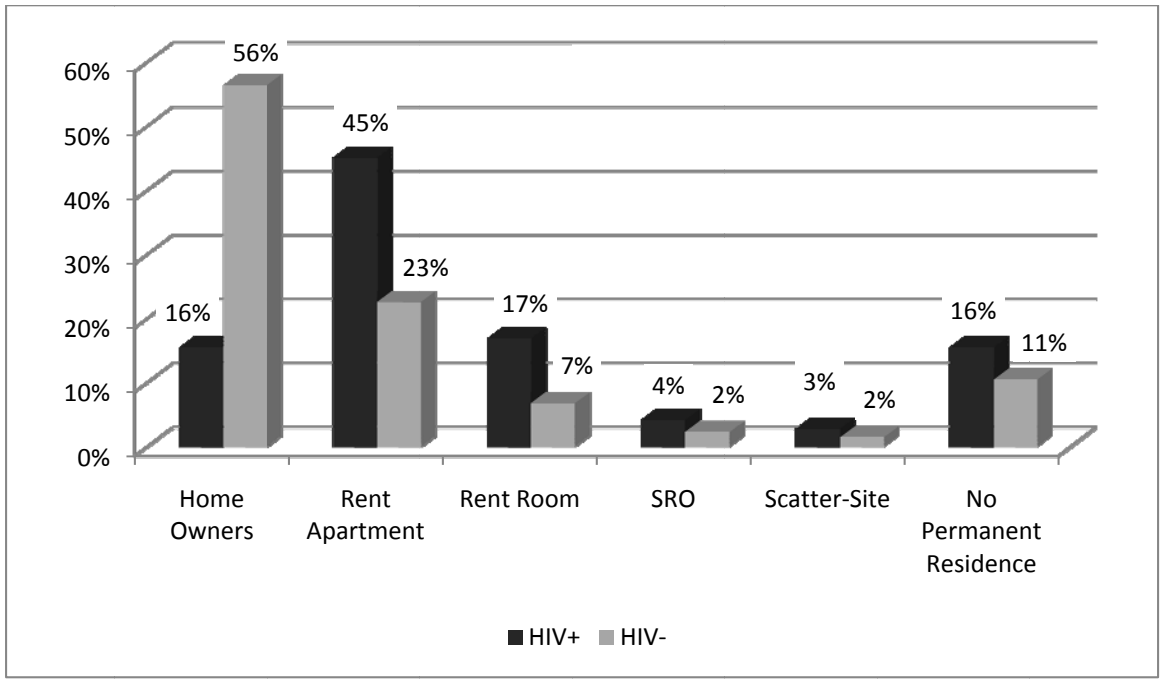

Figure 9: Housing Situation by HIV Status

Among those who rented, 86% reported that their name was on the lease, while among those living in non-rental housing, 93% indicated their name was on the title of the property. This did not vary significantly by HIV status.

RELIGIOUS AFFILIATION, PARTICIPATION & SUPPORT

With regard to religious affiliation, the largest proportion (43%) of older LGBT respondents reported being Christian (23% Protestant and 19% Catholic). Other religious denominations were mentioned much less frequently; Jewish (8%), Buddhist (2%), and Muslim (1%). Eighteen percent indicated that their religious affiliation was "other" (e.g., New Age, agnostic). However, nearly one-quarter reported no religious affiliation (24%) and 3% indicated being atheist. There were no significant differences in religious affiliation by HIV status.

When asked if having an LGBT identity had negatively affected participation with their religious congregations, most (77%) felt that it had not been a factor. Among those who were HIV-positive, two-thirds reported that living with HIV had not affected their participation, while 19% reported they were more involved with their congregations following diagnosis. However, 15% indicated they participate less often than they did before they were diagnosed.

Nearly two-in-five older LGBT adults (38%) said that they had turned to their religious congregations for support, and this did not differ significantly by HIV status. The types of support received from congregations varied, but the most frequently reported was spiritual and emotional support, as well as opportunities for socialization. Others reported receiving assistance through counseling, or receiving transportation help, financial assistance or nutritional support. Many noted how their congregations were "gay-friendly" and welcoming places to go. Those not receiving support were often reluctant to disclose their LGBT identities to the congregations, and/or felt that such information would not be well-received by the congregation due to homophobia and the anti-gay stance of their religion.

HEALTH STATUS & MEDICAL TREATMENT

When asked to rate their physical health, a majority of older LGBT adults indicated that their health was good (48%) or excellent (28%). However, 21% reported that their health was only fair, and 3% said they were in poor health. While not statistically significant, older LGBT adults with HIV were less likely to rate their health as excellent compared to their peers (19% and 32%, respectively) and more likely to rate their health as being good (57% and 43%, respectively).

Participants were asked if they had experienced any of 26 health problems in the previous year. On average, 2.6 health conditions were reported. Older LGBT adults with HIV reported significantly more health problems on average (3.1, SD = 2.5) as compared to their non-infected peers (2.4, SD = 2.0).

As shown in Table One below, older HIV+ LGBT adults were significantly more likely to report a number of health conditions as compared with their peers, including all types of hepatitis, sexually transmitted diseases (i.e., herpes, syphilis), neuropathy, and vision loss. Older LGBT adults who were not living with HIV were significantly more likely to report arthritis and hypertension compared to those who were HIV+, not surprising given the greater average age in the former group, and were also more likely to report "other" health problems as well (e.g., allergies, incontinence, back problems).

Table One: Proportion of Older LGBT Adults with Health Conditions by HIV Status			
Health Condition	**Total**	**HIV+**	**HIV-**
Arthritis***	35.9	21.1	43.7
Broken Bones	4.9	4.2	5.2
Cancer	7.3	5.6	8.1
Depression	46.1	52.1	43.0
Dermatological	15.5	15.5	15.6
Diabetes	15.5	12.7	17.0
Hearing Loss	11.2	8.5	12.6
Heart Condition	13.2	12.7	13.4
Hepatitis A**	2.9	7.0	0.7
Hepatitis B***	6.3	18.3	0.0
Hepatitis C***	7.8	16.9	3.0
Herpes***	7.8	18.3	2.2
Hypertension**	19.4	8.5	25.2
Impotence (males only)	13.1	14.9	11.5
Menstrual Difficulties (females only)	6.0	0.0	6.1
Migraines	4.4	5.6	3.7
Nervous System Disorder	4.4	7.0	3.0
Neuropathy***	14.1	25.4	8.1
Pneumonia	2.4	2.0	2.2
Respiratory Condition	2.4	1.4	3.0
Sexually Transmitted Disease (other)***	4.4	12.7	0.0
Shingles	1.9	2.8	1.5
Staph Infection	1.9	0.0	3.0
Stroke	2.4	2.8	2.3
Syphilis***	3.4	9.9	0.0
Vision Loss***	6.8	15.5	2.2
Other Health Problem*	12.1	5.6	15.6
* $p < .05$, ** $p < .01$, *** $p < .001$, Chi-square tests of significance			

When asked where they go for medical treatment, older LGBT adults were most likely to report a private doctor/clinic (57%), followed by a public clinic or hospital (29.9%). Given that few had served in the armed forces, it was not surprising that only 5% received medical treatment at a Veteran's Administration (VA) hospital. Older LGBT adults with HIV were significantly more likely than their non-infected peers to receive medical treatment at a public clinic/hospital (40% and 25%, respectively), and significantly less likely to use a private doctor/clinic (31% and 70%, respectively).

In terms of HIV-related medical providers, only 3% of older LGBT HIV+ adults reported using day programs at AIDS service organizations (ASOs), but 24% had used services at a Ryan White funded clinic.

When asked about using complementary and alternative (CAM) treatments for medical issues, the most frequently reported was taking vitamins (20%), and 10% reported using either nutritional supplements,

herbal supplements or teas. Massage was used by 13% of older LGBT adults, while 10% used the services of a chiropractor, 7% practiced yoga, but only 1% reported the use of Reiki therapy. Lastly, 9% reported that they meditated and 4% used acupuncture. Use of CAM did not differ significantly by HIV status.

HIV/AIDS STATUS AND SOURCE OF INFECTION

The HIV+ older LGBT adults (n=71) were asked a series of questions about their HIV status. On average, the length of time since HIV diagnosis was 176.9 months (SD=86.2) or 14.7 years. Twenty-five percent had been infected within the past 10 years, and 13% within the past 5 years. When asked how they had become infected with HIV, the majority indicated receptive or insertive anal sex (see Figure 10).

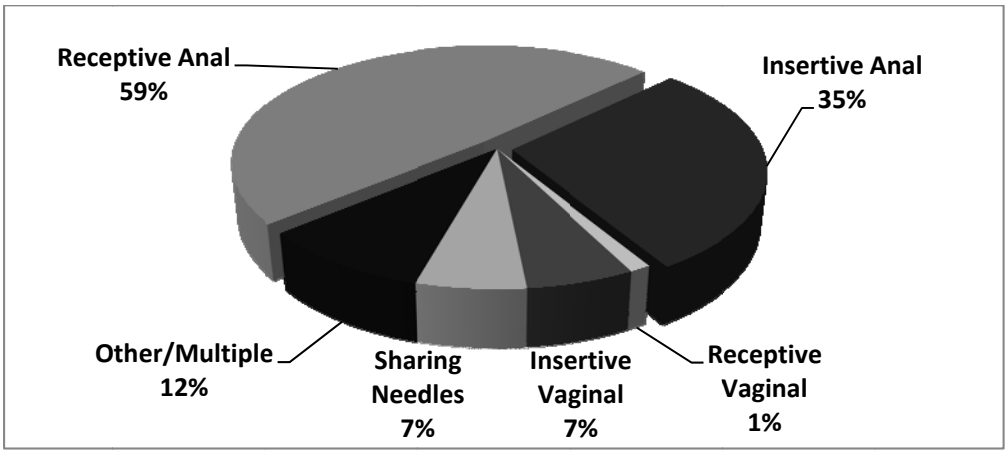

Figure 11: Self-reported Mode of HIV Transmission

Over half of these older LGBT adults had received an AIDS diagnosis (i.e., CD-4 count 200 or less or presence of opportunistic infection) at some point after HIV diagnosis. Nearly all (97%) were currently taking medications for HIV. When asked about their current CD-4 counts, the majority reported counts of 500 or more, indicating that their HIV disease is being well-managed (see Figure 11). However, it is notable that that nearly one-quarter had CD-4 counts below 350, with 15% reporting counts from 201 to 349, and nearly one-in-ten reporting CD-4 counts of 200 or less, indicative of poor immune system functioning.

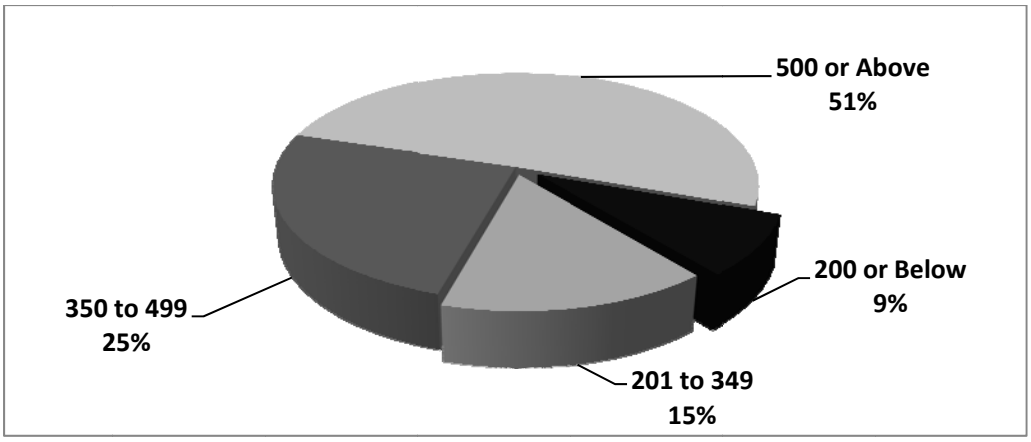

Figure 11: Most Recent CD-4 t-cell Counts of HIV+ LGBT Older Adults

VISION & HEARING FUNCTION

Participants were asked to self-report on their vision and hearing and indicate if they experienced "no trouble", "a little trouble", or "a lot of trouble" (including when wearing glasses/contact lenses, or hearing aids, respectively). With regard to vision, 38% indicated they did not have trouble with vision, while 60% indicated having a little trouble with vision, and 2% indicated having a lot of trouble with vision. Problems with vision function did not differ significantly by HIV status. With regard to hearing, 62% indicated no trouble, 37% reported having a little trouble, and 2% indicated they had a lot of trouble with hearing. Given the well-documented associations between hearing impairment and age, it was not surprising that older LGBT adults who were not HIV-infected reported greater problems with hearing as compared with the HIV+ group, given the former group's greater average age (see Figure 12).

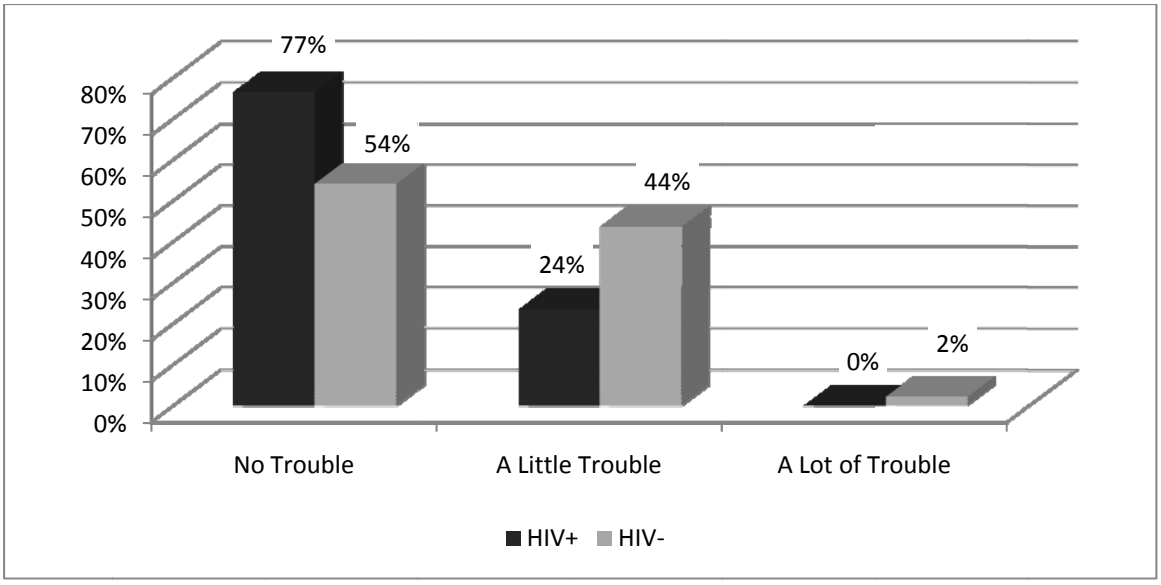

Figure 12: Self-reported Hearing Trouble by HIV Status

MENTAL HEALTH

In addition to the question about experiencing depression in the past year, participants completed the 10-item Center for Epidemiological Studies Depression Scale (CES-D).[8,9] Scores range from 0 to 30 with higher scores indicating more depressive symptoms. Scores of 10 or higher are considered clinically significant. The average score on the CES-D in among the current sample of older LGBT adults was 8.3 (SD=5.9). Older adults with HIV had significantly higher average CES-D scores as compared with their non-infected peers (9.8 and 7.5, respectively). Thirty-five percent of older LGBT adults had scores of 10 or higher, and nearly one-in-five had scores of 14 or above indicating a severe level of depressive symptoms. [10] Significantly, older LGBT HIV+ adults were twice as likely to report severe levels of depressive symptoms as compared with their peers as seen in Figure 13.

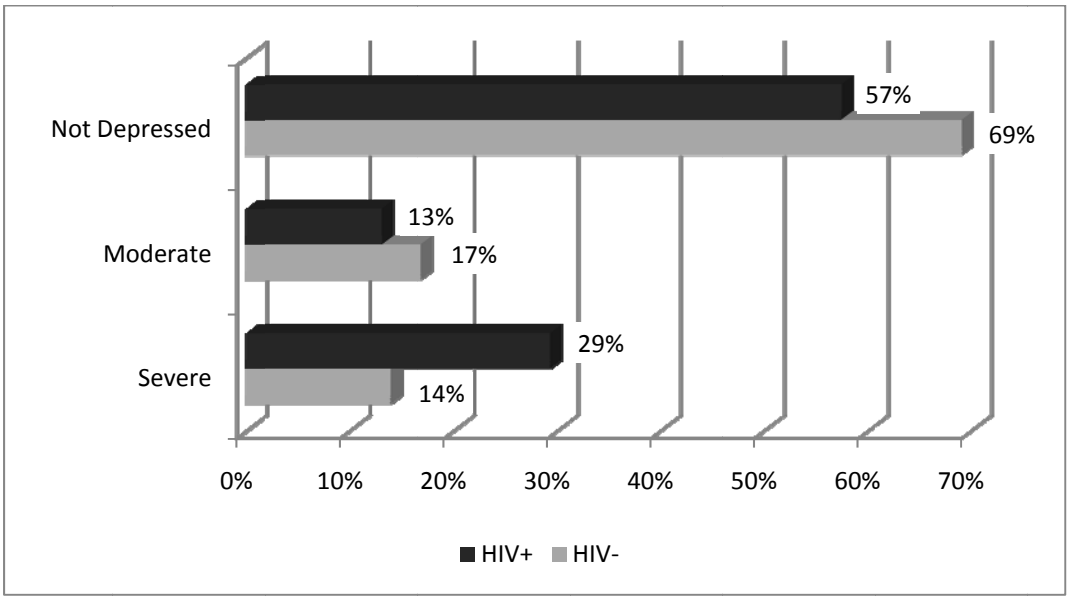

Figure 13: Depression Symptom Severity by HIV Status

In addition to depressive symptoms, older LGBT participants were assessed for positive affect using the Positive and Negative Affect Schedule (PANAS). [11] The PANAS contains five items referring to positive affect (e.g., excited) ranked on a five-point scale ranging from Not at all to Extremely, with higher scores indicating greater positive affect (the 5 negative affect items were not used). Possible scores range from 5 to 25. The average score in the current sample was 12.0 (SD=4.3). Reflecting differences in levels of depressive symptoms, non-HIV infected older LGBT adults had significantly higher PANAS scores as compared with the HIV+ group (12.2 and 11.6, respectively).

[8] Radloff, L.S. (1977). The CES-D Scale: A self-report depression scale for research in the general population. *Applied Psychological Measurement*, 1, 385-401.

[9] Andersen, E.M., Malmgren, J.A., Carter, W.B., & Patrick, D.L. (1994). Screening for depression in well older adults: evaluation of a short form of the CES-D (Center for Epidemiologic Studies Depression Scale). *American Journal of Preventative Medicine*, 10, 77-84.

[10] Swenson, S.L., Rose, M., Vittinghoff, E., Stewart, A., & Schillinger, D.(2008). The influence of depressive symptoms on clinician-patient communication among patients with type 2 diabetes. *Medical Care*, *46*(3), 257-65.

[11] Watson, D., Clark, L.A., & Tellegen, A. (1988). Development and validation of brief measures of positive and negative affect: The PANAS scales. *Journal of Personality and Social Psychology*, 54(6), 1063-1070.

LIFETIME & CURRENT SUBSTANCE USE

Participants were asked about their lifetime and current (past 3 months) use of tobacco, alcohol and other drugs as shown in Table Two.

Table Two
Lifetime and Current (Past 3 Months) use of Cigarettes, Alcohol and other Drugs by HIV Status (Percents)

Substance		Total	HIV+	HIV-
Cigarettes	*Lifetime	63.3	71.8	58.1
	***Current	25.6	48.6	13.4
Alcohol	Lifetime	89.6	85.9	91.2
	Current	63.0	56.5	66.2
Crystal Meth	*Lifetime	12.3	18.3	8.8
	**Current	1.4	4.3	0.0
Cocaine	***Lifetime	40.3	57.7	31.4
	***Current	4.8	13.0	0.7
Crack	***Lifetime	20.4	39.4	10.2
	**Current	4.3	10.0	1.5
Heroin	**Lifetime	10.4	16.9	5.8
	*Current	1.0	2.9	0.0
Ecstasy	Lifetime	7.1	8.5	6.6
	Current	0.0	0.0	0.0
GHB	Lifetime	3.8	5.6	2.2
	Current	0.5	1.4	0.0
Ketamine	Lifetime	2.8	2.8	2.2
	Current	0.0	0.0	0.0
LSD/PCP/Hallucinogens	Lifetime	24.2	22.5	24.8
	Current	0.0	0.0	0.0
Marijuana/Hashish	Lifetime	71.4	77.5	68.4
	***Current	17.3	31.4	10.4
Poppers	**Lifetime	49.3	63.4	41.6
	**Current	11.1	20.0	6.7
Pain Killers	Lifetime	64.3	56.5	68.9
	Current	26.6	28.6	25.4

* $p < .05$, ** $p < .01$, *** $p < .001$, Chi-square tests of significance

Participants were most likely to report using alcohol either currently (63%) or at some point in their lifetimes (90%). Approximately two-thirds of older LGBT adults had used cigarettes during their lives, and 26% were current smokers. A similar proportion (71%) reported having used marijuana/hashish and 17% were current marijuana users. Life time use of painkillers was also prevalent (64%) and 27% reported current use of pain medications. The prevalence of lifetime use of poppers (amyl nitrate) was 49%, with 11% having used poppers in the last 3 months. In terms of other illicit substances, lifetime

cocaine use was 40% (5% currently using), and crack-cocaine lifetime use was 20% (4% currently using). Twelve-percent had tried crystal meth, but only 1% reported currently using this substance. One-in-ten of had used heroin, but current use was low (1%). With regard to other substances, lifetime use of hallucinogens like LSD was reported by one-quarter of older LGBT adults (24%), while lifetime use of club drugs (ecstasy, GHB, ketamine) was approximately 10% or less. No one reported the current use of hallucinogens, ecstasy or ketamine, and only one participant was currently using GHB.

Overall, older LGBT adults living with HIV were significantly more likely to report both the lifetime and current use of a number of substances, namely, cigarettes, crystal meth, cocaine, crack, heroin, and poppers. Notably, nearly half of those living with HIV were current smokers compared with only 13% of those who were not HIV-infected. With regard to marijuana use, while lifetime prevalence did not differ based on HIV status, those who were HIV-positive were significantly more likely to report current use than their peers (31% and 10%, respectively). However, use of alcohol and club drugs (ecstasy, GHB, and ketamine) did not differ significantly as a function of HIV status.

Twenty-percent of the sample reported that they were currently in recovery for a drug or alcohol problem, and this did not differ significantly by HIV status.

FUNCTIONAL ABILITY

We asked respondents about any difficulty they encountered with 7 instrumental and 6 personal care activities of daily living (i.e., IADL and PADL, respectively) based on the OARS assessment.[12] The task which the sample reported most frequent difficulty was found for the IADL task of housework (25%), such as sweeping or dusting, washing dishes or laundry. Difficulty getting to places out of walking distance (21%) and shopping (18%) were the next most problematic IADL tasks for the current sample of older LGBT adults, while 16% reported difficulty with meal preparation. Less than one-in-ten reported difficulty with using the telephone (5%), taking medications (5%) or handling money (8%). The average number of difficult IADL tasks was 1.3 (SD = 2.6), and this did not differ significantly by HIV status. Overall, 37% reported difficulty with at least one IADL task, and older LGBT adults with HIV were significantly more likely to report difficulty with at least one of these tasks as compared with their peers (47% and 31%, respectively). Figure 14 shows the proportion reporting difficulty with each IADL task by HIV status. The overall pattern was for greater proportions of those living with HIV to report difficulty with IADLs compared with their peers, however, only in the case of taking medications was this difference statistically significant.

[12] Fillenbaum, G. G. (1988). *Multidimensional functional assessment of older adults: The Duke Older Americans Resources and Procedures.* Hillsdale, NJ: Lawrence Erlbaum Assoc.

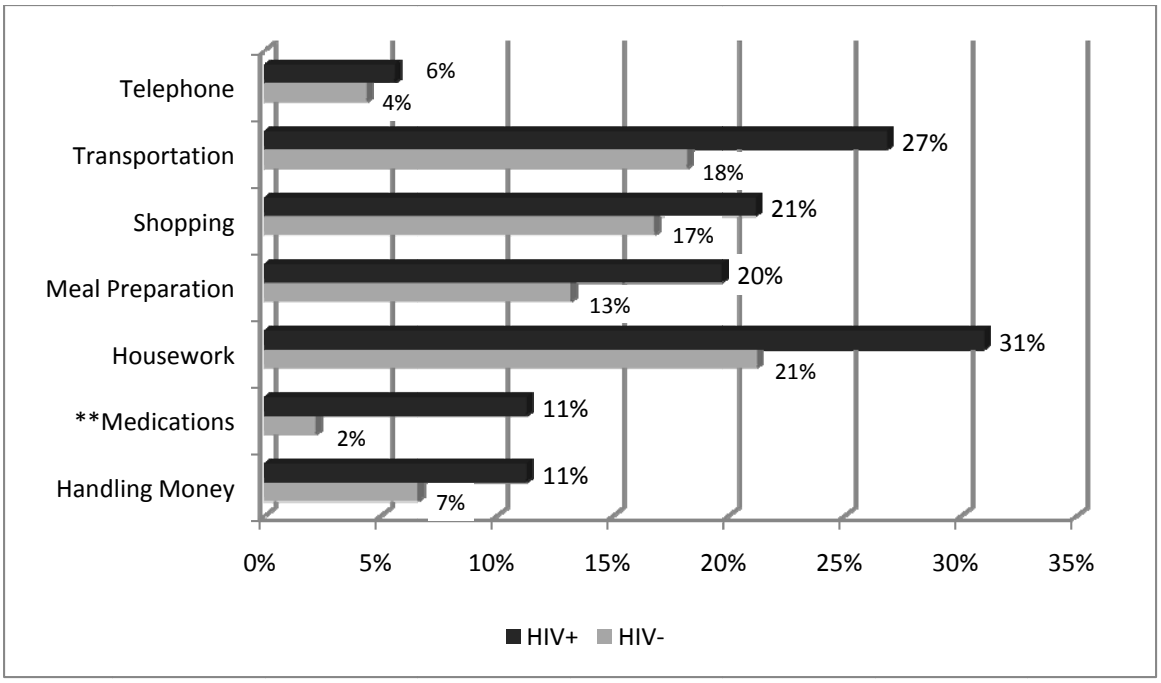

Figure 14: IADL Difficulty by HIV Status

Older LGBT adults were less likely to report difficulties with PADL tasks as compared with IADL tasks. The tasks with the greatest proportion indicating difficulty was for getting in and out of bed (12%) and dressing/undressing (9%). Seven percent or less reported difficulty with the remaining tasks; walking across a small room (7%), bathing (6%), grooming (5%), and feeding oneself (3%).

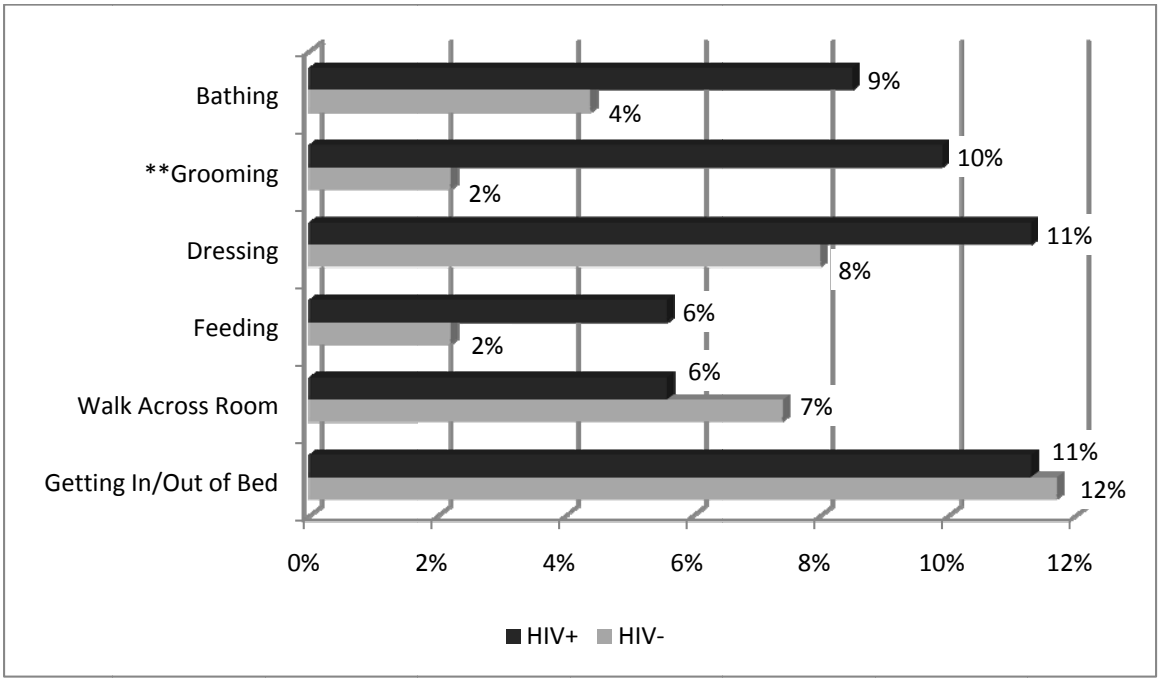

Figure 15: PADL Difficulty by HIV Status

The average number of difficult PADL tasks for the current sample was .73 (SD=2.5), and this did not differ significantly by HIV status. There were also no significant group differences in the proportion reporting difficulty with at least one PADL task, which was 17% for the sample as-a-whole. While greater proportions of older LGBT adults with HIV reported difficulty on four of the six PADL tasks (see Figure 15), only with respect to grooming was this difference statistically significant (10% HIV+ vs. 2% HIV-). However, these data may under-report the extent of PADL difficulty in the older LGBT population since all participants were able to travel to the data collection site, which likely excluded those individuals with more severe levels of disability from taking the survey.

SEXUAL ACTIVITY, HEALTH & RISK

Older LGBT adults were asked about their sexual activity during the past five years using items adapted from the National Social Life, Health and Aging Project.[13] On average, participants reported an average of 20.5 (SD = 85.8) sexual relationships during this time frame, ranging from none to over 200. However, the median number of sexual relationships reported was 2.0. Thirty-one percent reported no sexual relationships in the past year. Age was significantly related to the likelihood of sexual activity in the past year, with those under age 60 more likely to report being sexually active than their older peers (78% and 56%, respectively). Older LGBT adults with HIV reported significantly more sexual relationships in the past 5 years compared with their peers who were not infected (41.3 vs. 9.4, respectively).

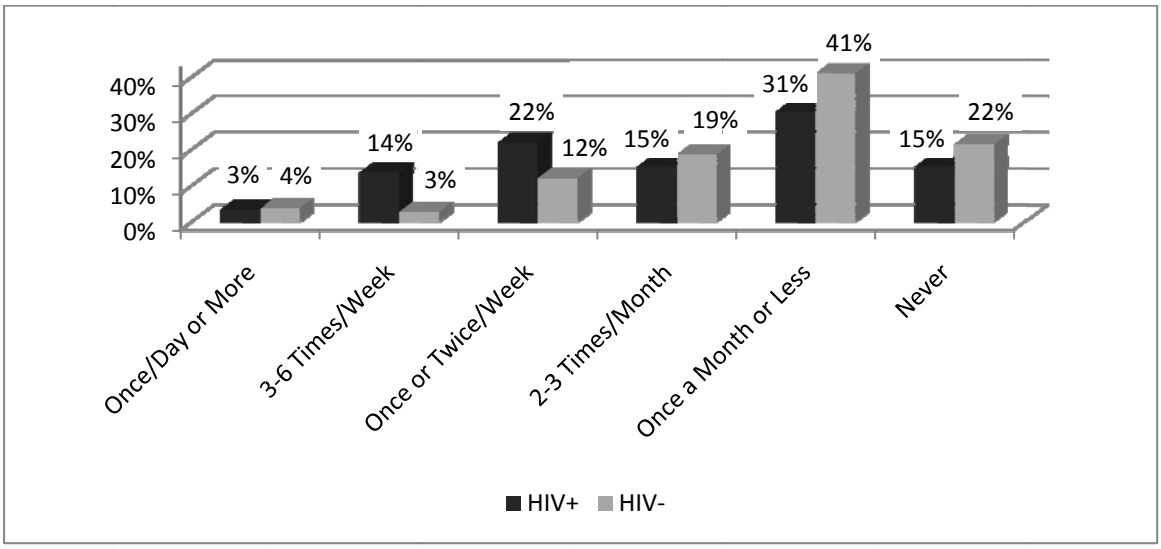

Figure 16: Frequency of Sexual Activity in Past Year with Most Recent Partner

[13] Lindau, S. T., Schumm, L. P., Laumann, E. O., Levinson, W., O'Muircheartaigh, C. A., & Waite, L. J. (2007). A study of sexuality and health among older adults in the United States. *New England Journal of Medicine, 357*(8), 22-34.

Participants were asked a series of questions about sex with their most recent partner.[14] There were significant differences in the gender identity of the partner by HIV status, which was expected given the preponderance of gay and bisexual men in the HIV+ group, and the greater proportion of women (36%) in the HIV-negative group. Thus, 92% of the HIV+ group reported their most recent partner was male, while 8% reported a female partner and no one in this group reported a partner who was transgender. In the HIV-negative group, 59% reported a male partner, and 40% reported a female partner, while 1% reported a transgender partner. Most older LGBT adults were involved with a partner who was younger (64%), 16% were involved with someone older, and 13% reported that their sexual partner was the same age as themselves (6% were unsure, and 1% reported their partner had deceased). Age of most recent partner did not differ significantly by HIV status.

Older adults with HIV had significantly greater frequency of sexual activity with their most recent partner in the prior twelve months as shown in Figure 16 as compared with HIV- older LGBT adults. Sixty-five percent of older LGBT adults expected to have sex with their most recent partner again, and this did not differ by HIV status.

Participants were asked to rate how important sex was to them personally, and older adults with HIV were significantly more likely to indicate sex was extremely important as compared to their peers as seen in Figure 17.

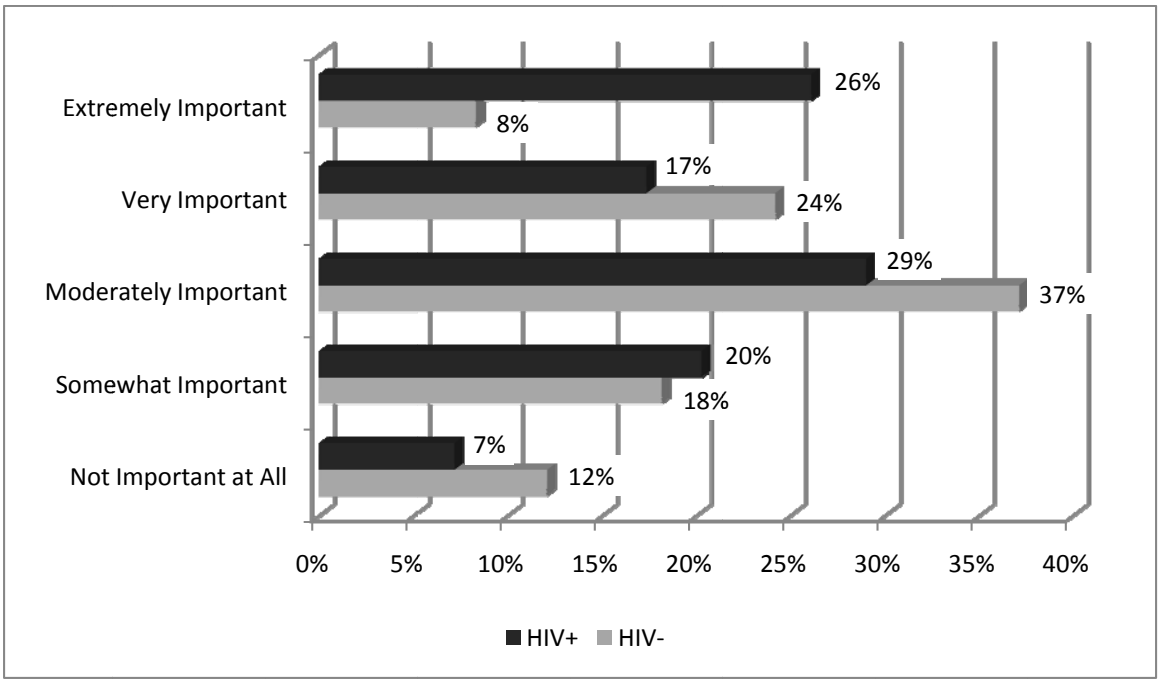

Figure 17: Importance of Sex by HIV Status

[14] The HIV status of the most recent sexual partner was not asked.

However, there were no differences based on HIV status in terms of how often older LGBT adults reported thinking about sex (see Figure 18).

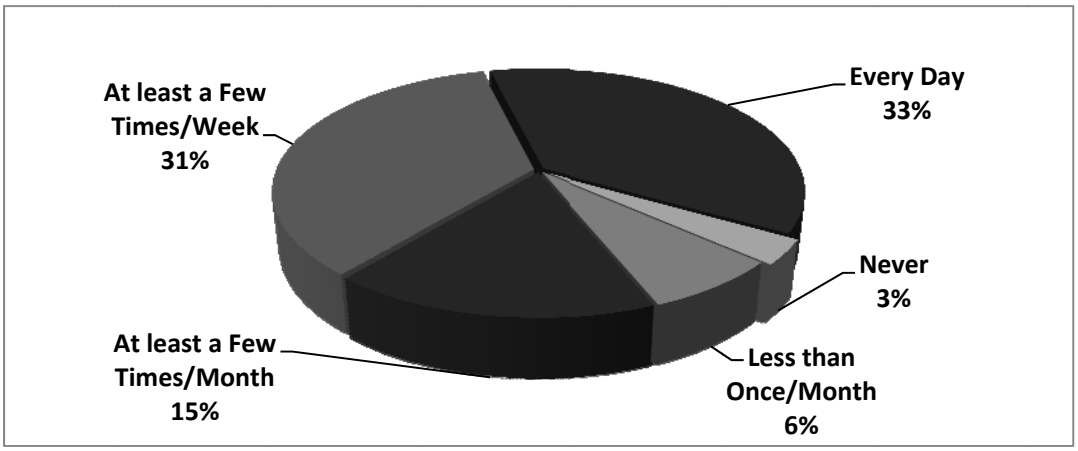

Figure 18: How Often Do You Think about Sex?

Participants were asked to rate their level of satisfaction with frequency of sexual activity in the past 12 months (i.e., more often than preferred, satisfied with current frequency, less often than preferred, much less often than preferred). One-third (32%) indicated that their sexual frequency was about as often as they preferred, whereas over 60% reported not having sex as often as desired, 34% indicating they had sex less often than desired, and 26% reporting having sex much less often than they would like. However, 8% indicated that they had sex more frequently than they preferred. Overall, older LGBT adults were satisfied with the physical and emotional pleasure they felt from sexual activity. In terms of physical pleasure, the majority rated their sexual relationship as extremely (25%) or very (46%) pleasurable. Twenty-five percent reported their sexual relationship as being moderately physically pleasurable, while 5% said it was slightly pleasurable. Considering emotional pleasure, 30% said their sexual relationship was extremely pleasurable, and 32% said it was very pleasurable, and one-quarter said it was moderately pleasurable. However, approximately one-in-ten reported that their sexual relationships were only slightly pleasurable (9%) or not pleasurable at all (4%). HIV status was not related to satisfaction with frequency of sex or physical/emotional sexual pleasure.

If there was no sexual activity in the past three months, older LGBT adults were asked to name all the reasons why this was the case (see Figure 19). Lack of partner availability emerged as the most frequently named reason, with 61% indicating they had not met the right person, 37% indicating they have not had the opportunity, and 28% reporting they had not met a willing partner. Participants also frequently mentioned physical and emotional health problem as reasons for not having had sex (38% and 29%, respectively). About one-third indicated they had not had sex because they weren't interested, while 19% wanted to avoid contracting a sexually transmitted disease (STD). Less than 10% indicated physical or emotional health problems of their partners interfered with sex, or that they lacked privacy. Very few indicated that they had not had sex due to disapproving attitudes of family or friends, or because of their religious beliefs. HIV status was not significantly related to reasons for not having sex in the prior three months.

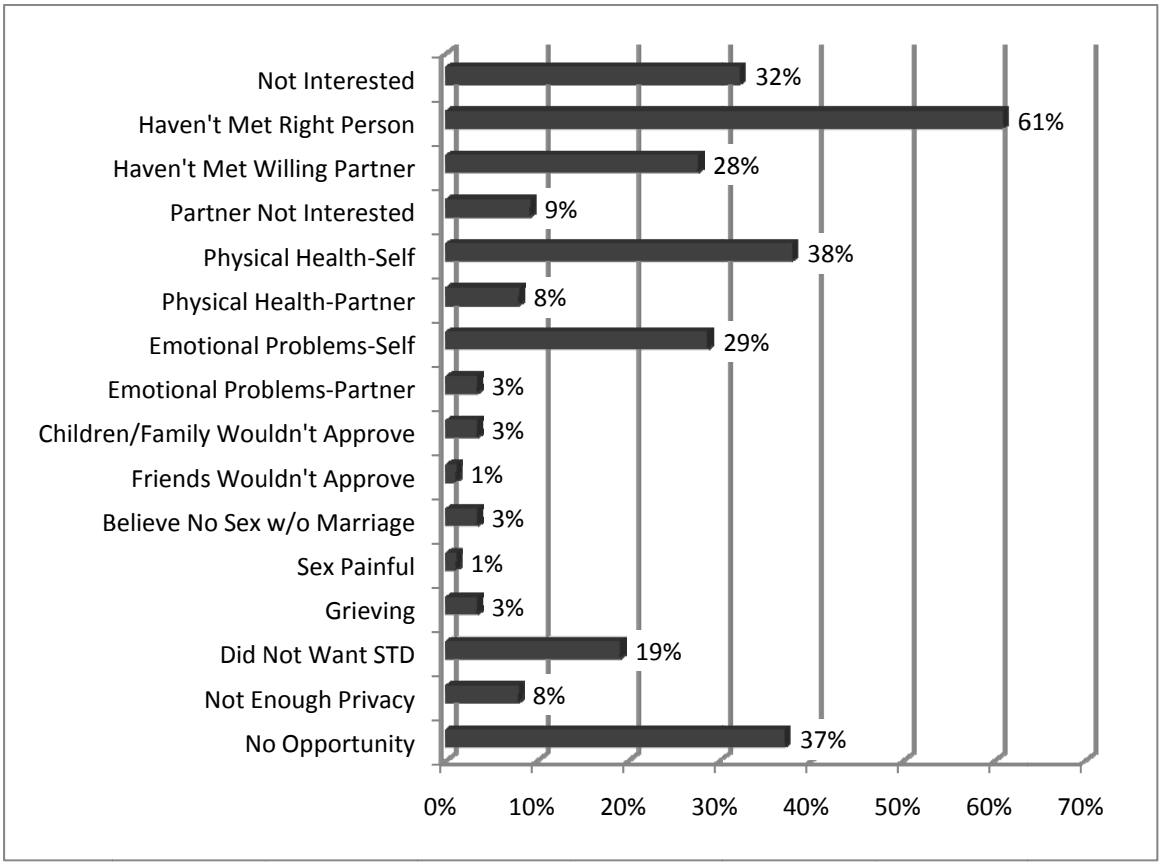

Figure 19: Reasons for No Sexual Activity in the Past Three Months

Participants were asked why they may not have been interested in sex, or had difficulty with sexual gratification, during the last 12 months (see Figure 20). The most frequently mentioned reason was lack of interest (50%). Problems with getting and maintaining an erection were also mentioned frequently (43%), and about one-in-five mentioned lubrication issues. Over one-third were anxious about how well they could sexually perform, and a similar proportion reported difficulty in coming to climax/orgasm, while one-quarter had issues with coming to climax too quickly. Approximately one-in-five were not interested in sex because they did not find it pleasurable, and very few (6%) mentioned pain during intercourse as a reason for not being interested in sexual activity. There was only one significant difference based on HIV status on lack of interest/problems with sexual gratification, with those who were HIV-positive being more likely to indicate coming to climax/orgasm too quickly as an issue as compared with their peers (38% and 20%, respectively).

Forty-one percent of older LGBT adults indicated that they had avoided sexual activity due to one or more of the issues detailed in Figure 20, and this did not differ significantly by HIV status.

When asked if they would go to a clinic to have sexual matters addressed, about half reported that they would be very likely (33%) or somewhat likely (17%) to do so, with approximately one-quarter each saying they would be unlikely or very unlikely to seek such help. Willingness to seek help at a clinic to

address sexual matters differed significantly by HIV status, with two-thirds of HIV+ older LGBT adults indicating they were at least likely to seek such help as compared with 43% of HIV- adults. Eighteen-percent of participants reported that they had actually sought medical help for sexual issues, and most were either very (47%) or somewhat satisfied (39%) with the help that they had received. HIV status was not significantly related to seeking medical help or satisfaction with such help.

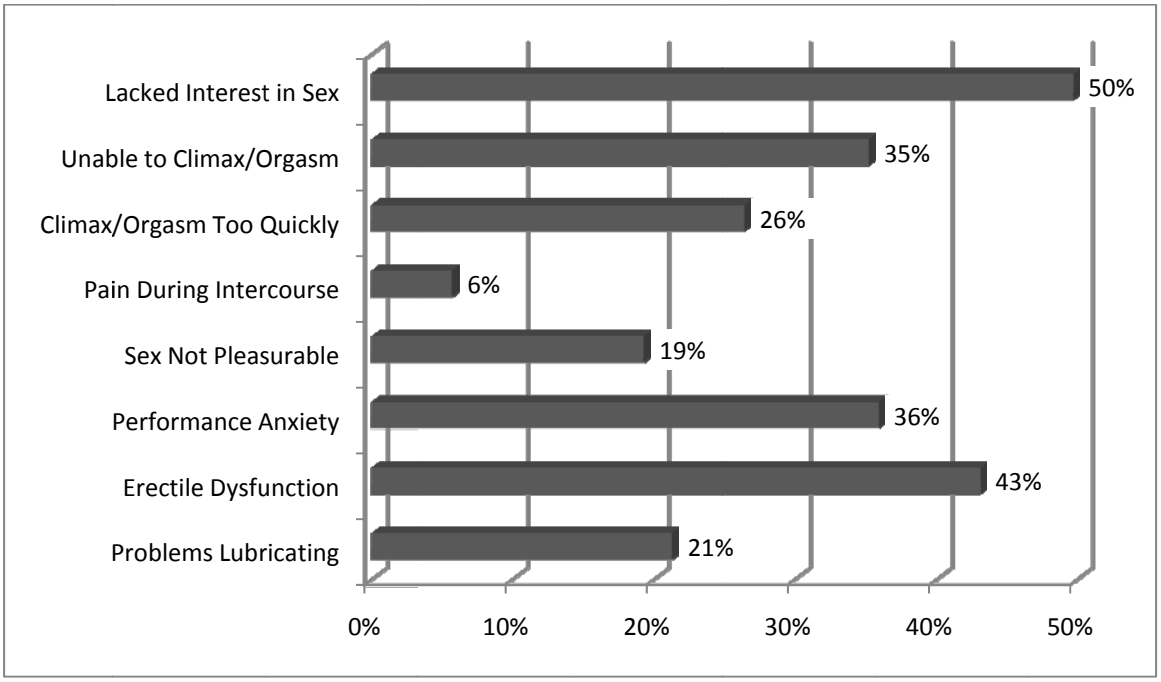

Figure 20: Reasons for Lack of Sexual Interest or Gratification in the Past 12 Months

Participants were asked about the use of condoms and other sexual precautions they took during anal, vaginal, or oral sexual activity and when using sex toys. With regard to vaginal intercourse, 44% indicated that they always used condoms, while 20% said that they usually used condoms. However, 8% reported rarely using a condom during vaginal intercourse and 28% said that they never used protection.

Similar rates of protected sex were observed for anal intercourse, with 42% saying that condoms were always used, and 7% indicating that they usually used a condom during anal intercourse. Twelve-percent indicated that condoms were used sometimes, and 4% reported rarely using a condom during anal intercourse. Over one-third (35%) never used condoms during anal intercourse.

In terms of taking precautions with sex toys, a similar pattern emerged with 51% always taking precautions and 7% saying that they usually took precautions. Eight-percent sometimes took precautions with sex toys and 5% rarely did so, while 28% never took precautions with sex toys. There were no significant differences in engaging in safer vaginal or anal sex, or play with sex toys, based on HIV status.

However, with regard to precautions during oral sex, older LGBT adults with HIV were significantly more likely to use condoms or dental dams as compared to the HIV-negative group as shown in Figure 21.

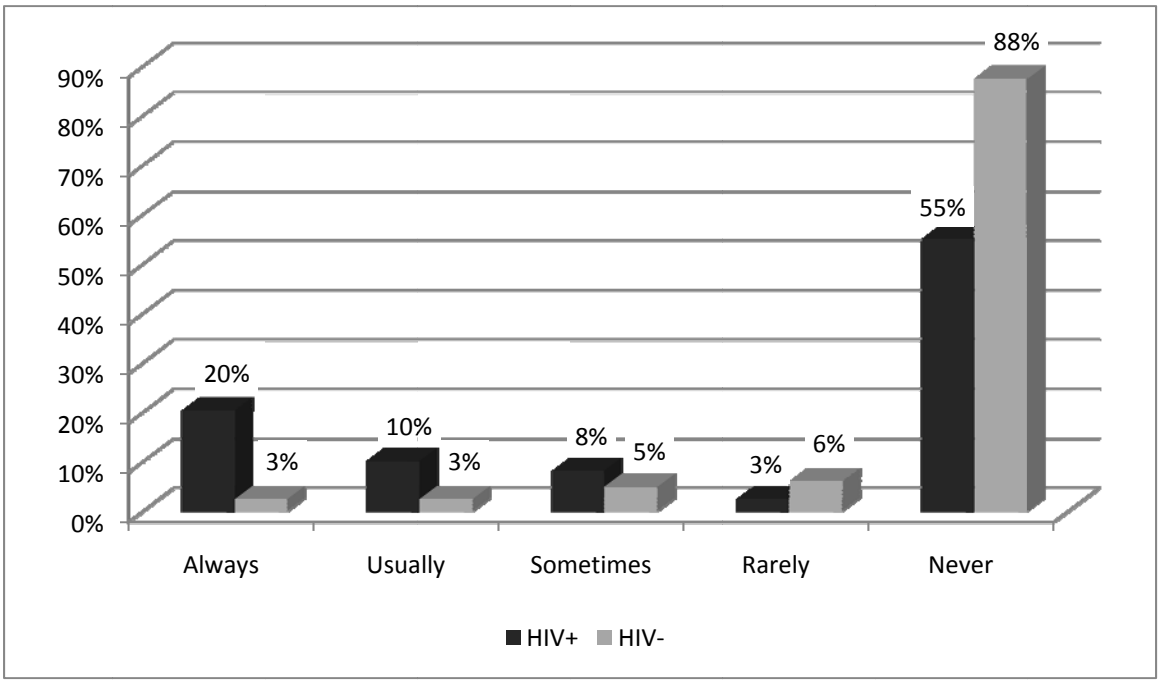

Figure 21: Frequency of Using Condoms/Dental Dams during Oral Sex

Older LGBT adults who were sexually active were asked about a variety of situations in which they might be tempted to have unprotected sex (see Table Three), and there were a number of significant differences based on HIV status.

Table Three
Reasons for Wanting to Have Unprotected Sex by HIV Status (Percents)

Reason	Total	HIV+	HIV-
I Really Want Sex	21.2	26.2	18.5
I Really Need Affection	12.3	12.3	12.3
With Very Sexy/Attractive Person	12.6	15.4	10.8
Partner Says Doesn't Want to Use Condom	8.6	13.8	6.2
Think Risk of STDs is Low**	18.7	6.2	24.6
Feel Depressed**	6.1	13.8	2.3
Think Partner Doesn't Want to Use Condom***	5.1	12.3	1.5
Drunk or High on Drugs***	11.6	23.1	6.2
With a Younger Person	7.1	7.7	6.2
With an Older Person	3.0	1.5	3.8
* $p < .05$, ** $p < .01$, *** $p < .001$, Chi-square tests of significance			

SOCIAL SUPPORTS FROM FAMILY, FRIENDS & NEIGHBORS

As they age, people rely increasingly upon their social networks for informal support and caregiving. But as people age, their social networks often decrease in size due to events such as relocation, illness and death.[15] For older LGBT adults research suggests this trend of decreasing network size is exacerbated. Many older LGBT adults rely on friends for informal support. [16] Consequently, the social networks of many of these individuals may be inadequate to provide needed levels of support as this population ages. While these friends serve as a critical source of support, they may be less likely to provide supportive care as they will likely face the challenges of aging and may need support themselves.

The current study assessed the presence of potentially supportive people in these networks of older LGBT adults. We asked about the presence and number of support element, frequency of contact, feelings of closeness, and the types of support received from family and friends. These data also allowed us to determine if those network members were "functional." A functional member of the social network is defined as having monthly face-to-face contact and/or talking on the phone at least weekly, and has been used in other large-scale studies of older adults. Functional social network members are considered to be relatively available to provide assistance in times of need, and it is their presence in a social network that provides a good indicator of social support sufficiency.

Presence of Social Network Members and Functionality. On average, older LGBT adults reported 10.6 people in their social networks (SD=7.4). Those with HIV reported significantly smaller social networks on average as compared with their non-infected peers (8.9 and 11.5 people, respectively).

As has been documented in previous research on older LGBT adults, there was limited presence of biological family social network elements in the current sample, which was further limited when considering the functionality of these network members (see Figure 22). While 42% of participants reported having a living parent, only 26% of these parents were functional social supports. Less than one-third reported the presence of a child (either biological or adopted/foster), and less than one-quarter had a functional child. A similar pattern emerged with regard to grandchildren (i.e., 21% report a grandchild, but only 10% a functional grandchild). And while nearly all older LGBT adults reported a living brother or sister (84%), only 38% reported having at least one functional sibling. Furthermore, half the sample did not report the presence of other, more distant relatives in their social networks. The reasons for the discrepancy between living social network members and functional elements are varied, but include geographic relocation to the Chicago area (likely for work opportunities and the presence of a large gay and lesbian community) and unfortunately, homophobia and estrangement from biological family because of sexual identity. To compensate for the lack of informal family supports, older LGBT participants appear to rely heavily on friends, or so-called families-of-choice. Friends were the most prevalent social network element mentioned (86%), and most of these friends are functional (77%) and

[15] Cantor, M. H., & Brennan, M. (2000). *Social care of the elderly: The effects of ethnicity, class and culture.* New York: Springer.
[16] Cantor, M. H., Brennan, M., & Shippy, R. A. (2004). *Caregiving among Older Lesbian, Gay, Bisexual and Transgender New Yorkers.* New York: The National Gay and Lesbian Task Force Policy Institute.

could be considered reliable sources of support in times of need. Lastly, 45% reported knowing at least one of their neighbors well.

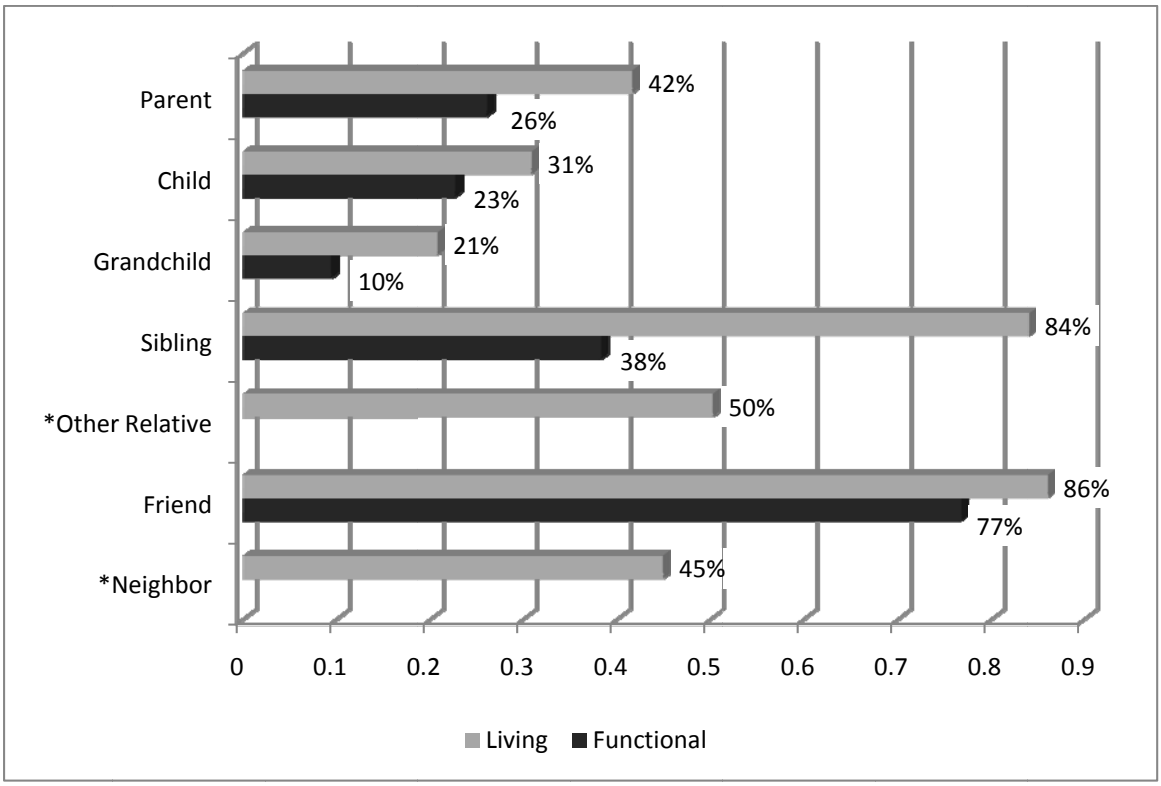

Figure 22: Presence of Living Social Network Elements and Functional Elements. [*Data on Functionality is Not Available for Other Relatives and Neighbors]

HIV+ older LGBT adults were significantly more likely to report the presence of a functional parent in their networks compared with their peers (37% and 21%, respectively), likely due to the greater average age of the HIV- group and concomitant older age of their parents. However, the HIV+ group was significantly less likely to have a functional child (10%) compared to older LGBT adults who were not HIV-infected (29%), which is a function of the greater proportion of lesbians in the latter group who are more likely to report children (both living and functional) as compared with gay men. However, the difference in the proportion in the two groups reporting a functional grandchild was not statistically significant, nor were there significant group differences in the presence of a functional sibling. The presence of functional friends was also not significantly different based on HIV status.

The reliance on non-kin supports among older LGBT adults is also evidenced by the average number of network element reported when that element was present. Namely, the average number of parents was (1.4), children (2.6), grandchildren (5.0), siblings (3.0), and other relatives (1.8). This compares to 4.9 close friends on average and 1.5 neighbors. The number of social network members in each of these categories did not differ significantly by HIV status.

Considering the importance of friends in the social networks of older LGBT adults, participants were asked how many of their friends were living with HIV, since this would likely impact the ability of this person to provide support given the greater likelihood for health comorbidities as they age. Overall, older LGBT adults reported having 1 friend on average living with HIV. Those living with HIV reported a greater number of friends living with HIV on average (1.6) as compared 0.4 among those who were not HIV-infected. This finding suggests even greater fragility of the social networks of older LGBT HIV+ adults.

Feelings of Closeness to Social Network Members. When asked about how close they felt to various members of their social networks, older LGBT adults by and large reported having close relationships when these individuals were present. Fifty-five percent reported feeling very close to parents (24% said they were somewhat close), while 61% indicated that they were very close to their children (29% somewhat close), and 47% reported being very close to grandchildren (33% somewhat close). With regard to siblings, however, feelings of closeness were mitigated with 36% saying they were very close and 33% indicating that they were somewhat close. But again, the importance of the family-of-choice for older LGBT adults was evidenced by 68% saying they were very close to their friends, and 30% reporting that they were somewhat close.

Geographic Location of Family and Friends. Suggesting that many of these older LGBT adults had migrated to Chicago from elsewhere, 65% reported that their parents lived outside of the Chicago metropolitan area, while 11% reported their parents lived in the Chicago suburbs. Nineteen-percent reported a parent in Chicago, but out of walking distance, and only 5% had a parent living nearby (walking distance or same building). With regard to children, nearly two-thirds lived in the Chicago metro area, but only 17% lived nearby. One-third had children living elsewhere in Chicago and 9% had children in the Chicago suburbs. Geographic location of grandchildren and siblings was similar, with approximately 55% of participants reporting that these people lived outside of the Chicago metro area and 5% of less had these members of their networks within walking distance. As might be expected, the majority of older LGBT adults reported that their friends lived in the Chicago metro area (77%), with 22% living either in the same building or in walking distance, 39% in Chicago but not in walking distance, and 15% living in suburban areas. The geographic proximity of family and friends did not differ significantly by HIV status.

Receipt of Assistance from Family, Friends and Neighbors. Older LGBT adults were asked about help they received from family and friends, respectively. For both family and friends, participants indicated if they received help with instrumental tasks (i.e., shop/run errands, keep house/prepare meals, drive/escort to places, help with mail/correspondence, help manage money) as well as emotional support (i.e., advice on a big decision, need cheering up, talk about personal/private matters).

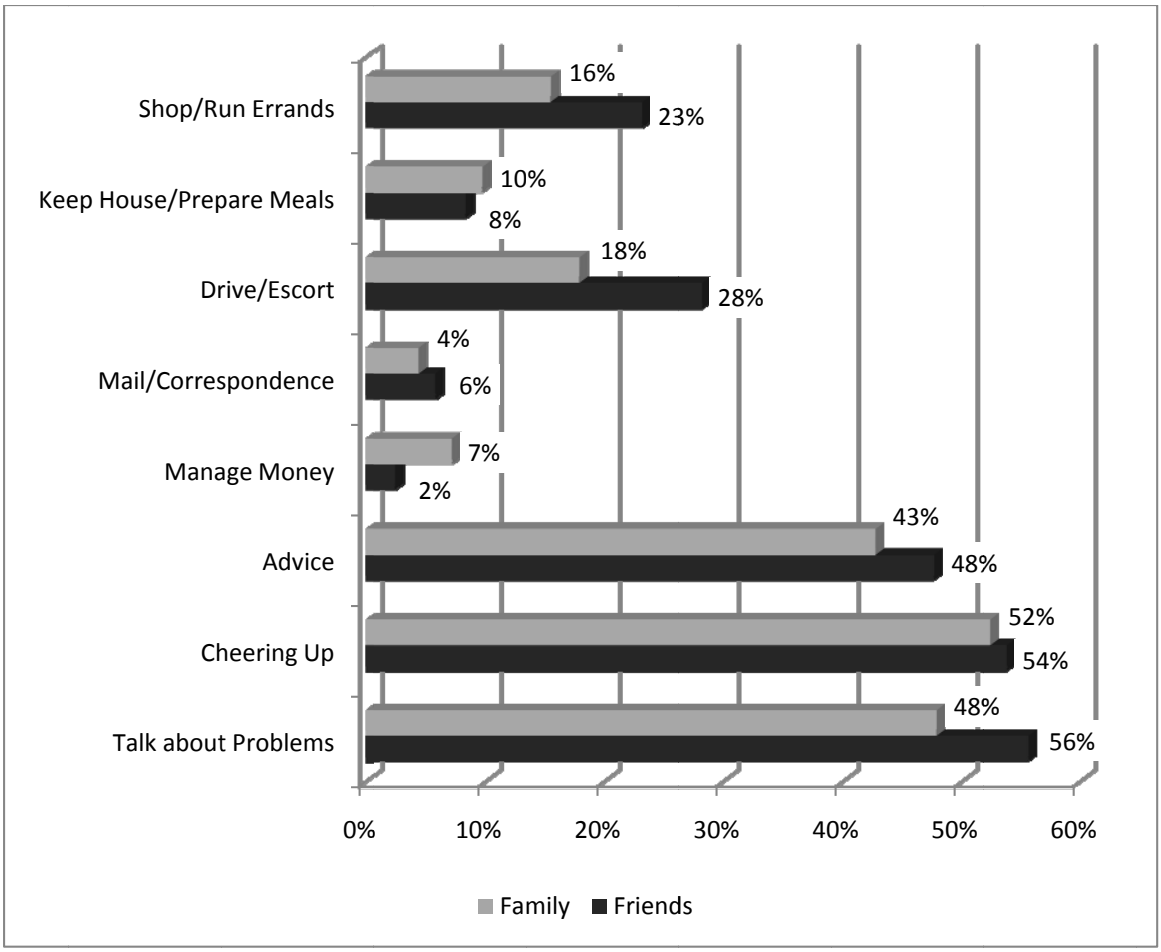

Figure 23: Receipt of Instrumental and Emotional Support from Family and Friends

As illustrated in Figure 23, instrumental support from either family or friends tended to be limited, with less than 30% reporting this type of assistance from either source of support. In addition, with the exception of keeping house/preparing meals and managing money, greater proportions of older LGBT adults reported receiving these types of assistance from friends as opposed to family members. For example, while nearly one-quarter of participants reported that friends helped with shopping/running errands, only 16% reported such help from family members. In a similar pattern, 28% of older LGBT adults reported that friends provided them with a ride or escort to places they needed to go, as compared with 18% who reported family members provided such assistance.

Older LGBT adults were much more likely to report receiving emotional support compared to assistance with instrumental tasks (range = 43% to 56%), and again, greater proportions indicated such support came from friends rather than family members. There were no significant differences based on HIV status in the likelihood of receiving any of these types of support from either family or friends with one exception. Older HIV+ LGBT adults were significantly more likely to receive help with mail/correspondence from family compared to their peers (9% and 2%, respectively). On average, participants reported receiving 1.9 types of assistance from family members and 2.2 types of assistance from friends, and this did not differ significantly by HIV status. With regard to neighbors, we asked about

the level of mutual help provided. Over one-quarter (27%) of older LGBT adults indicated that they and their neighbors helped each other a lot, while 37% said that such assistance was provided only in emergencies. However, about one-third (36%) indicated that they and their neighbors did not provide help to each other. These helping relationships with neighbors did not differ significantly by HIV status.

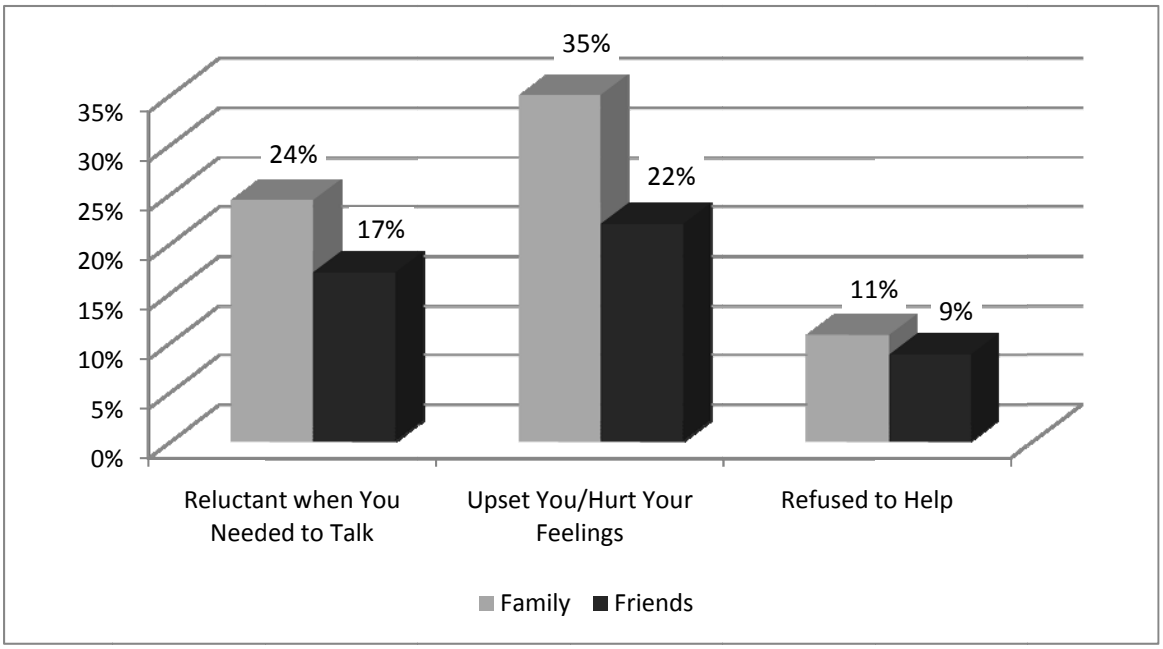

Figure 24: Negative Support Received from Family and Friends

Negative Social Support. Not all interactions with members of the social network are positive, and some may be negative in nature. Therefore, we asked participants about negative experiences with family and friend in their social networks as shown in Figure 24. Older LGBT adults were more likely to report negative support from family as compared to friends, particularly with regard to them being reluctant to talk (24% vs. 17%) and upsetting the participant or hurting their feelings (35% vs. 22%). There were no significant differences by HIV status in the likelihood of reporting negative support from either family or friends.

Social Support Reciprocity. While older LGBT adults may receive support from family and friends, they may also be sources of assistance to members of their social networks. We assessed the degree of reciprocity in their support exchanges with the members of their social networks by asking for each relationship type whether they provided more support than they received, if the support exchange was equal, or if they received more support than they provided in return. As illustrated in Figure 25, there was a trend for older LGBT adults who were HIV+ to receive more help, or be in reciprocal relationships, than to provide more help than they received as compared with their peers. This would be consistent with a greater level of need among HIV+ older LGBT adults. However, these differences were only statistically significant with regard to parents and siblings. But regardless of HIV status, these data illustrate a pattern of inter-dependence between older LGBT adults and members of their informal social networks.

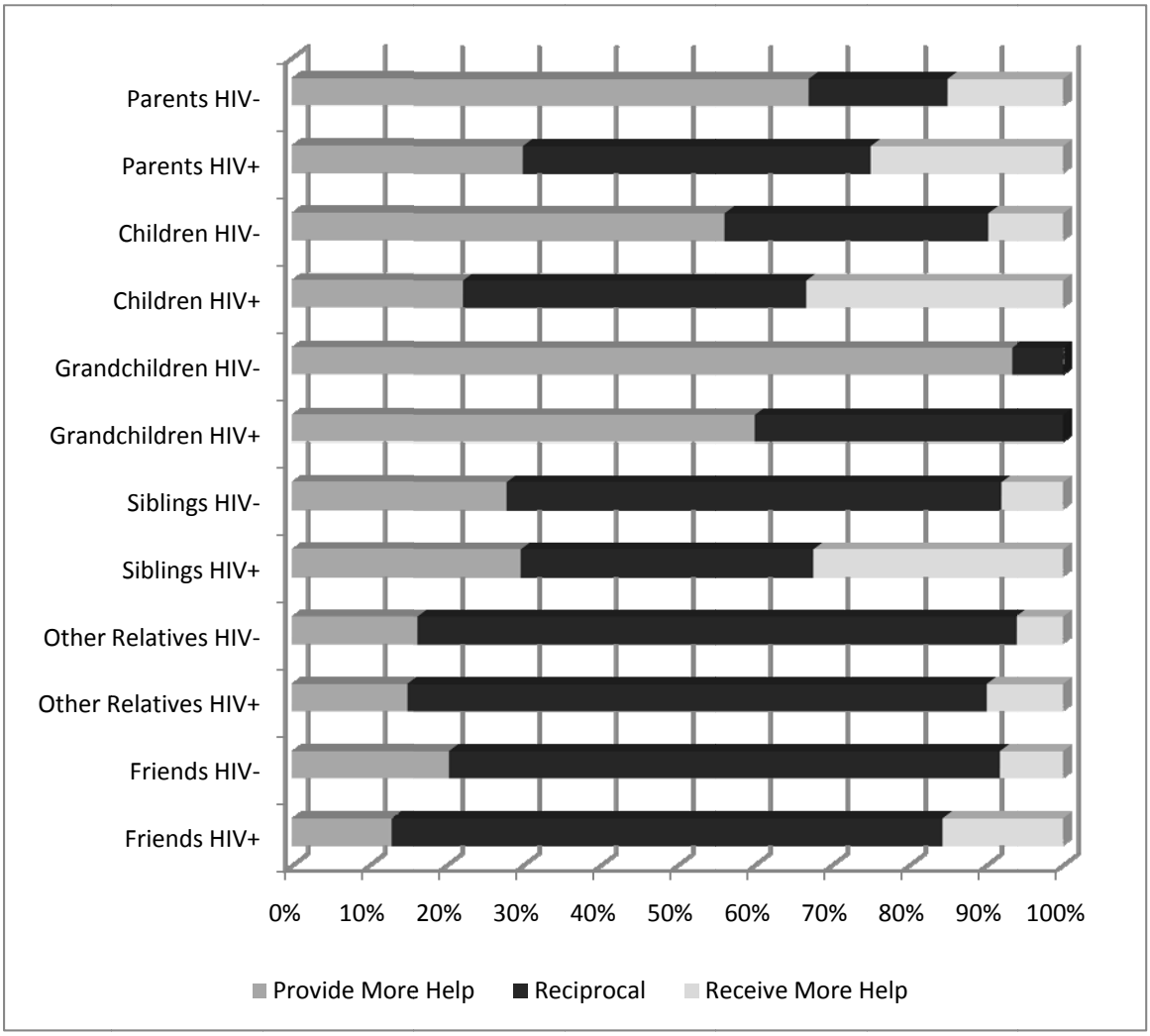

Figure 25: Social Support Reciprocity by Network Element and HIV Status of Participant

Availability and Adequacy of Social Support. Participants were asked about the availability of instrumental help with tasks of daily living (e.g., cooking, cleaning, meal preparation) and emotional support (e.g., advice, someone to talk to) during the past year. For each type support, older LGBT adults reported if such assistance was available all/most of the time, some of the time, only occasionally, or not at all. Participants were also asked about the adequacy of instrumental and emotional support and to indicate whether they had received all the help they needed, or whether they needed a little more, some more, or a lot more support. In terms of instrumental support, less than half (46%) indicated that such support was available all/most of the time. An almost equal proportion indicated only intermittent availability of instrumental help either some of the time (21%) or only occasionally (17%). Approximately one-in-six reported that they did not have access to instrumental help, rendering them with few resources during times of need. Two-thirds (68%) reported receiving all of the instrumental help they

needed during the previous year. But for the remaining third, instrumental support was not adequate (19% needed a little more help, 7% needed some more help, and 5% needed a lot more help). Neither the availability nor the adequacy of instrumental support differed significantly by HIV status.

In terms of emotional support, a greater proportion indicated that it was available all/most of the time (60%) as compared with instrumental help. Nearly equal proportions indicated that emotional support was available some of the time (17%) or only occasionally (16%). However, for almost one-in-ten (8%), emotional support had not been available during the previous year. Despite the greater availability of emotional support, fewer older LGBT adults reported that they had received all/most of the support they needed in this regard (49%) as was the case for instrumental help. Twenty-three percent said they needed a little more support during the previous year, while 14% indicated needing some more support, and 14% said they needed a lot more emotional support during this period. There were significant difference in the perceptions of emotional support availability and adequacy based on HIV status.

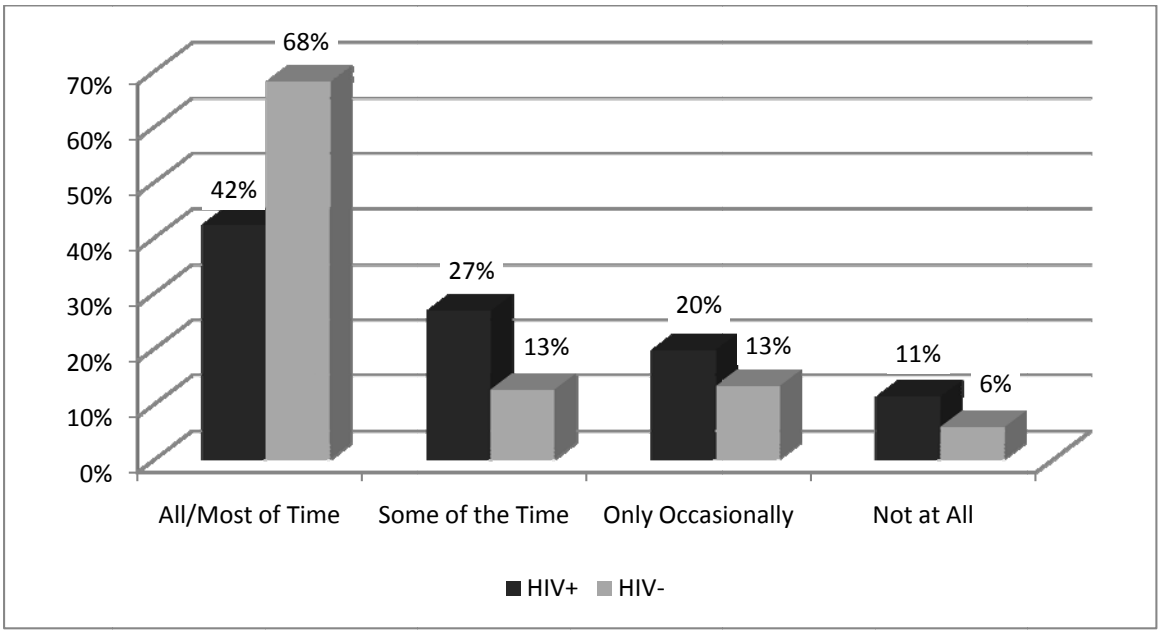

Figure 26: Emotional Support Availability by HIV Status

As illustrated in Figure 26, older LGBT adults who were HIV+ were significantly less likely than their peers to indicate emotional support was available all or most of the time (42% and 68%, respectively), and were more likely to indicate the unavailability of support. As seen in Figure 27, the HIV+ group was significantly less likely to indicate having received all the emotional support they needed in the past year (39% and 54%, respectively), and were more likely to indicate needing additional support. This was particularly of note with regard to needing a lot more emotional support, endorsed by 24% of the HIV-positive group as compared with 8% of the non-infected group.

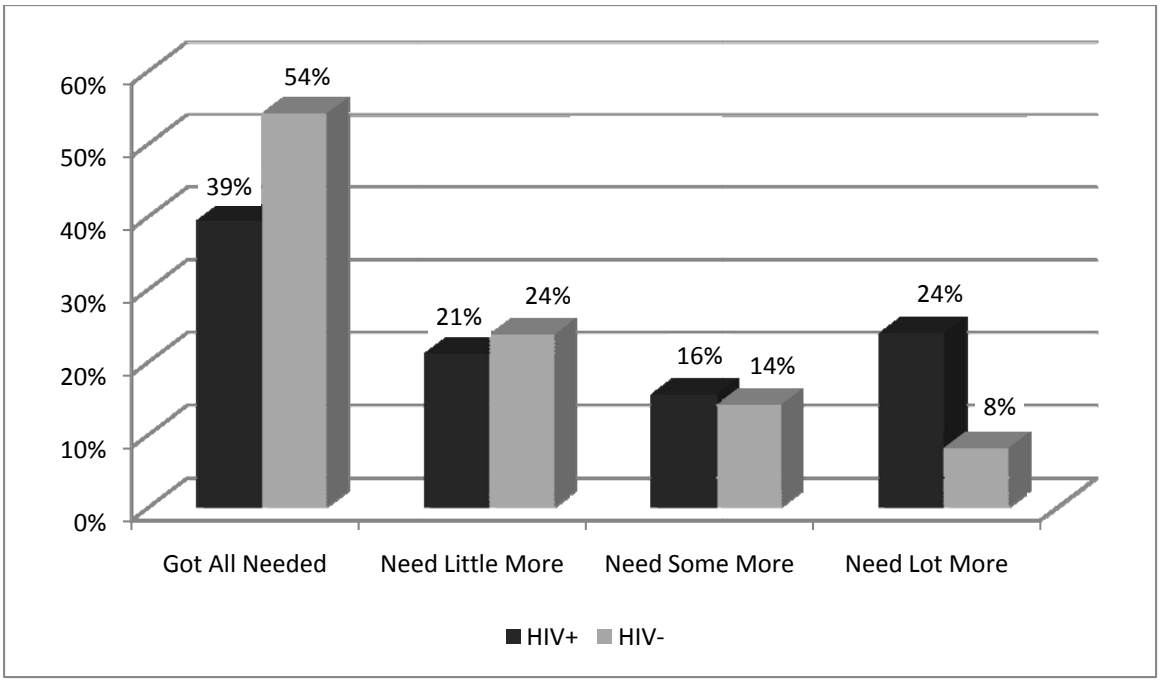

Figure 27: Emotional Support Adequacy in the Past Year by HIV Status

CAREGIVING

Older LGBT adults were asked about their current and past needs for caregiving due to illness (including HIV), disability or frailty. Most (81%) indicated that they did not currently need assistance and had not needed it in the past. Eleven-percent indicated that they had a current need for caregiving assistance, and 8% reported having needed caregiving in the past, but not at present. Older adults with HIV were significantly more likely to indicate caregiving needs. Nineteen-percent of this group reported currently needing caregiving help (see Figure 28), and 14% said they had needed such help in the past. Among older LGBT adults without an HIV diagnosis, 7% reported currently needing caregiving help and 5% reported needing such help in the past. The types of caregiving assistance needed ranged from help with instrumental tasks of daily living (i.e., shopping, cooking, and household chores), to personal care (i.e., help with mobility issues, post-hospital care). Partner/spouses and other family members were the most likely to be reported as caregivers (14% and 21%, respectively), while an additional third (30%) received caregiving from paid helpers such as home health aides or visiting nurse. Friends were named as caregivers 22% of the time. However, 10% reported that they had not received the needed caregiving assistance. Twenty-percent indicated that their caregiver was HIV positive. There were no significant differences by HIV status in who provided caregiving assistance and if they had received help from an HIV+ caregiver.

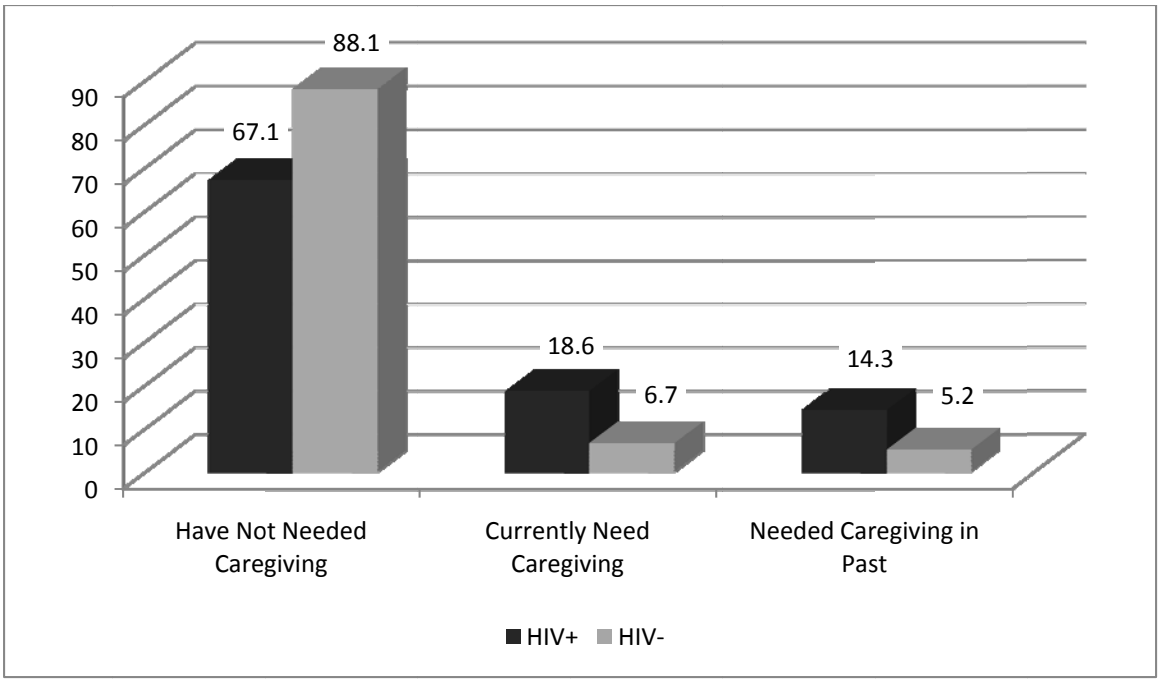

Figure 28: Current and Recent Caregiving Needs by HIV Status

Older LGBT adults are not only recipients of caregiving, but previous research has found that they provide extensive caregiving assistance to both their families of origin and their families of choice. We asked participants whether they had provided caregiving assistance to others within the past five years. Nearly one-quarter (24%) reported that they had provided such assistance. Of this group, 26% reported that they were currently caring for someone, 22% said they had provided care to someone within the past two years, and 52% had provided care between three and five years ago. The likelihood of providing care and the time since the caregiving episode did not differ significantly by HIV status. Participants were most likely to report caring for a family member (44%), followed by a friend (24%) or a partner (20%). Only 5% reported caring for a child or neighbor, and 2% for a grandchild. Older LGBT adults with HIV were more likely to report caring for a friend as compared with their peers (62% and 17%, respectively), and less likely to have cared for a partner/significant other (15% and 25%, respectively). Twenty-two percent of older LGBT caregivers reported that they had cared for someone who was HIV-positive, and those who were HIV+ themselves were significantly more likely to indicate this experience (46%) as compared to their peers without an HIV diagnosis (14%), suggesting considerable levels of mutual caregiving support among the HIV community. Twenty-percent of caregivers indicated that their caregiving responsibilities had interfered with their ability to care for themselves, but this did not differ by HIV status.

USE OF FORMAL SERVICES

Older LGBT adults were asked about their use of services obtained from government offices and agencies, HIV-related services and AIDs Service Organizations (ASOs), health-related services, and other community-based services. Participants were also asked specific questions about their utilization of and satisfaction with services provided by the Center on Halsted.

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. Use of the Veterans Administration (8%) and Police (12%) were the least frequently reported services. As shown in Figure 29, use of government offices and agencies differed significantly by HIV status, with HIV+ older LGBT adults more likely to report such utilization than their peers. On average, older LGBT adults used 1.7 services (SD=1.9). Those who were HIV+ used significantly more services of this type on average than did their non-infected counterparts (2.6 and 1.2, respectively).

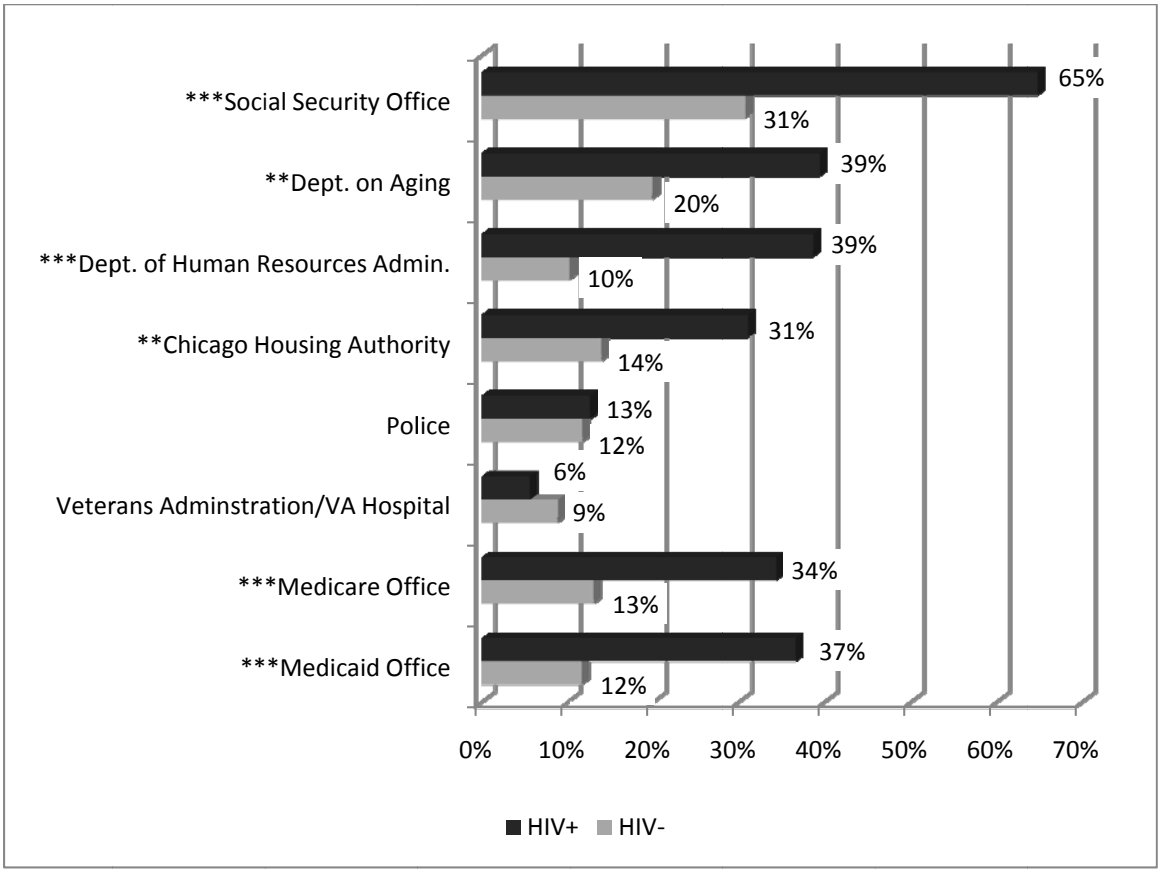

Figure 29: Use of Government Offices and Agencies by HIV Status [* $p < .05$, ** $p < .01$, *** $p < .001$, Chi-square tests of significance]

HIV-related Services and ASOs. As expected, older LGBT adults who were HIV-positive were significantly more likely to report the use of ASOs and HIV-related services than those without an HIV diagnosis (see Figure 30). The AIDS Foundation of Chicago was the most frequently mentioned (57%), followed by Test Positive Aware Network (41%), the HIV/AIDS services from the Center on Halsted (38%) and Howard Brown Health Center (38%). However, approximately 20% of non-HIV infected LGBT adults reported using services at either the Center on Halsted or Howard Brown (23% and 17%, respectively), which is likely due to testing and counseling programs at these agencies. On average, older LGBT adults reported using 2.9 HIV-related/ASO services, significantly greater than the 0.3 reported by their peers.

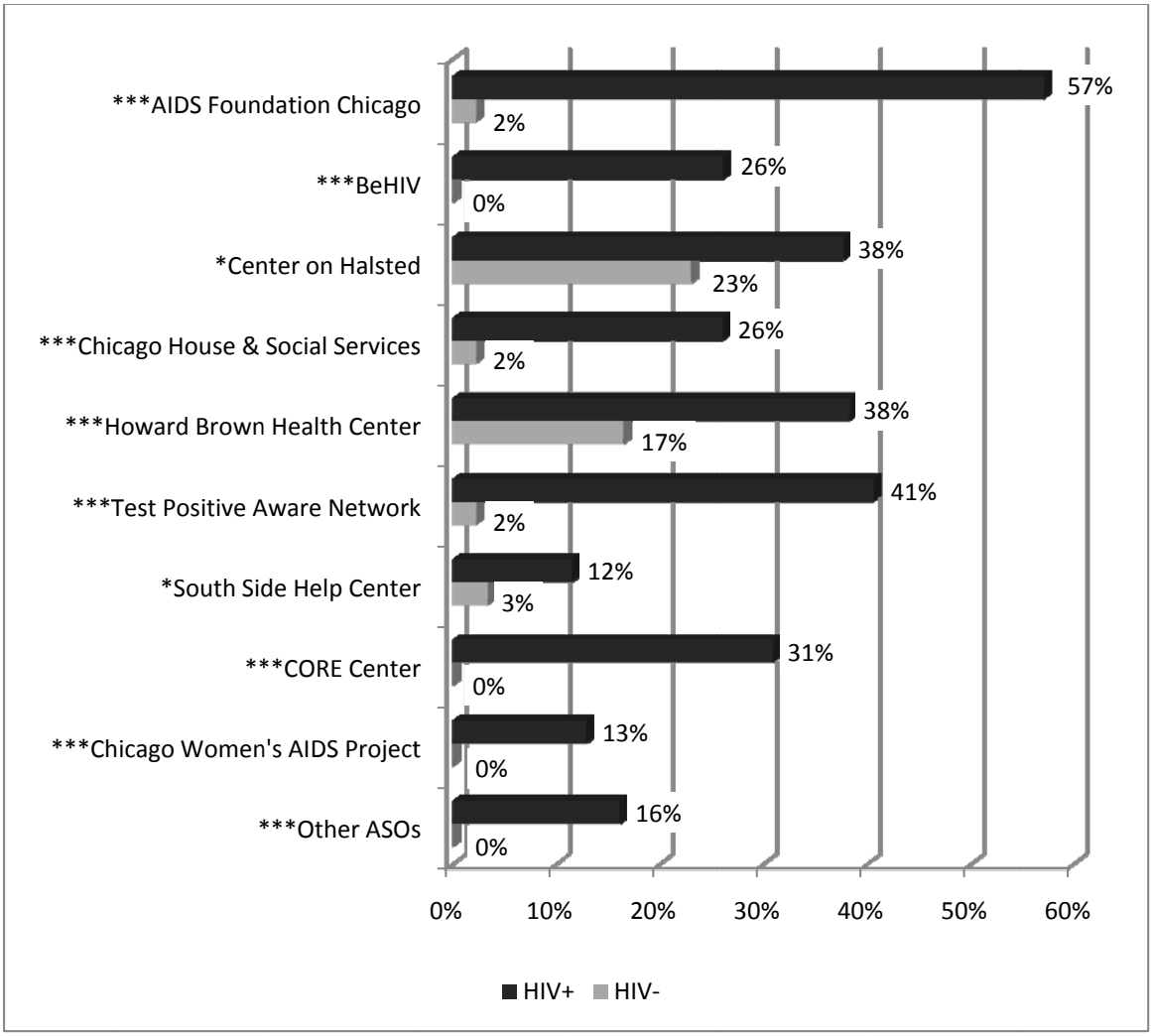

Figure 30: Use of HIV-related Services and ASOs [* $p < .05$, ** $p < .01$, *** $p < .001$, Chi-square tests of significance]

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% of participants, while 19% had received inpatient hospital care (see Figure 31). Slightly less than one-third had used the hospital emergency room in the past year. One-third reported going to a private medical clinic and one-in-ten had utilized a health maintenance organization (HMO). Behavioral health and substance use treatments were also utilized, with 27% having received mental health treatment and 11% utilizing drug or alcohol treatment/recovery programs. Case management, which can serve as a bridge to other services was reported by nearly one-third of participants (29%). Relatively few older LGBT adults had accessed homecare services (17%) or institutional long-term or continuing care (5%). Only 3% reported using hospice during the previous year.

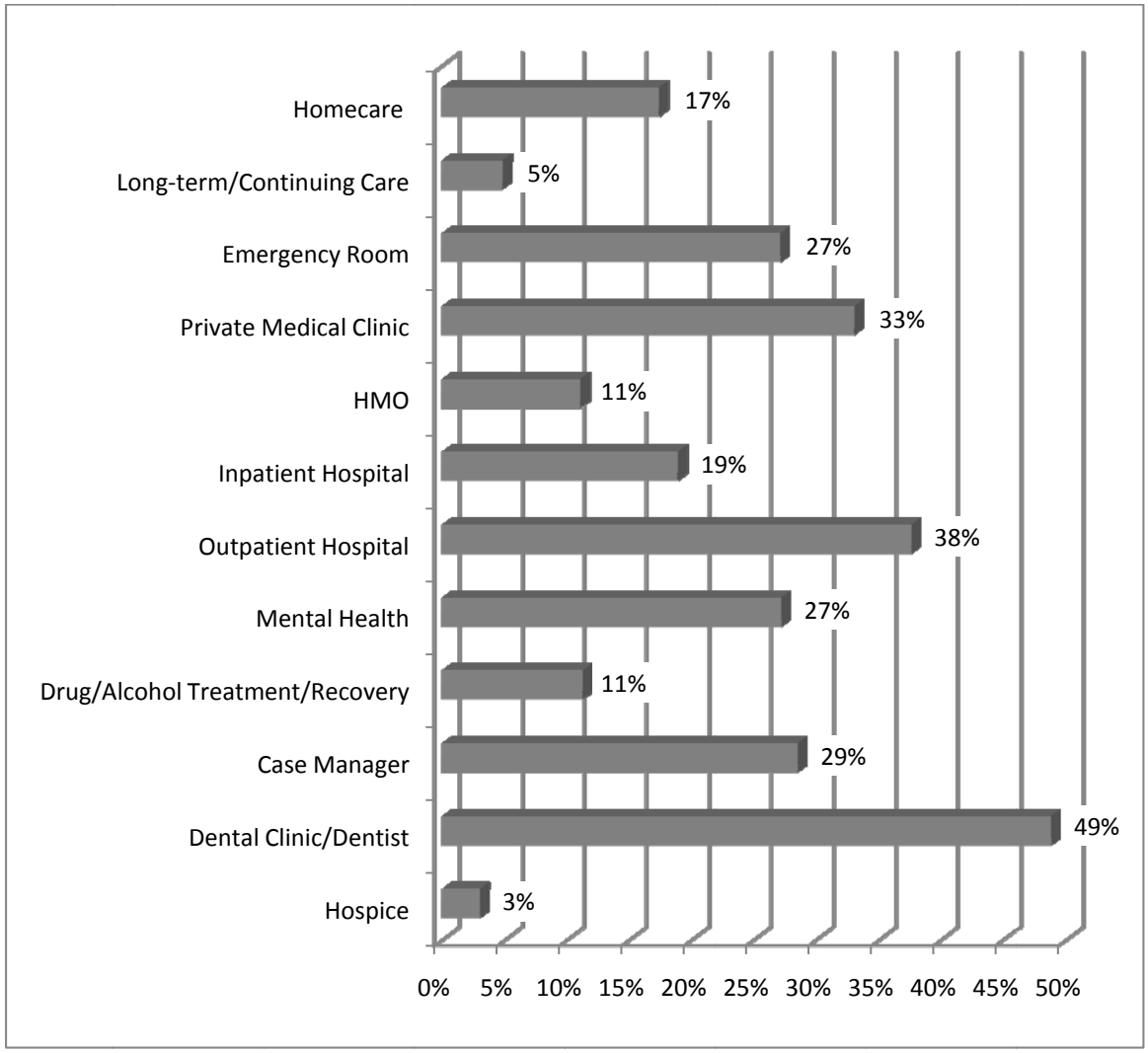

Figure 31: Use of Health and Long-term Care Services by HIV Status [* $p < .05$, ** $p < .01$, *** $p < .001$, Chi-square tests of significance]

There were only two instances where HIV status was significantly related to use of health and long-term care services. Older HIV+ adults were significantly more likely to have used case management (61%) as compared to those without an HIV diagnosis (12%). Similarly, while one-in-five HIV+ adults used drug and alcohol treatment/recovery in the past year, this proportion was only 8% among non-HIV infected older LGBT adults. The average number of health and long-term care services used (2.6, SD=2.3) did not differ significantly by HIV status.

Other Community-based Services. Senior centers were the most frequently mentioned community based service (25%). Clergy, meal/nutrition programs, and legal services were used by about one-in-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. Significant differences in service use in this group based on HIV status emerged in only two areas. Older LGBT adults without an HIV diagnosis were more likely to use senior centers (35%) as compared to those who were HIV-positive (7%), explained by the greater average age of the former group and the age criterion (60+) required for eligibility in many senior programs. With regard to legal services, HIV+ older adults were more than twice as likely to report such utilization as their peers (32% and 15%, respectively). Older LGBT adults used 1.0 of these services on average (SD=1.2), which did not differ significantly by HIV status.

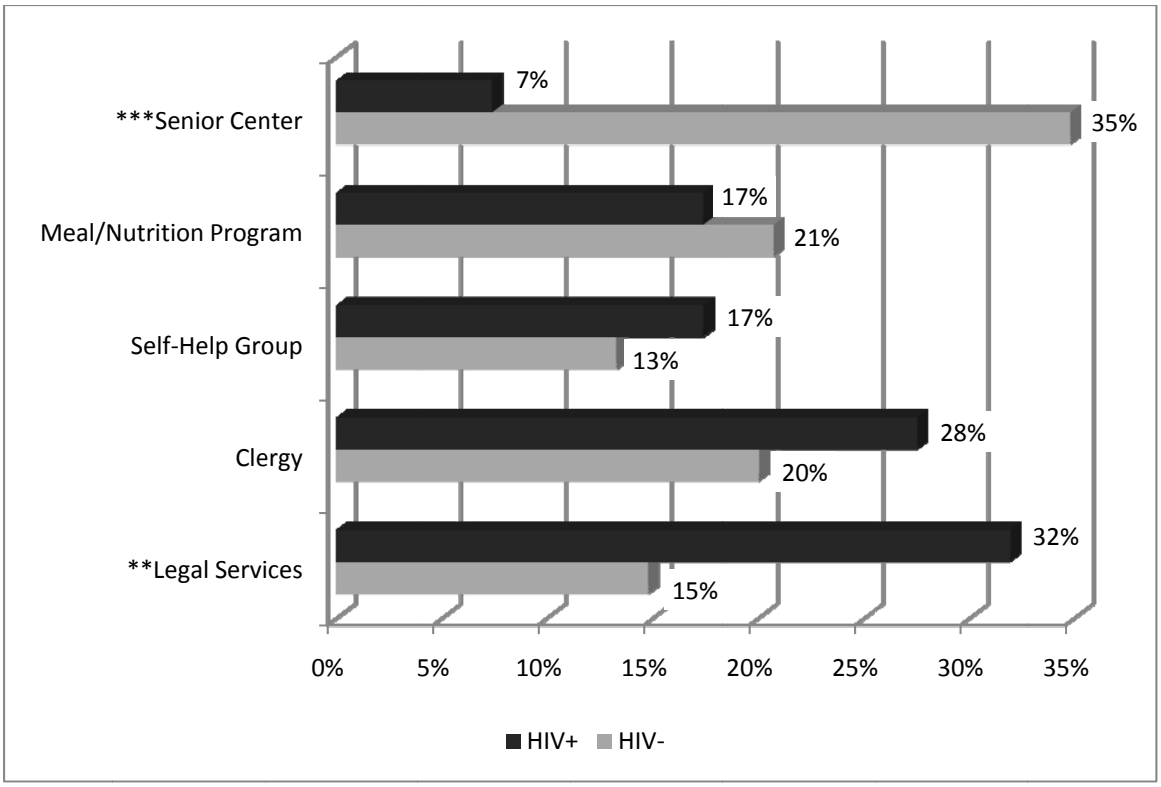

Figure 32: Use of Community-based Services by HIV Status [* $p < .05$, ** $p < .01$, *** $p < .001$, Chi-square tests of significance]

Use and Satisfaction with Services Provided by the Center on Halsted (COH). Participants were asked about non-HIV/AIDS services provided by COH. The most frequently utilized service provided by COH was the SAGE[17] Congregate Meal Program (36%). SAGE at Center on Halsted's social and education programs were the next most frequently used (28%), followed by the computer technology center (26%). Approximately one-in-ten had had used the COH HIV support group (10%), mental health supportive services (11%) and legal services (11%). As expected, HIV+ older LGBT adults were the significantly more likely than their peers to have used the HIV support group (see Figure 33). However, it was the non-infected older LGBT adults who were more likely to use SAGE programming at COH, namely, congregate meals and the social/educational programs, which may be related to the greater average age in this group. Sixty-percent of participants reported using at least one service provided by COH, while the average number of services used was 1.1 (SD=1.3), and this did not differ by HIV status.

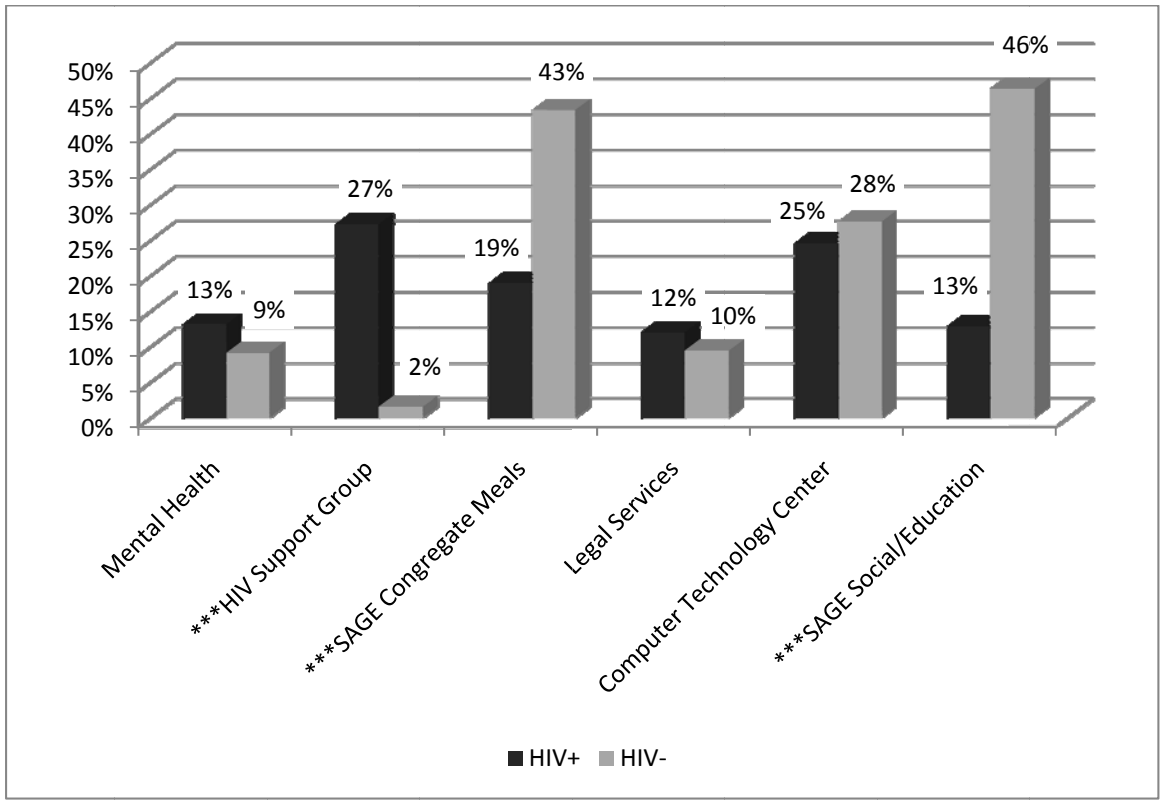

Figure 33: Services Used at the Center on Halsted by HIV Status [* $p < .05$, ** $p < .01$, *** $p < .001$, Chi-square tests of significance]

[17] Services and Advocacy for GLBT Elders (SAGE). www.sageusa.org .

Older LGBT adults who had received services at COH were asked how helpful they found the service (i.e., helpful, somewhat helpful, not too helpful, not helpful at all) in order to gauge satisfaction with their participation. Overall, satisfaction with COH services was high and did not differ significantly by HIV status (see Figure 34), with a minimum of 80% considering the services either being helpful or somewhat helpful. The most highly rated services was the computer technology center, with 73% saying this service was helpful and 23% reporting it was somewhat helpful, closely followed by SAGE social and educational programs (70% helpful, 24% somewhat helpful) and SAGE congregate meals (67% helpful, 21% somewhat helpful). For the remaining programs, approximately 60% found them to be helpful and an additional 25% found them to be somewhat helpful.

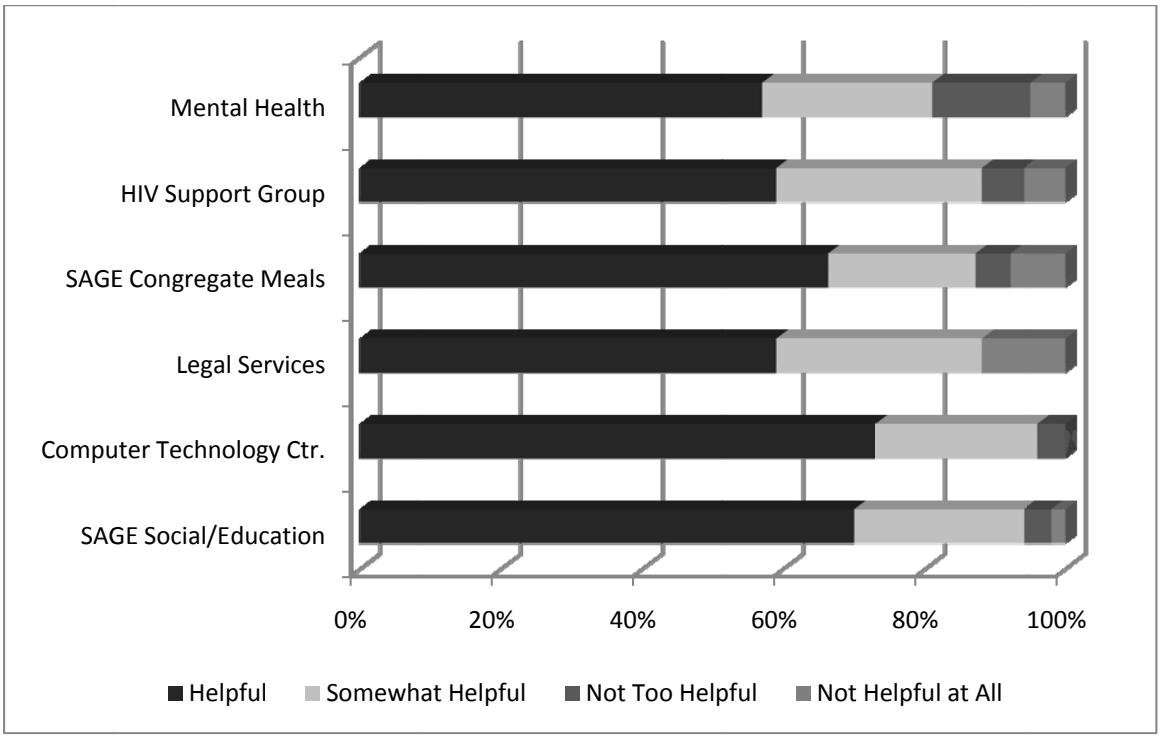

Figure 34: Satisfaction with Services Used at the Center on Halsted

We asked older LGBT adults what additional services they would like to see COH provide. The most frequently mentioned were assistance with housing and employment issues, more opportunities for socialization, and more programs aimed specifically at women.

BENEFITS & ENTITLEMENT PROGRAM PARTICIPATION

Participation in government benefit and entitlement programs is shown in Table Four. Older LGBT adults were most likely to indicate Medicare coverage (45%) followed by private health insurance (43%). Approximately one-quarter were enrolled in means-tested entitlements such as Medicaid and Food Stamps/SNAP. Approximately one-in-five reported income support either through SSI or SSD. Only about one-in-ten had purchased long-term care insurance, and even fewer (3%) had private disability coverage. Very few (2%) received General Assistance. Finally, although 14% had served in the armed forces, only 7% indicated health care coverage through the VA. Ten-percent of older LGBT adults indicated that they were not participating in any of these benefit or entitlement programs.

There were a number of significant differences in benefit and entitlement program participation based on HIV status. Older LGBT adults without an HIV diagnosis were significantly more likely to be enrolled in private or long-term care insurance plans (58% and 12%, respectively) as compared with their HIV-positive peers (14% and 1%, respectively). Conversely, older adults with HIV were more likely to receive means-tested entitlements such as Medicaid and Food Stamps (49% and 41%, respectively) as compared to the non-HIV positive group (16% and 18%, respectively). Older LGBT adults with HIV were also more likely than their counterparts to receive income support in the form of SSI (30% vs. 18%, respectively) or SSD (43% vs. 10%, respectively). The HIV+ group was also more likely to be receiving General Assistance (6%) compared to those without HIV (1%).

Table Four
Benefits and Entitlements by HIV Status (Percents)

Program	Total	HIV+	HIV-
Medicare	44.5	51.4	40.1
Medicaid***	26.8	48.6	16.1
Private Health Insurance***	42.6	14.3	57.7
Long-term Care Insurance**	12.4	1.4	12.4
Private Disability Insurance	2.9	1.4	3.6
SSI (Supplemental Security Income)*	21.5	30.0	17.5
SSD (Social Security Disability)***	21.1	42.9	9.5
VA (Veterans Administration) Health Coverage	6.7	5.7	7.3
General Assistance (GA)*	2.4	5.7	0.7
Food Stamps/SNAP***	25.8	41.4	18.2
Not Enrolled in Any Program	9.6	11.4	8.8

* $p < .05$, ** $p < .01$, *** $p < .001$, Chi-square tests of significance

BARRIERS TO SERVICES

We asked older LGBT adults about perceived barriers they faced when accessing community-based services (see Table Five). These barriers can be grouped into access barriers, staff and organizational barriers, and contextual issues. Fifty-eight percent of participants reported at least one barrier to service, and the average number of barriers reported was 2.8 (SD=3.5). Older adults with HIV reported a significantly higher number of barriers, on average, in comparison to the non-HIV infected group (3.9 and 2.2 barriers, respectively).

As a group, access barriers were the most frequently mentioned, ranging between 23% and 43%. Financial considerations were prominent, with 43% saying they didn't think they would be eligible to receive free services, while 32% worried about the cost of such services. Knowledge of available services (24%) and where one could obtain such services (35%) were also frequently mentioned. Twenty-eight percent felt that the process of getting services was confusing and/or difficult, while 23% thought that they would have to wait too long.

Table Five
Perceived Barriers to Community-based Services

Service Access Barriers	**Valid Percents**
Don't think services exist around here	23.5
Don't know where to go for services	34.5
Would have to wait too long for services	23.4
Services cost too much to afford	31.7
Don't think eligible for free services	43.1
Process of getting services too confusing/difficult	28.1
Staff/Organizational Barriers	**Valid Percents**
People at the agency not helpful/Don't seem motivated to help	21.2
People who run services don't like people like you	10.8
Afraid you won't be treated if you go for services	9.9
People at the agency don't speak the same language as you	5.5
Have trouble telling people at the agency what you need	8.4
Contextual Barriers	**Valid Percents**
Its' hard to get there (transportation)	17.2
Don't know what to do with kids when getting services	4.0
Someone might find out HIV status	6.9
Hard to make or keep appointments	7.4
You have to take care of other people	6.5
Worry that family/friends would be against the service	5.0

With regard to staff and organizational barriers, the most frequently mentioned was that staff was unhelpful or seemed unmotivated which was endorsed by over one-fifth of older LGBT adults. Stigma and discrimination issues were mentioned by approximately one-in-ten, namely, feeling that staff did not like people like themselves or that they would not receive services if they tried. Less than 10%

mentioned communication difficulties with staff, namely, language barriers and the ability to articulate their needs to providers.

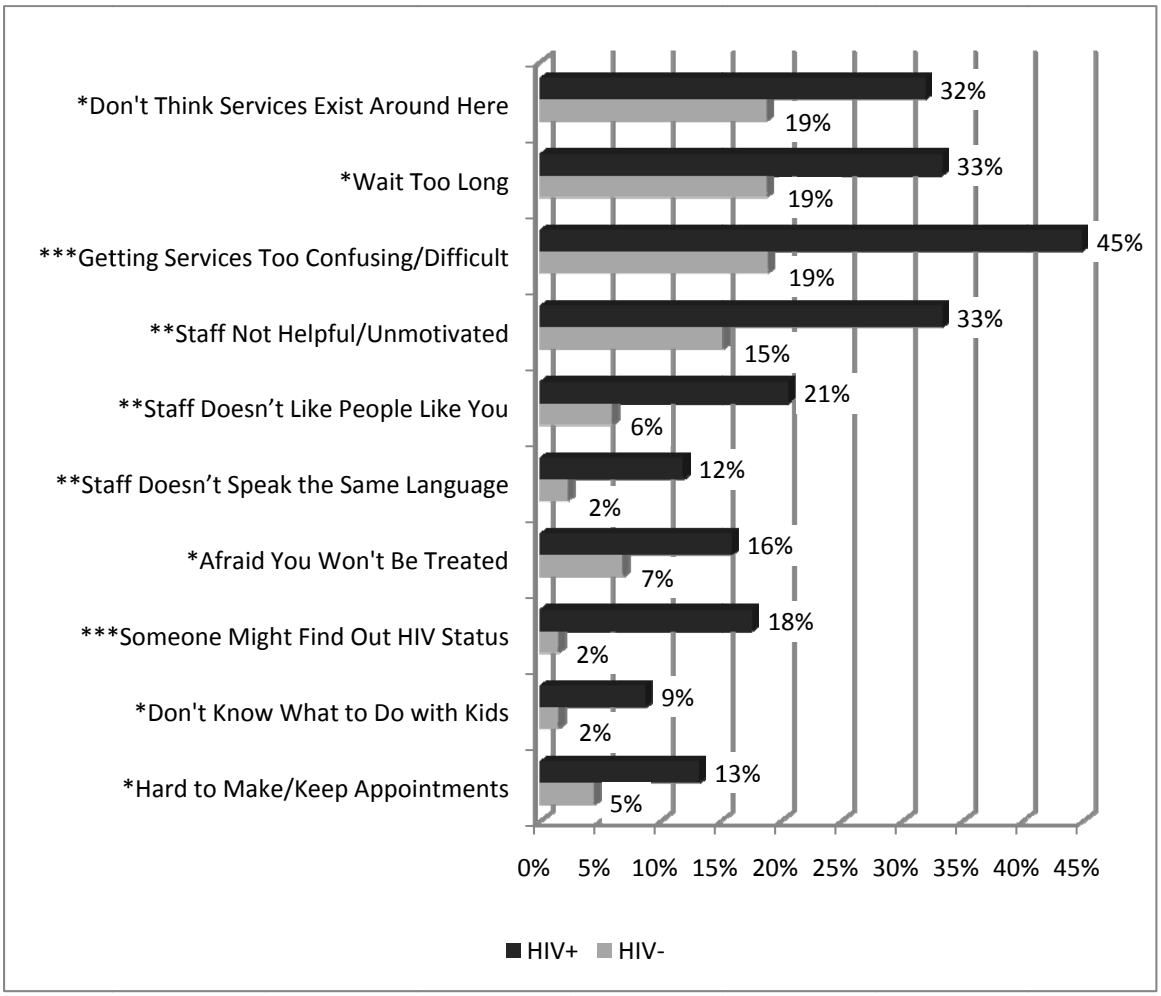

Figure 35: Barriers to Service by HIV Status [* $p < .05$, ** $p < .01$, *** $p < .001$, Chi-square tests of significance]

In terms of contextual issues, problems with transportation topped the list, with 17% reporting it was difficult to get to the service site. Approximately 7% were concerned that their HIV status would be revealed in the process of obtaining services. Childcare (4%) and other caregiving responsibilities (7%) followed. Seven-percent also noted difficulty in making or keeping appointments, and 5% indicated their family or friends would disapprove if they accessed services.

Consistent with the finding that older LGBT adults with HIV reported significantly more service barriers on average as compared with their peers, there were a number of significant differences in the likelihood of perceived barriers based on HIV status. As illustrated in Figure 35, HIV+ older LGBT adults perceived more barriers in all three domains. In terms of access barriers, difficulty and confusion with accessing services was endorsed by nearly half of the HIV+ group, while approximately one-third indicated that they were not sure they could access services locally or felt they would have to wait too long. Only about 20% of the HIV- group reported these access barriers.

With regard to staff and organizational barriers, HIV+ LGBT older adults were twice as likely as their peers to feel that staff was unmotivated or unhelpful (33% and 15%, respectively). HIV stigma also appears to be an issue, with one-in-five HIV+ adults feeling "staff didn't like people like them" as compared with only 6% of the non-HIV diagnosed group. Similar patterns were observed regarding language barriers or not receiving treatment.

Older HIV+ LGBT adults were also more likely to cite contextual issues, such as disclosure of their HIV status (18%), difficulty in making or keeping appointments (13%) and childcare issues (9%). In contrast, 5% or fewer of the HIV- group reported these contextual service barriers.

NEED FOR SERVICES IN THE PREVIOUS YEAR & UNMET NEEDS

Older LGBT adults were asked about their need for services in the past year from a list of commonly utilized health and social services, whether their needs had been met, and if so, who provided the help (e.g., family, community-based organization). Figure 36 shows the extent of need for services among participants in the current study and unmet need. The average number of services needed in the past year was 2.5 (SD=2.2) and the average number of unmet needs was 0.6 (SD =0.9); this did not differ significantly by HIV status.

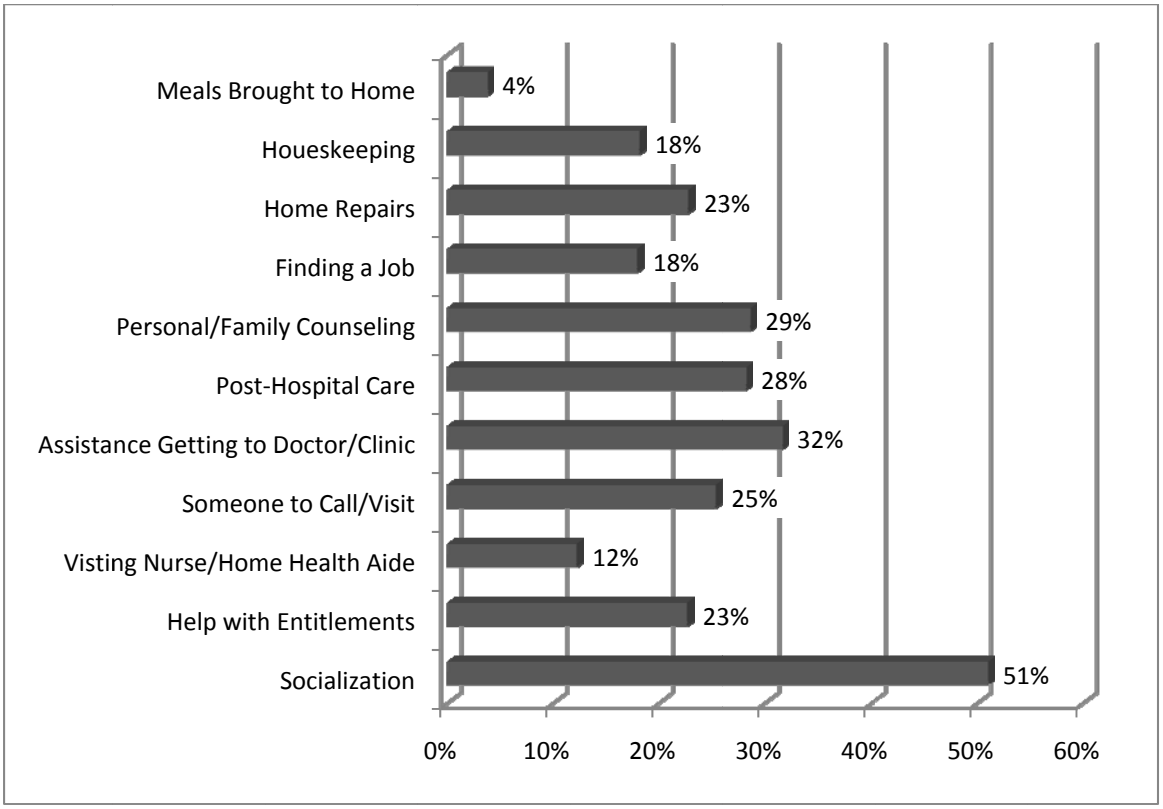

Figure 36: Need for Services in the Previous Year

Meals Brought to the Home. Four-percent of older LGBT adults reported that they needed meals brought to them at home during the previous year (n=8). Of those, two-thirds indicated that they had not gotten all the help they needed. Sources of help for this need included family and friends (44%), while 56% received help from community-based organizations (i.e., Vital Bridges, Meals-on-Wheels). HIV status was not significantly related to the need for meals at home, whether this need was met, or who provided the help.

Housekeeping and Home Care. Nearly one-in-five older LGBT adults reported that they had needed help with housekeeping or personal care in the home over the previous year (18%). Eighteen-percent of those needing such help indicated that they did not receive all the help they needed with housekeeping and care in the home. In most cases, family, friends and neighbors supplied the needed assistance (45%), although the Division of Rehabilitation Services (DRS) provided assistance to 18% of those with this need. An additional 38% received help from other sources, usually other social service agencies (e.g., Catholic Charities), the VA, or paid helpers. The need for housekeeping/home care, the extent to which this need was met, and source of assistance did not differ significantly by HIV status.

Home Repairs. Help with home repairs was needed by 23% of older LGBT adults, and of those who needed this help, 26% did not receive all the help they needed. Friends and neighbors were the most likely to have provided this help (48%), while family members helped 17% of the time. Only 6% had turned to the Illinois Housing Development Authority Home Modification Program. Approximately one-third had hired a contractor/paid helper or asked for assistance from the building superintendent or management. The need for home repairs, as well as unmet need and source of support did not vary by HIV status.

Help Finding a Job. Eighteen-percent of older LGBT adults reported that they had needed help finding a job in the past year. Of those, slightly less than two-thirds (64%) did not receive all the help that they needed in this area. Nearly two-thirds (64%) turned to family and friends for help in finding a job, while 18% had received help from Chicago House. The remainder had mostly received help from the other agencies, such as the Illinois Department of Employment Services or Jewish Vocational Services. The need for help in finding a job, unmet need, and sources of assistance were not related to HIV status.

Personal or Family Counseling. Counseling assistance, either personal or family, was the third highest in terms of need in the previous year (29%), and over one-quarter (27%) who needed this assistance reported that they did not receive all the help they needed. Relative to other service needs, family and friends were not relied upon extensively (26%). Nearly one-in-five (19%) had turned to COH for such assistance. The remaining two-thirds received help with counseling from private therapists, hospitals (including the VA), and other community-based organizations. The need for personal and family counseling, unmet need, and source of help did not vary significantly by HIV status.

Post-Hospital Care. Approximately one-in-five (21%) older LGBT adults reported needing help following a stay in the hospital in the previous year and most (86%) received all the help they needed in this regard. Sources of assistance for help after a hospital stay was largely provided by friends and neighbors (54%) followed by family members (30%). Fourteen-percent had received assistance from a

case manager. Twenty-four percent received help from other community-based organizations. HIV status was not significantly related to need for post-hospital help, unmet need, or source of support.

Someone to Take to Doctor/Clinic. The second most frequently mentioned need by older LGBT adults in the past year was assistance in getting to the doctor's office or a medical clinic (32%). Only 10% reported not receiving all the help they needed in this regard. Family (41%) and friends/neighbors (54%) were the most frequently named sources of assistance, although 10% had relied on a case manager and 15% had used some other source of help (the PACE program was most often mentioned). The need for an escort to the doctor/clinic, unmet need and source of assistance did not vary significantly by HIV status.

Someone to Call or Visit Regularly. The need for a regular contact, either by a visit in-person or by phone, was indicated by one-quarter of older LGBT adults. Seventeen-percent reported that they did not have their needs in this area met. Support in this area was equally likely to come from family (41%) as compared with friends (44%). Six-percent had utilized the SAGE friendly visiting program, and 9% had used the services of another source, with medical personnel being the most frequently mentioned. HIV status was not significantly related to need, unmet need, or source of assistance in this area.

Visiting Nurse, Home Health Aide, or Home Attendant. Need for this type of homecare service was reported by 12% of older LGBT adults and nearly one-third who needed such help indicated they did not receive all the assistance they needed in the past year. Thirteen-percent relied on family members and the same proportion relied on friends. Seventeen-percent had turned to a case manager for help with homecare services, but most (58%) had turned to some type of home health care agency for assistance. The need for this type of assistance, unmet need and source of support were again unrelated to HIV status.

Help with Government Entitlements. Help navigating the entitlement system was an expressed need for 23% of older LGBT adults in the past year. Approximately one-third had turned to family (15%) or friends (15%) for assistance in this area. Twenty-one percent had used Ryan White Case Management, and all of these individuals were HIV positive. About half (49%) had turned to some other social service organization for help with entitlements. The need for help with entitlement in the past year differed significantly by HIV status, with 40% of older LGBT HIV+ adults indicating this need as compared with 14% of non-HIV diagnosed individuals. However, the proportion whose needs were not met and the source of assistance did not differ significantly by HIV status.

Someplace to Socialize or Meet People. Need for socialization opportunities was the most frequently mentioned expressed need among older LGBT participants in the current study. Over half (51%) expressed the need for more socialization and 14% reported that they did not receive all the help they needed in this regard. COH was the most frequently cited source of providing a place for socialization (39%), while 19% had turned to some other community-based organization such as a church, ASO or Howard Brown. One-quarter (24%) had received help in this regard from friends and neighbors, and 19% reported family members as their source of assistance. The need for socialization and unmet need in this area did not differ as a function of HIV status. However, older LGBT adults who

were not diagnosed with HIV were more likely to name COH as a source of socialization help (75%) as compared with the HIV+ group (33%).

CONCLUSIONS & IMPLICATIONS

This research study data conducted for COH provides a comprehensive assessment of the present and emerging needs of their aging LGBT community. There are several subgroups within this study which include those defined by gender and those defined by HIV serostatus. Many significant differences were seen when HIV status is a factor. Some of these differences are most evident in health measurements. But it is noteworthy that the HIV+ group, who are overwhelmingly men, have an average age of 55, while those without an HIV diagnosis were 62 years-of-age on average. This age difference is one contributing factor to observed group differences base on HIV serostatus.

This sample of older LGBT adults reflects the immediate environs of Chicago. Nearly half own their residence, with most others having secure housing. However, an almost equal percentage stated they were unemployed and were barely able to meet expenses. This population has social networks that are largely reliant on friends rather than families of origin. The majority lives alone and do not have a long-term partner/relationship. Without the typical supports intrinsic to close family connections and those derived from long-term relationships, this group of older adults will confront increasing financial challenges as well as increased isolation. Sustaining the costs of a residence by a single aging person, with a fixed income, reduced work options and decreased opportunities for socialization, creates high risk for successful aging. This is especially true of the HIV+ group within this study. Additionally the burden of chronic disease can make normal routines difficult and strain financial resources.

The vast majority of the sample report being in good health, and many receive coverage for healthcare via private insurance. But rates of smoking, substance and alcohol use, and depression may represent a risk to their current favorable health status. Over half of the HIV+ group currently smokes cigarettes on a regular basis. This behavior places them at very high risk for multiple illnesses and must be addressed. One-in-five of older LGBT adults were in a substance abuse recovery program, and others may also be at risk for substance use problems. Outreach to encourage enrollment in these programs is needed.

Depression is the single most consistent predictor of poor health outcomes. The high rates of depressive symptoms in this population reflect a major need for targeted mental health services for older adults in general, that appear to be exacerbated among the older LGBT population. To address this problem, encouraging those with depression to seek care from their health providers is needed, as well as public education campaigns that describe the symptoms and management options of depression. Depression in the LGBT population in part reflects the internalization of social stigmas that contribute to social isolation and destructive self-medication behaviors.

The sexual health of these aging LGBT people provides data that is new and emerging. The study shows clearly that regardless of HIV status large proportions of older LGBT adults engage in sexual behaviors that place them and partners at risk for STI infection including HIV, regardless of HIV status. These data support the need for STI and HIV prevention programs that target the LGBT older adult as well as

education and social media campaigns that are inclusive of people who are every age and sexual identity. Sexual desire and behavior is not the domain exclusively of young people. That misperception must be changed.

Barriers were encountered by this population as they sought aging support services outside of the COH programs. Those perceived barriers can only be ameliorated and removed by communication and interaction between the LGBT communities, especially COH. In order to achieve successful aging the older LGBT adult must be able to access all community based services. This will require outreach and education to mainstream senior service providers to ensure that they are culturally competent when engaging older LGBT and/or HIV-positive adults, and understand the special needs and characteristics of these populations.

The service need that was identified as having the highest priority and highest level of unmet need was opportunities for socialization. Socialization has long been recognized as a critical determinant of successful or healthy aging. As one ages social networks reduce in size as friends die or can no longer travel due to disease burden. A spouse who survives the death of a partner is often left with surviving children and other relatives who share this loss and provide support. This is not typical of the aging LGBT adult. Research shows that those older adults with strong social networks often have a higher quality of life, longer life spans and better health status. Many studies show that strong social support may be a protection against cognitive decline. Socialization allows a person to feel connected and to create meaningful relationships. Catalysts for this include social gatherings, as well as home visits and even the telephone call or connections that occur on line. Providing opportunities for socialization that are welcoming and accessible for large numbers of aging LGBT people with diverse interest and personalities is a massive challenge. Addressing that challenge will define the near future of LGBT centers and result in better health and well-being for those whom they serve.