
Trends, Implications, and Future Directions for Policy, Practice, and Research on LGBT Elders

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Pamela B. Teaster and Debra A. Harley

Abstract

LGBT elders remain nearly invisible to advocates, researchers, educators, practitioners, administrators, and policy makers. The topics of sexual orientation and gender identity are rarely addressed in health and human service delivery or educational degree programs, and their relevance to LGBT elders is further marginalized or omitted from these venues. In this chapter, we identify trends and anticipate future directions and implications for policy practice and research on LGBT elders. This chapter serves simultaneously as a capstone of the previous 34 chapters and as a roadmap for advancing a research and service delivery agenda to address the challenges of LGBT elders.

Keywords

Research · Future trends · Policy · Practice · LGBT elders

Overview

LGBT elders struggle with the same issues about aging as the broader community and with unique concerns that are not represented by mainstream institutions and laws (Abercrombie and Johnson 2007). This chapter is both a capstone of the previous chapters in this book and a roadmap for discussion of trends and future directions of

policy, practice, and research on LGBT elders. The intent is to focus on gaps that remain to be addressed. Legal standing for same-sex couples is a hotly debated issue. Over the past two decades, American voters have voted numerous times on the rights of LGBT persons, and more often than not, the outcomes have not been favorable (Russell 2012). Integration of sexual orientation and gender identity into current legislation pertaining to aging and older persons remains tenuous at best. Comprehensive health-care and social policies and practices that are inclusive and sensitive to the unique needs of LGBT elders remain elusive. In addition, variation in state and local policy regarding LGBT persons adds another dimension for consideration. Although policy, practice, and research on

P.B. Teaster (✉)
Virginia Tech, Blacksburg, VA, USA
e-mail: pteaster@vt.edu

D.A. Harley
University of Kentucky, Lexington, Kentucky, USA
e-mail: dharl00@email.uky.edu

LGBT elders are limited in comparison with their non-LGBT counterparts, transgender persons are the most marginalized, excluded, and discriminated against of all sexual minorities or gender-variant persons. However, there appear to be hopeful signs that the tide of public opinion is changing with such initiatives as the repeal of DOMA and the election of an openly gay bishop by one of the mainline churches.

Learning Objectives

By the end of the chapter, the reader should be able to:

1. Identify future trends in policy, practice, and research that will impact LGBT elders.
2. Identify the core competencies for practice with LGBT elders.
3. Discuss existing gaps in policy, practice, and research on LGBT elders.

Introduction

It is difficult to imagine that any sector of the aging population as a whole has been ignored or under-investigated, particularly given the plethora of scholarly and practice gerontological literature that has been produced over the past fifty years. Robert Hudson, highly recognized scholar of aging policy for over 30 years, observes, "... LGBT older adults have remained nearly invisible to the community of advocates, researchers, practitioners, administrators, and politicians who associate themselves with the modern aging enterprise" (Hudson 2011, p. 1). Though topics of sexual orientation and gender identity among middle-age and older adults are rarely addressed in health and human service delivery training or in educational degree programs (Fredriksen-Goldsen et al. 2014), more clinicians, counselors, social workers, and human service providers are finding

themselves working with LGBT elders. In order to help LGBT persons at any age, it is important to understand LGBT issues and stigma, as well as to become aware of available resources, or the lack thereof (Hillman 2012). According to Fredriksen-Goldsen et al. (2014), "health and human service providers must comprehend the intersectionalities of history, social structures, and cultural factors and how they have shaped the life experiences of LGBT elders. In addition, practitioners must identify the typical and the highly unique, yet normative experiences of LGBT people as they age, recognizing distinct transitions over the life course, such as identity management (e.g., coming out or not), and how they influence service use" (p. 86).

Although older, baby boom, and younger LGBT persons share common themes such as concerns about coming out, difficulties with prohibitive religious beliefs, anxiety about HIV and AIDS, disparities in health care and job opportunities, fear of discrimination, concerns about support networks, and legal issues related to same-sex marriage and partnerships, important differences exist between these age cohorts (Hillman 2012). Many LGBT elders came of age when the prevailing social norm was to ignore or subvert homosexual tendencies and to ascribe to traditional family values and relationships. Consequently, they (a) are less likely to receive vital information about HIV education, treatment, and prevention (Makadon and Cahill 2012; National Institute on Aging 2009), (b) have fewer family members available to tend to basic and instrumental needs, (c) are more likely to have endured persecution by the community at large, (d) encounter difficulties forming informal social support groups or romantic relationships because they are less likely to easily identify one another due to concern about revealing LGBT identity, and (e) were raised in a generation in which one was not forthcoming about one's sexual preferences (Hillman 2012; MetLife Mature Market Institute 2010). Each of these issues influences policy development, service delivery, and research foci for LGBT elders.

Disparities in Outcomes for LGBT Elders and Older Heterosexual Populations

Substantial differences with their heterosexual counterparts persist for LGBT elders in important domains such as health care, housing, socioeconomic status, social isolation, equal treatment under the law, and targeted programming. At both younger and older ages, LGBT persons remain “invisible” in healthcare settings (Makadon and Cahill 2012). Clinicians, most of whom receive little or no training regarding sexual orientation and gender identity, rarely if ever inquire about their patient’s sexual history, sexual orientation, and gender identity (Makadon and Cahill).

As with practice settings, a growing body of research literature suggests that LGBT elders are discriminated against by health and social service providers: many have received substandard care because of their LGBT identities (Gratwick et al. 2014). Even when providers of aging services indicate a willingness to become more responsive to the needs of LGBT elders (e.g., relevant staff training), evidence suggests that they rarely follow through (Knochel et al. 2012). According to Gehlert et al. (2010, p. 408), “because the determinants of disparities occur at multiple levels, from the molecular to societal and interact with one another in ways not yet fully understood, they represent a challenge to researchers attempting to capture their complexity.”

The San Francisco LGBT Aging Policy Task Force (2014) identified key areas of concern and associated solutions to address: data collection, cultural competency, health and social services, housing, and legal services (see Table 35.1). In (2012), a summit hosted by Healing Detroit (an African American LGBT initiative) and the LGBT Older Adult Coalition was held to explore the needs and experiences expressed by LGBT elders on their experiences and concerns about aging in the Detroit area. The Coalition attracted a mainly Caucasian audience from the suburbs, while Healing Detroit attracted primarily an inner city African American audience. In exploring

Table 35.1 Concerns and solutions for LGBT elders

Concern 1: Lack of data on gender identity and sexual orientation among city agencies prevents understanding of service needs and utilization in the LGBT population

• **Solution:** Collect data on gender identity and sexual orientation whenever other voluntary demographic data are collected

Concern 2: Senior service providers do not have adequate cultural competence to appropriately serve LGBT seniors

• **Solution:** Require training to improve cultural competency of service providers in working effectively with LGBT elders

Concern 3: LGBT elders lack information and enrollment support for social services, financial support, benefits counseling, legal advocacy, and health insurance access

• **Solution:** Develop and implement an information, referral, enrollment assistance, and case management referral program that provides a single place for LGBT elders to receive information, referral, and enrollment assistance for a wide range of available social services and health care

Concern 4: Availability of limited supportive services to aid in the provision, coordination, and planning of care to address unique challenges facing LGBT elders

• **Solution:** Develop and implement an LGBT elder case management and peer specialist program

Concern 5: Availability of limited support services to address the emotional, behavioral health, and social isolation challenges of LGBT elders

• **Solution:** Develop and implement an LGBT elder peer counseling program and an LGBT peer support volunteer program

Concern 6: LGBT elders have unique barriers to accessing information about and services for Alzheimer’s and dementia care

• **Solution:** Create an LGBT-targeted education and awareness campaign and increase availability of related support groups

Concern 7: LGBT elders struggle with low income and poor financial literacy

• **Solution:** Develop and implement financial literacy training services targeting LGBT elders

Concern 8: LGBT elders are especially vulnerable to losing their residential housing as a result of eviction and physical barriers to aging in place, and the consequences of losing housing late in life are severe for most LGBT elders

• **Solution:** Improve eviction prevention protections for LGBT elders through rental and homeowner assistance,

(continued)

Table 35.1 (continued)

legal services, and increased restriction on evictions and increase resources for LGBT elder homeowners

Concern 9: LGBT elders need more access to affordable housing

• **Solution:** Increase availability of and access to affordable housing by including LGBT elders in planning processes, prioritizing developments that target them, and providing LGBT-focused housing counseling and rental assistance

Concern 10: Conditions in apartments and single room occupancy (SRO) where many LGBT elders live are often unacceptable

• **Solution:** Improve conditions in apartments and SROs through improved Department of Building Inspections (DBI) policies and enhance work on habitability

Concern 11: Many LGBT elders feel unsafe and unwelcome in city shelters

• **Solution:** The city should address unsafe and unwelcoming treatment of LGBT elders in city shelters by providing targeted shelter services and implementing training at existing shelters

Concern 12: LGBT elders in long-term care facilities face systemic discrimination and abuse

• **Solution:** Improve legal protections and resources for LGBT elders in long-term care facilities

Concern 13: LGBT elders face obstacles to and lack resources for drafting appropriate life-planning documents

• **Solution:** Promote LGBT life-planning legal clinics, referral protocols, and sample documents, and develop resources to aid LGBT elders who wish to complete the planning process

Adapted from San Francisco LGBT Aging Policy Task Force (2014)

similarities and differences faced by each of these groups, Lipscomb and LaTosch (2012) reported that (a) mature LGBTQ persons are isolated by their community, and their peers are self-afflicted; (b) if they relocated to a senior living facility, mature LGBTQ persons are most likely sent back into the closet; (c) the LGBTQ community is youth-oriented to the point that women and men aged 55 and over cannot relate to the present social network; (d) financially and career successful women and men aged 55 and over are becoming increasingly isolated by their education, career climbing, and inadequately developed partnerships and community network

building; (e) current LGBTQ women and men aged 55+ have lived an isolated lifestyle that has not condoned discussion of issues such as physical illness, financial troubles, and personal relationships; and (f) the younger cohort of baby boomers includes women and men aged 55+ who are not as economically able for their final years as their same-gender counterparts. Older and retired LGBT persons have concerns (e.g., healthcare affordability, competent care) different from their younger counterparts (e.g., housing, independence).

The most common concern for both inner city African American LGBT elders and their suburban Caucasian counterparts was social isolation created by feeling unwelcome at social activities in an LGBT community geared for younger persons, fear of social ostracism within the mainstream senior social community, and unwelcome senior living communities. The most significant difference between them was African American LGBT elders' challenges of living in the city (e.g., unemployment, poverty, systemic racial inequity issues) and Caucasian suburban LGBT elders' challenges for acquiring culturally competent healthcare and appropriate housing options (Lipscomb and LaTosch 2012). Findings by Lipscomb and LaTosch are consistent with results from other studies (e.g., Espinoza 2013, 2014; Fredriksen-Goldsen et al. 2011; Kim and Fredriksen-Goldsen 2014) and other sources reported in this book.

In addition to health disparities, research findings point to other legal, political, and social issues that significantly impact the health and well-being of LGBT persons (Ard and Makadon 2012). One important and highly visible issue is the heated debate over the legality of same-sex marriage, along with its associated benefits. According to Badgett (2011), the right to marry is associated with greater feelings of social inclusion among LGBT persons, whether married or not. Another issue is that, across the lifespan, LGBT elders may experience **violence and mistreatment** at higher rates than do heterosexual elders and are at high risk for elder abuse, neglect, and exploitation (MAP et al. 2010). Although his work on elder mistreatment

did not address LGBT elders, the national prevalence study by Acierno et al. (2010) identifies that elders most at risk are those who have a lack of social support and who were previously exposed to a traumatic event, situations that are very common for LGBT elders. A third issue is that gay men and lesbians tend to place high value on self-sufficiency and thus may **hesitate to accept assistance** in old age (SAGE and MAP 2010). Such hesitation may well increase the vulnerabilities to mistreatment cited previously. Finally, in addition to hereditary factors, general socioeconomic, cultural, and environmental conditions; living and working conditions; social and community influences; and individual lifestyle factors constitute **social determinants** influencing disparities between and among LGBT elders (Makadon and Cahill 2012).

Interdisciplinary Perspective to the Study of Aging and Sexual Minorities

Three major approaches to collaboration are multidisciplinary, interdisciplinary, and transdisciplinary. *Multidisciplinary* involves experts, researchers, or service providers from a variety of disciplines working together, but with each approaching the issue at hand through his or her own disciplinary lens. *Interdisciplinarity* has the goal of transferring knowledge from one discipline to another and allowing experts, researchers, or service providers to inform one another's work and discuss and compare their individual findings. *Transdisciplinarity* is collaboration in which experts, researchers, or service providers operate outside their disciplines or specialties (Gehlert et al. 2010). Each represents an improvement over a monodisciplinary approach in that it can capture the multifaceted and complex nature of the causes and consequences of group differences, "with disciplinary scholars operating in concert at more than one level throughout the entire research process" (Gehlert et al. 2010, p. 410). Similarly, service providers gain a better understanding of the multiple needs

of LGBT elders and of how to provide services in a more integrated and comprehensive way. Although the approach used to collaborate may be determined by one's discipline, specialty, or setting, the acknowledgment of different perspectives to service delivery will advance access and quality of service to LGBT elders.

Human and social service, medical, nursing, and health sciences disciplines represent many of the professions that knowingly or unknowingly work with LGBT elders. A major challenge across disciplines is the lack of understanding concerning how to educate people to engage in an interdisciplinary approach for examining the impact of contextual factors on the lives of LGBT elders. Disciplines typically teach and train service providers in isolation, resulting in disciplinary myopia—a lack of awareness and understanding of competencies and expectations of practitioners with whom they will work in delivering services to LGBT elders. Effective communication across disciplines is crucial in order to implement the latest educational approaches and evidence-based strategies to address challenges facing LGBT elders.

Bridging the Gap Between Policy and Practice

Chance (2013) argued that while the Affordable Care Act (ACA) will likely help remedy some of the discrimination that results in the LGBT community's disparate access to health care, it is ineffective in combating broader LGBT healthcare discrimination. Its reformatory focus is on increasing access to care; however, it fails to address the specific needs of the LGBT community and the stigma that results from lower quality care. Chance believes that the social stigma associated with a patient's LGBT status is the driver of gaps in access to quality healthcare services, the result of which causes him or her to delay seeking health care when needed or to avoid it altogether. Thus, there is a need to shift the policy and regulatory focus toward improving the quality of health care for LGBT persons, to remedy the LGBT community's disparate healthcare status, and to

require cultural competency training for health-care providers. Also, Chance proposes that as a national legislative and regulatory effort should be launched amending the ACA to focus on provisions aimed at the discrimination that causes substandard provision of care to LGBT persons as well as cultural competency training to students in medical schools and existing practitioners. The justification to amend the ACA to include provisions requiring applicable agencies to issue rules aimed at increasing implementation and utilization of LGBT-specific cultural competence training is predicated upon the older adults' participation in Medicare and Medicaid programs and the agencies' recipients of federal research dollars.

LGBT persons, especially transgendered persons, are subject to arbitrary and discriminatory practices in private insurance coverage, which limit access to safe and competent care. Private health insurance plans often exclude coverage for medically necessary care related to gender transition, which can range from psychotherapy to medication, gender-specific examinations, and surgical care (Auldridge and Espinoza 2013; Feldman and Goldberg 2007). Auldridge and Espinoza concluded that these practices are more devastating for LGBT elders of color who are concentrated in low- and fixed-income statuses. The result is a wide disparity in health care for rich and poor and for Caucasian and ethnic and sexual minority elders.

Innovative Approaches to Improve Services for LGBT Elders

Cultural differences of LGBT elders are poles apart from other older adults and should be taken into consideration during assessment and in service provision in order to reduce health, housing, and economic disparities (Pugh 2005). An example of a program taking this approach is the *Los Angeles Gay & Lesbian Center's Seniors Services Department* (hereafter referred to as the Center). The Center responds to the needs of LGBT elders with a three-pronged service approach that includes opportunities for

socialization, supportive case management services, and training to help other service providers develop affirmative, supportive practices with helping these populations. The Center is the largest LGBT community center in the world and includes a comprehensive health clinic, mental health clinic, legal services, senior services, youth shelter and services, substance abuse programs, and community cultural arts (Gratwick et al. 2014). The Center's continuum of services is akin to the interdisciplinary approach mentioned earlier in this chapter. The Center is integrated in that it provides services to LGBT persons and to their heterosexual counterparts aged 50 and older.

In an exploration of how to work toward an interdisciplinary approach to assisting the LGBT aging community, Abercrombie and Johnson (2007) reported the major themes of a *Town Hall meeting on aging in the LGBT community convened in Decatur, Georgia*. The goal of the meeting was to answer two questions: (1) What are the LGBT community's most significant concerns about its aging community members? and (2) What are the approaches and actions that can best improve the quality of life of the growing number of aging LGBT community members? The most significant concerns identified included a fear of aging; concerns about the availability of money, housing, and services; and retaining the ability to maintain as much control over their lives as possible. The most important approaches and actions to mollify these concerns were as follows: (1) mobilization of the LGBT community, (2) creation of alternative housing and healthcare opportunities, (3) increase education and research, (4) increase planning and advocacy, (5) foster greater collaboration, and (6) more effective communication through new technologies. Attention to such efforts, conducted on multiple levels and through a truly interdisciplinary effort, would allow the reduction of socioeconomic disparities for LGBT elders.

Services and Advocacy for Gay, Lesbian, Bisexual and Transgender Elders (SAGE) and Movement Advancement Project (MAP) (2010) offered broad-based recommendations for building change and improving the lives of LGBT

elders. The first recommendation was to provide immediate relief for LGBT elders through increasing funding for and provision of LGBT elder programs, affording immediate access to volunteer-based care, and providing education tools and legal services to LGBT elders. The second recommendation was to create an effective LGBT aging infrastructure through the creation and support of a much-needed advocacy infrastructure by building a strong coalition of allies. The third recommendation was to expand an understanding of LGBT aging issues through advocating for more research on LGBT older adults and generating a national public discussion about LGBT aging issues.

Electronic Medical Records. In addition, the agendas outlined above are the issue of electronic record keeping and the data fields it captures. Documenting patients and clients' progress is frequently linked to data. Given this situation, it is only logical to gather data on sexual orientation and gender identity (a) to increase providers' ability to screen, detect, and prevent conditions more common in LGBT persons; (b) to create a better understanding of LGBT persons' lives; (c) to allow comparison of patient/client outcomes with national survey samples of LGBT persons (Makadon and Cahill 2012); and (d) to enhance the patient-provider interaction and regular use of health care (Healthy People 2020). Supporting the institution of these practices, in 2003, the Institute of Medicine recommended collecting data on sexual orientation and gender identity in electronic health records (EHR) (see Table 35.2 for the core functions of EHR) and

Table 35.2 Core functions of electronic health records

Health information and data
Result management
Order management
Decision support
Electronic communication and connectivity
Patient support
Administrative processes and reporting
Reporting and population health

Adapted from Institute of Medicine (2003)

recommended the creation of structured data elements to allow for comparing and pooling data to analyze the unique needs of LGBT persons. However, in a study of the use of EHRs in US hospitals, Jha et al. (2009) found that, contrary to a consensus that the use of information technology should lead to more efficient, safer, and higher quality care, no reliable estimates of the prevalence of adoption of EHR existed (see Research Box 35.1).

Research Box 35.1

Jha, A.K., Des Roches, C.M., Campbell, E. G., Donelan, K.D., Rao, S.R., Ferris, T.G., Shields, A., Rosenbaum, S., & Blumenthal, D. (2009). Use of electronic health records in US hospitals. *New England Journal of Medicine*, 360, 1628–1638.

Objective: This study aimed to determine the extent to which large hospitals, teaching hospitals, non-teaching hospitals, and private hospitals adopt electronic health records.

Method: All acute hospitals that are members of the American Hospital Association were surveyed for the presence of specific electronic record functionalities. Using a definition of EHR based on expert consensus, the proportion of hospitals that had such systems in their clinical areas was determined. In addition, the relationship of adoption of EHR with specific hospital characteristics and factors that were reported to be barriers to or facilitators of adoption were examined.

Results: Based on responses from 63.1 % of hospitals surveyed, only 1.5 % of US hospitals have a comprehensive EHR system in all clinical units and an additional 7.6 % have a basic system in at least one clinical unit. Computerized provider order entry for medications has been implemented in only 17 % of hospitals. Larger hospitals in urban areas and teaching hospitals were more likely to have EHR. Capital requirements and high maintenance costs were cited as the

primary barriers to implementation, although hospitals with systems were less likely to cite these barriers than hospitals without such systems.

Conclusion: The very low levels of adoption of EHR in US hospitals suggest that policy makers face substantial obstacles to the achievement of healthcare performance goals that depend on health information technology. A policy strategy focused on financial support, interoperability, and training of technical support staff may be necessary to help with adoption of such systems in US hospitals.

Questions

1. How can this study be redesigned to do a comparative study of US hospitals and international hospitals in developed countries?
2. What were the independent and dependent variables?
3. If VHA hospitals were excluded from this study, how differently would the results be?

In Canada, many consider EHR systems to be critical for achieving another goal of interdisciplinary collaboration: improved continuity of care, reduced duplication, and decreased incidents of adverse events. However, a number of potential barriers continue to exist (e.g., creating safe, accessible computer-generated records, the ability of health professionals to generate, add to and share documents) (Deber and Baumann 2005). To surmount these barriers, Deber and Baumann recommend attention to three aspects to promote the initiative they support: How health care is financed, how health care is funded, and how it is delivered. Upon resolution of these conundrums, they contend that attention must be paid to the barriers created by interpretations by provincial governments of legal definitions inherent in the Canadian Constitution and the Canadian Health Act.

Future Directions and Implications for Policy, Practice, and Research on LGBT Elders

The National Academy on an Aging Society published *Public Policy & Aging Report* (2011) in which they explore several topics related to LGBT elders, including the absence of research and public policies devoted to LGBT populations, the failure of existing general aging policies to incorporate LGBT needs and interests, the need of cultural competency training among service personnel, partnerships between organizations working with LGBT elders and elders of color to advance common policy goals, and the implications of a demographic estimate showing that one in two Americans living with HIV will be aged 50 and older by 2015 (Hudson 2011). Adults over the age of 50 who receive a diagnosis of HIV are more likely to receive a concurrent AIDS diagnosis (51 %) compared to their younger peers (33 %) (Centers for Disease Control 2013). Moreover, the stigma of HIV may be perceived to be greater in the elderly population, leading them to hide their diagnosis or avoid testing. HIV prevention campaigns that exist do not typically target elders (Pratt et al. 2010). It is critical that the spheres of research and practice come together to reliably and appropriately inform each other so that desirable policies affecting the very real issues that LGBT persons face be created, developed, and implemented wisely and well.

Policy. For decades, the lives of LGBT persons have been restricted and dictated by public opinion and exploited by the homophobia and heterosexism that pervades the cultural and political landscape of many institutions (Russell 2012). Public opinion has often been the arbiter of public policy, which, in the main has not been sympathetic to the plight of many LGBT persons, including upholding and expanding their rights under the law. According to Russell, when the political and the personal collide, LGBT persons are often vulnerable political targets. On a more positive note, the passage of the ACA provides new health coverage options that should

benefit LGBT elders. Prior to the ACA, one in three lower income LGBT adults in the USA had no health insurance. To remedy that situation, Section 1557 of the ACA prohibits discrimination against individuals based on sex, sex stereotyping, and gender identity. Even in light of the potential benefits of the ACA for many LGBT elders, Heinz and Choi (2014) contend that the sweeping policy is only effective if people are aware of it and if outreach, education, and communication are instituted to ensure that LGBT persons have access to quality, affordable health care, and freedom from discrimination. Until these efforts are realized, LGBT elders will be marginalized and oppressed, victims of a variety of disparities, health care being paramount among them.

Practice. Culturally competent practice with LGBT elders in health and human services is an area of critical need. Various disciplines and professional organizations (e.g., American Psychological Association, American Counseling Association, Commission on Certified Rehabilitation Counselors, Council on Social Work Education) “prioritize multicultural competency as an essential factor in both educational training and practice, with the inclusion of sexual and gender minority groups in definitions of multiculturalism” (Fredriksen-Goldsen et al. 2014, p. 82). The implementation of standards and policy statements by professional organizations in their respective Codes of Ethics has propelled LGBT persons into the forefront as populations that traverse a variety of practice settings and are worthy of appropriate and quality treatment. Fredriksen-Goldsen et al. outline 10 core competencies to improve professional practice and service development to promote the health and well-being of LGBT elders (see Table 35.3) in an effort to provide a blueprint for addressing the increasing needs of this population, their families, and their communities. Those competencies were developed from existing LGBT health and aging literature and, although the focus is on social work competencies, they are applicable to other disciplines. Until these competencies are addressed in part or in whole, the lives of LGBT

Table 35.3 Core competencies for practice with LGBT elders

Critically analyze personal and professional attitudes toward sexual orientation, gender identity, and age, and understand how culture, religion, media, and health and human service systems influence attitudes and ethical decision-making
Understand and articulate the ways that larger social and cultural contexts may have negatively impacted older adults as a historically disadvantaged population
Distinguish similarities and differences within the subgroups of LGBT elders, as well as their intersecting identities (i.e., age, gender, race, health status) to develop tailored and responsive health strategies
Apply theories of aging and social and health perspectives and the most up-to-date knowledge available to engage in culturally competent practice with LGBT elders
When conducting a comprehensive biopsychosocial assessment, attend to the ways that the larger social context and structural and environmental risks and resources may impact LGBT elder
When using empathy and sensitive interviewing skills during assessment and intervention, ensure the use of language is appropriate for working with LGBT elders to establish and build rapport
Understand and articulate the ways in which agency, program, and service policies do or do not marginalize and discriminate against LGBT elders
Understand and articulate the ways that the local, state, and federal laws negatively and positively impact LGBT elders, to advocate on their behalf
Provide sensitive and appropriate outreach to LGBT elders, their families, caregiver and other supports to identify and address service gaps, fragmentation, and barriers that impact LGBT elders
Enhance the capacity of LGBT elders and their families, caregivers, and other supports to navigate aging, social, and health services

Adapted from Fredriksen-Goldsen et al. (2014)

elders will continue to be compromised by their relegation to less than full citizenship status.

Research. Although more research on LGBT elders is available than in previous years, there remains a general lack of empirical research (Hillman 2012) to inform future research as well as the practice community. In part, two major factors appear to contribute to limited research on LGBT elders: non-self-disclosure of sexual minority status and lack of data collection on

sexual minority status by investigators and service providers (Gratwick et al. 2014). Discussed earlier, the Town Hall meeting on aging in the LGBT community, preparing for the future meeting in Decatur, Georgia, identified specific recommendations in the areas of education and research: to educate the LGBT community about aging issues and to educate both the general public and the organizations that should serve the needs of LGBT elders (Abercrombie and Johnson 2007).

HIV/AIDS and its implications for LGBT elders is another arena where research is needed. Although HIV/AIDS has evolved into a chronic, manageable disease due to the success of anti-retroviral therapy, many persons aging with HIV are living with considerable consequences of the disease as a result of early onset (i.e., often in their 50 s) and of multiple comorbid health conditions, elevated mental health issues, substance abuse, stigma driven social isolation, and concomitant loneliness. Many LGBT elders who are living with HIV face the disease without the social support networks that they need to age successfully, despite the fact that they have exhibited significant levels of resilience as long-term survivors. Consequently, there continues to be an increased need for research focused on the medical management of HIV in the older population, including sexual minorities. In addition, medical providers must become better educated in the care of older patients with HIV and risk assessment for HIV (Brennan-Ing and Karplak 2011). And, as a part of an older patients' health assessment, questions about exposure to HIV should become normative rather than atypical.

Summary

One of the most important issues that must be addressed is the present gap between policy and practice for LGBT elders. Does the gap exist because of a lack of evidence-based practices to inform policy, or because of a lack of policy to chart a course for interventions to be developed? Several common themes are explicit in policy

issues, practice, and research pertaining to LGBT persons and aging: (1) discriminatory practices are a health risk; (2) stigma is associated with aging, sexual orientation, and gender identity; (3) service providers are in need of education and training about aging and LGBT issues; and (4) research is needed to understand health and health outcomes for LGBT elders. Without attention to these themes, improvements in the health and well-being of LGBT elders will be sporadic—another in the list of disparities that this growing and deserving population of elders faces.

Resources

Center for Population Research in LGBT Health: www.lgbtpopulationcenter.org

LGBT Aging Project: www.lgbtagingproject.org
 Movement Advancement Project (MAP): www.lgbtmap.org

Public Policy & Aging Report: www.aging-society.org

Services & Advocacy for Gay, Lesbian, Bisexual & Transgender Elders (SAGE): www.sageusa.org

The Fenway Institute: www.thefenway-institute.org

The National Gay and Lesbian Task Force: <http://thetaskforce.org/13>

Learning Exercises

Self-Check Questions

1. What are some of the commonalities and difference across age cohorts of LGBT persons?
2. What is one of the major challenges across disciplines to an interdisciplinary approach to addressing issues relevant to LGBT elders?
3. How can the Affordable Care Act be improved to address broader LGBT health-care discrimination?

4. What are the major contributing factors to limited research on LGBT elders?
5. What concerns have LGBT elders identified as the most important?

Experiential Exercises

1. Imagine that you have the ability to develop or influence policy pertaining to LGBT elders. Select a specific area (e.g., health care, housing, employment) and outline issues that need to be addressed, specify potential policy/solutions, and how you would implement them.
2. Research an LGBT elder who has influenced policy on older LGBT adults. How has he or she been able to establish or change current policies?

Multiple-Choice Questions

1. Which type of approach to collaboration occurs when experts or practitioners operate outside their disciplines or specialty?
 - (a) Interdisciplinary
 - (b) Transdisciplinary
 - (c) Multidisciplinary
 - (d) Intradisciplinary
2. The Affordable Care Act has been criticized for failure to do which of the following for LGBT persons?
 - (a) Ensure access to health care
 - (b) Promote life care planning
 - (c) Ensure quality of care
 - (d) Promote a full spectrum of services
3. In addition to health disparities, which of the following may be a reason for disparities between LGBT and non-LGBT elders?
 - (a) LGBT elders place high value on self-sufficiency
 - (b) Non-LGBT elders are able to better handle criticism from family members
 - (c) LGBT elders are able to use their domestic partners' health insurance
 - (d) Unmarried non-LGBT elders are able to use their domestic partners' health insurance

4. Which of the following legislation prohibits discrimination bases on sex, sex stereotyping, and gender identity?
 - (a) Americans with Disabilities Act
 - (b) Civil Rights Act
 - (c) Affordable Care Act
 - (d) Medicare
5. Which of the following is a logical reason to gather data on sexual orientation and sexual identity?
 - (a) Increases ability to screen, detect, and prevent conditions more common in LGBT persons
 - (b) Helps develop a better understanding of patients' lives
 - (c) Allows comparison of patient outcomes with national survey samples of LGBT person
 - (d) All of the above
 - (e) None of the above
6. Which of the following is the intended purpose of electronic health records?
 - (a) Reduce duplication
 - (b) Allow clinician to share information
 - (c) Improve quality of care
 - (d) All of the above
 - (e) None of the above

Key

- 1-b
2-c
3-a
4-c
5-d
6-d

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