

# **Healthy Aging for Gay and Lesbian Seniors in Canada: An Environmental Scan**

Shari Brotman and Bill Ryan  
McGill University, School of Social Work  
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## **1. Introduction**

Research in the area of health promotion for seniors has documented several key factors in the development of healthy aging strategies that lead to a better quality of life among both currently healthy seniors and those with chronic illness and disability. These include: self care strategies such as physical activity, healthy eating, and tobacco control, the development of supportive environments, including opportunities for civic participation, mutual aid, appropriate housing, community-support and access to health services. Age-friendly communities that consider both social and physical environments that reduce risk of injury and provide opportunities for respect and inclusion have been demonstrated to contribute greatly to the health of seniors as they age. These factors, plus a few others, could broadly be called, in health population discourse, the determinants of health for this population. New research within the gay and lesbian community has identified organizations and initiatives that support people in their decisions about coming out as gay or lesbian is also a major determinant of health.

Although in Canada generally, and in many provinces, strategies have been developed with all seniors in mind, gay and lesbian seniors may face increased challenges to healthy aging on several fronts. Gay and lesbian seniors have faced a lifetime of discrimination which has had a negative impact upon their health as they age. Research has documented that the stress associated with coping with homophobic social discourse and heterosexist discrimination in multiple arenas over the life course (such as family, workplace, education, healthcare, legal and social milieus) can lead to an increased risk for the development of unhealthy behaviours, both from a preventive and treatment perspective, and to overall ill health. This reality is particularly salient for today's gay and lesbian seniors, all of whom lived their youth and young adult lives, to varying degrees, in hostile environments, prior to the development of the modern day gay liberation movement. This has resulted in feelings of great stigma and shame that continue to shape their lives, often requiring them to keep their sexual orientation hidden as a strategy of survival. Many gay and lesbian seniors have not benefited from the recent changes in law, policy and attitudes that the younger gay and lesbian community can now take for granted in Canada. This results in a need to stay hidden for fear of discrimination that has remained a prominent coping mechanism in the lives of many older gay men and lesbians. Higher rates of depression, suicidal ideation, drug and alcohol abuse, smoking, and obesity have all been linked to negative health outcomes among those coping with lifelong exposure to discrimination. While the research documenting this reality among gay and lesbian seniors is limited, there is substantial information available on the general

population of gay and lesbian people. We also know little about how resistance to discrimination may engender positive health outcomes and what strategies those older gays and lesbian people have developed with respect to healthy habits. The community and voluntary sectors play an important role in the development of programs and policies designed to support healthy aging, both from the perspective of social inclusion and healthy habits. Research has documented the role of social inclusion and respect in the development of self-care among seniors generally. Here too, older gays and lesbians are subject to increased risk as heterosexist environments in seniors mutual aid and community sectors and ageism within the gay and lesbian community might hinder gay and lesbian seniors from social, recreational and cultural participation thus limiting the capacity to develop supportive environments, mutual aid and self care strategies to enhance well being. Finally limitation in access to care might result in seniors gaining access to needed services at a later – and more dangerous - point or in fearing to access services for fear of exposure to discrimination which means that seniors with disabilities may also be invisible within the health care system.

Given the invisibility of gay and lesbian seniors and potential risks to healthy aging as a result of lifelong exposure to discrimination, it is important to understand the factors that contribute or inhibit healthy aging for this population. This includes understanding their specific needs and realities, and the role of both seniors' associations and the gay and lesbian community and voluntary sector as key players in the healthy aging of gay and lesbian seniors.

This environmental scan is a first step in documenting the current challenges and risks to healthy aging among gay and lesbian seniors<sup>1</sup>, to understand the role of community and voluntary sectors working with gay and lesbian seniors and to identify gaps in order to inform a healthy aging approach that can contribute to the health and well being for this population.

## **2. Objectives of Environmental Scan**

To develop a healthy aging approach for gay and lesbian seniors in Canada by (1) documenting the particular challenges to healthy aging experienced by gay and lesbian seniors; (2) documenting the programs currently in place to address health promotion strategies for this population, both in the gay and lesbian community organizations, and in mainstream seniors' organizations; and, (3) providing distinct recommendations that can inform the development of programs and policies for the health, community and voluntary sectors.

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<sup>1</sup> We believe that a first-step focus on gay and lesbian seniors is warranted, given their particular historical experience as well as the significant and unique role that stigma plays in the context of sexual orientation. We recognize that the unique needs and issues of both bisexual and transgendered seniors (who face gender discrimination) must also be better understood, particularly in relation to health care outcomes, and recommend separate inquiries be undertaken to address these populations.

### 3. Literature Review

#### *Healthy Aging for Gay and Lesbian Seniors*

The concept of 'healthy aging' is generally described as encompassing not simply absence of disease, nor the valorisation of youthfulness, but instead the promotion of mental, physical, and social well-being, with an appreciation for both the abilities and disabilities associated with aging (Hughes, 2006; PHAC, 2006). Among gay and lesbian seniors, it is important not only to describe the ways in which their physical, mental, and social contexts resemble or differ from those of their heterosexual counterparts, but also to acknowledge from the onset the ways in which their particular experiences may in some ways actually increase their potential capacities for healthy aging. First, researchers have found that a lifetime of dealing with the stigmas, crises, and discrimination experienced by gays and lesbians may actually better equip some, upon entering later-life, for dealing more expertly with the stigmas, crises, and discrimination experienced by seniors in an often ageist society (Berger & Kelly, 2001; Brotman, Ryan, & Cormier, 2002; Cahill & South, 2002; Orel, 2004). Practically, as well, it would appear that many have lived lives characterised by far more resilience, independence, and self-reliance than many heterosexuals. The reasons for this are perhaps intuitive: often unable to count on the support of their biological families and other traditional institutions, many gays and lesbians learned early-on to rely on themselves and run their own affairs, often with little assistance (Brotman et al., in press; Greene, 2002; Morrow, 2001). These experiences also necessitated a certain amount of traditional-gender-role flexibility, suggesting that a fair number of lesbians and gay men will likely enter late-adulthood having already practiced and learned "skills that many heterosexual men and women may have expected their spouses to accomplish" (Ramirez Barranti & Cohen, 2000, p.349; see also Brown, Alley, Sarosy, Quarto, & Cook, 2001).

None of this should by any means imply that all gay and lesbian seniors are equally prepared or able to fight a new round of discrimination in old age. As Terry Kaelber, former executive director of SAGE (Senior Action in a Gay Environment) usefully points out, the "idea that aging is the same for everyone comes from the belief that aging is a medical issue, pure and simple. ... Which is, of course, the dream of all the large drug companies" (in National Gay and Lesbian Task Force, 2005, p.14). A great diversity definitely exists within the gay and lesbian senior community, and an individual's age, gender, class, race, and ability positions will all influence their life situation as they enter—and throughout—old age (Chapple, Kippax, & Smith, 1998; Orel, 2004). Considering the exclusion of gays and lesbians (until relatively recently) from spousal benefits and other legal protections (Cahill & South, 2002), as well as a tendency for some to have stayed in safer but lower-paying jobs (City & County of San Francisco, 2003), it is perhaps not surprising that gay and lesbian seniors consider financial insecurity their biggest challenge as they age (Jacobs, Rasmussen, & Hohman, 1999; McFarland & Sanders, 2003), particularly among women, who have and continue to experience tremendous inequality in the workplace (Butler & Hope, 1999; Clunis, Fredriksen-Goldsen, Freeman, & Nystrom, 2005; Heaphy, Yip, & Thompson, 2003; Orel, 2004; River, 2006). Unfortunately, no research has yet been undertaken on many of the

other fronts, and so little is known about the particular needs of gay and lesbian disabled seniors or the ‘very old,’ and only occasionally have reports made mention of the specific needs of gay and lesbian seniors of colour (Hubbard & Rossington, n.d.; City & County of San Francisco, 2003).

### *Physical Health*

Studies assessing the self-reported health of gay and lesbian seniors have found that the majority rate their physical health as good to excellent (Butler & Hope, 1999; Clunis, Fredriksen-Goldsen, Freeman, & Nystrom, 2005), and about half report exercising regularly (Grossman, D’Augelli, & O’Connell, 2001), seemingly more than Canadian seniors in general (Turcotte & Schellenberg, 2007). Some researchers, though, have remarked on the tendency of this population to actually ‘understate’ their health problems (Brotman et al., in press; Gay & Grey, 2006), possibly reflecting the extent to which they value their self-reliance and are hesitant to access formal health services until absolutely necessary (Brotman, Ryan, & Cormier, 2002; 2003). Orel (2004), in fact, has pointed out that, although gay and lesbian seniors may share more-or-less the same preoccupations about their health as heterosexual seniors, one unique difference is the emphasis that the former place on “the discrimination and bias that they have experienced within health care settings” (p.64). This avoidance of formal health services because of past discrimination—although not well understood—has been identified as one possible reason for the seemingly higher prevalence of breast cancer among lesbians (Ramirez Barranti & Cohen, 2000). Although other associations with certain kinds of cancers have been suggested (particularly with anal cancer among gay men and cervical cancer among lesbians), the evidence is not conclusive (cf. Cahill, South, & Spade, 2000), but is at least alarming enough to indicate that reducing fears and eliminating the perceived barriers associated with formal health care among gay and lesbian seniors would go a long way towards bringing their physical health statuses to parity with their heterosexual counterparts.

The risks to healthy physical aging due to the lifestyles of gays and lesbians have been well-documented, and researchers studying seniors have found, not surprisingly, that unsafe sex, substance misuse, and disordered or unhealthy eating behaviours will not—if they existed previously—disappear when an individual reaches old age. Little has been written about safe sex among gay and lesbian seniors, presumably because seniors in general are often presumed to be asexual or at least not sexually active (discussed further below), but the fact that almost one-quarter of new HIV cases in major American cities are among those aged fifty and over indicates that gay seniors either do not consider themselves ‘at-risk’ or have not been adequately targeted in HIV-prevention campaigns (Campbell, in National Gay and Lesbian Task Force, 2005).

Substance misuse among gay and lesbian seniors has also not been well-researched, despite the fact that several authors (and study participants themselves) point to the ubiquity of alcohol in the lives of gays and lesbians, on the one hand presumably due to the centrality of the bar- and club-scenes for their social lives (Morrow, 2001; Satre, 2006), and on the other hand because internalised homophobia and other experiences of victimisation are seen as driving some to ‘drown’ their feelings in alcohol (Robertson, 1998; Wierzalis, 2001; Williamson, 1999). Interestingly, though, Grossman, D’Augelli, and O’Connell (2001) found that only nine percent of their sample could be

qualified as ‘problem drinkers,’ similar to rates among Canadian seniors in general (Turcotte & Schellenberg, 2007). Although smoking rates do appear higher among gays and lesbians (cf. Cahill, South, & Spade, 2000), it is drug-use that seems to most distinguish gay men from heterosexuals (Stall et al., 2001), but again limited data exist about lesbians, or seniors specifically. Usefully, Tonda Hughes (2003) has discussed how, whereas historically gays and lesbians were pathologised as having mental health problems because of their sexualities, it may not be unrelated that nowadays they are more likely to be considered ‘at-risk’ for substance abuse problems, and this perceived predisposition is often internalised: Hughes herself found that, although alcohol abuse among lesbians seems to be on the decline, lesbians are more likely to worry that they have a problem with alcohol. Here again, perhaps, the focus may more usefully be shifted to barriers to formal care, since substance misuse treatment and referral agencies do tend not to offer programs targeted specifically to gays and lesbians and are more likely to access younger patients, despite the fact that older clientele tend to have better outcomes post-treatment (Satre, 2006).

Finally, disordered and unhealthy eating habits among gay and lesbian seniors have not been documented, though it is known that poor nutrition is more likely to be a problem for seniors in general who are more isolated and living alone (PHAC, 2006). Although there is evidence that some lesbians may be at a slightly greater risk for obesity than heterosexual women with similar diets (Valanis et al., cited in McMahan, 2003), overall lesbians appear less concerned about body satisfaction and have lower prevalence of bulimic eating patterns than do heterosexual women (Lakkis, Ricciardelli, & Williams, 1999). Gay men, on the other hand—presumably because of the gay community’s emphasis on “youthfulness, slimness, and attractiveness” (Williamson, 1999, p.2)—seem to demonstrate a deeper investment in their bodies, as well as more distress about the physical changes associated with aging (Wierzalis, Barret, Pope, & Rankins, 2006), which may contribute to a more negative body image as they age, as well as a relatedly higher prevalence of dieting, bulimic symptoms, body dissatisfaction, and disordered eating, as compared with heterosexual men (Lakkis, Ricciardelli, & Williams, 1999; Williamson, 1999).

### *Mental Health*

Despite the recent legal and policy victories for gays and lesbians in Canada, it is important to remember that these changes are relatively recent in the life histories of today’s gay and lesbian seniors. Studies have found that, in the course of their lives, about half of all gay and lesbian seniors have been verbally harassed (Beeler, Rawls, Herdt, & Cohler, 1999), twenty-nine percent have been threatened with violence, and about sixteen percent (mostly men) have actually been physically attacked (D’Augelli & Grossman, 2001), all of which can affect an individual’s current mental health. Unfortunately, episodes of victimisation and harassment are not confined solely to the past: gay and lesbian adults report more discriminatory experiences in their day-to-day lives, and these too are associated with low self-rated mental health, as well as higher prevalence of psychological disorders and distress (Mays & Cochran, 2001).

Although it is comforting (and important) to note that eighty-four percent of gay and lesbian seniors report good mental health, those who had (for whatever reason) developed a mental disorder were more likely to report lower self-esteem, more lifetime

suicidal ideation, more negative views about their sexual orientation, more loneliness, and other related difficulties (D'Augelli, Grossman, Hershberger, & O'Connell, 2001). Among those with some sort of mental health problem, depression appears to be the most prevalent: Rawls's (2004) finding that twelve percent of his sample of older gay men indicated a high likelihood of clinical depression signifies that the problem—though afflicting only a minority of the population, and influenced by a person's income—is still perhaps more serious than previously believed, and lesbians similarly show a greater risk for depression than do heterosexual women (Valanis et al., cited in McMahon, 2003).

As with physical health, the primary barrier to healthy mental aging for gays and lesbians lies in fears around the biases, discrimination, or lack of knowledge they anticipate encountering if they disclose their sexuality to a general practitioner or a mental health professional (River, 2006), or worse, if they are forced into group therapy or support groups they perceive as gay-unfriendly (Cahill, South, & Spade, 2000). Although over half of Robertson's (1998) sample of gay men indicated "some experience of mental distress at some point in their lives related to their sexuality" (p.37), only one-quarter had accessed mental health care for anxiety or depression, indicating a possibility that treatable mental health issues may be going unaddressed and unreported for a sizable proportion of this population.

#### *Social Health – Informal Networks and Supports*

Despite the extraordinary resilience and independence often characteristic of gay and lesbian seniors, the importance of a social network—regardless of who it is made up of—is "one of the most dependable predictors of longevity," particularly for men (Rowe & Kahn, 1998, p.46). Unlike younger adults, seniors tend to have more condensed social networks, characterised by closer bonds but fewer members, making them more vulnerable to loss (PHAC, 2006). Gay seniors, though, tend to have more friends/confidants in their networks than do heterosexual seniors (Shippy, Cantor, & Brennan, 2004), and older lesbians tend to have even more people in their social networks (Grossman, D'Augelli, & O'Connell, 2001). Interestingly, whether the support networks consist of friends, family, neighbours, or partners, the *kind* of support seems to be more important than who provides it: older gays and lesbians tend to be more satisfied with the support they receive from those who know about their sexual orientation, regardless of their sexual orientation or age (Grossman, D'Augelli, & O'Connell, 2001).

It should come as no surprise that older gays and lesbians feel that having a partner makes ageing easier (Wierzalis, 2001). Even though older women especially are often seen as asexual—a position criticised by some authors (Calasanti & Slevin, 2001; Greene, 2002)—not only have recent studies demonstrated a high value placed on sexuality even among the oldest seniors (Lindau et al., 2007), but other researchers have demonstrated that relationships based on non-coital sexual expression can still be physically and emotionally fulfilling (Garnets & Peplau, 2006; Hughes, 2006). Partnered gay and lesbian seniors generally report better mental health and higher self-esteem than those not partnered (Grossman, D'Augelli, & O'Connell, 2001) and will look to their partners first for support (Butler & Hope, 1999; Shippy, Cantor, & Brennan, 2004), particularly among older lesbians, who tend to have more long-term partners than their gay male counterparts (Beeler, Rawls, Herdt, & Cohler, 1999).

Almost all authors researching the social networks of older gays and lesbians have remarked on the overwhelming extent to which friends constitute the primary support system for this population (Brown, Alley, Sarosy, Quarto, & Cook, 2001; Clunis, Fredriksen-Goldsen, Freeman, & Nystrom, 2005; Gay & Grey, 2006; Grossman, D'Augelli, & O'Connell, 2001)—sometimes even more than partners (Langley, 2001)—with Heaphy, Yip, and Thompson (2003) reporting the “striking” finding that ninety-three percent of men and ninety-six percent of women saw their friendships as ‘important’ or ‘very important’ (p.10). Some researchers have remarked on the fact that gay and lesbian seniors simply define their friendship networks differently than do heterosexuals, in that these networks constitute what have been called ‘families of choice,’ close-knit networks that nurture the sexual identities and independence of their members, while offering the social, emotional, and recreational support that is not otherwise available from their biological families (Beeler, Rawls, Herdt, & Cohler, 1999; City & County of San Francisco, 2003; Heaphy, Yip, & Thompson, 2003; Orel, 2004; Ramirez Barranti & Cohen, 2000). This may be especially true for older lesbians, who place an especial high value on their “community of friends” (Butler & Hope, 1999, p.41; see also Clunis, Fredriksen-Goldsen, Freeman, & Nystrom, 2005; Weinstock, 2004).

Social networks can also include many other kinds of members who provide varying kinds of support, including ex-partners, pets, neighbours, and biological family members (Butler & Hope, 1999), sometimes depending on the particular context of the senior's life. In rural settings, for example, a good relationship with neighbours is vital in an environment where “[i]nterdependence is a fact of rural life” (Comerford, Henson-Stroud, Sionainn, & Wheeler, 2004), and non-partnered older gay men may meet their affectional and sexual needs through casual or paid sex, as well as strictly-sexual friendships (Wierzalis, 2001; Wierzalis, Barret, Pope, & Rankins, 2006), sometimes placing them at odds with social workers who would prefer that they ‘remain’ asexual (Harrison, 2002). It is also important to note that, contrary to the prevailing belief, many gay and lesbian seniors do have close relationships with members of their biological families (Brown, Alley, Sarosy, Quarto, & Cook, 2001; Heaphy, Yip, & Thompson, 2003; Shippy, Cantor, & Brennan, 2004), the only main qualifier being that they place more value on the support of family members to whom they have disclosed their sexual orientation (Orel, 2004), including often siblings and extended family members rather than parents per se (Clunis, Fredriksen-Goldsen, Freeman, & Nystrom, 2005). Finally, a number of studies have documented that as many as half of gay and lesbian seniors have children from previous relationships (Beeler, Rawls, Herdt, & Cohler, 1999; Langley, 2001; Shippy, Cantor, & Brennan, 2004)—with lesbians living with them more often than gay men (Hubbard & Rossington, n.d.)—and that the support and strength they draw from their relationships with their children (and grandchildren; Orel, 2004) are invaluable and generally not affected by their sexual orientation (Clunis, Fredriksen-Goldsen, Freeman, & Nystrom, 2005; D'Augelli, Grossman, Hershberger, & O'Connell, 2001; Heaphy, Yip, & Thompson, 2003; Shippy, Cantor, & Brennan, 2004).

#### *Formal Social Supports: Inclusion, Innovation, and Exclusion*

In addition to accessing more informal networks largely made up of partners, friends, and family members, gay and lesbian seniors have the option of participating in more formal social structures, be it religious organisations, the voluntary sector, seniors

programming, or activities within the gay and lesbian community. Although some have discussed the increasing importance of spirituality as they age (River, 2006), general they report feeling excluded from most aspects of organised religion because of their sexuality (City & County of San Francisco, 2003; Orel, 2004). In the general community, volunteering for various causes, political activism, and other kinds of community organising are common (Brotman, Ryan, & Meyer, 2006), particularly among older lesbians (Jacobson & Samdahl, 1998; Nystrom & Jones, 2003), though study participants have indicated that they tend not to be 'out' about their sexuality in these contexts, due mainly to fears around acceptance and safety (Heaphy, Yip, & Thompson, 2003; Orel, 2004).

In terms of participation in the gay and lesbian community, many study participants (who are often recruited by researchers through community contacts and therefore probably over-represent those who are heavily involved) have indicated the importance of belonging to the gay and lesbian community, mainly for affirming their identities and providing opportunities to mix with 'similar others' (Brown, Alley, Sarosy, Quarto, & Cook, 2001; Heaphy, Yip, & Thompson, 2003; Langley, 2001; Orel, 2004). Closer examination, though, reveals that experiences within the gay and lesbian community are much more complex, often characterised by exclusion, and influenced by gender. For lesbians, their frequent exclusion from mainstream gay socialising spaces has led to some (though by no means all) developing bustling social lives in the form of "network-based relationships conducted in private and a reliance on each other for support" (Pugh, 2005, p.212), a finding echoed by other authors who have remarked on the vibrancy of smaller, informal networks of older lesbians (or including non-lesbian feminists; Butler & Hope, 1999) that provide for the leisure and social needs of their members (Chamberlain & Robinson, 2002; Comerford, Henson-Stroud, Sionainn, & Wheeler, 2004; Jacobson & Samdahl, 1998).

Although some researchers have found evidence of similar small community networks among gay men (Brotman et al., in press; Gay & Grey, 2006; Hughes, 2007), in general there is often little that exists for older gay men in terms of socialising opportunities outside of the 'commercial scene' of clubs and bars (Hostetler, 2004), which they either feel excluded from or simply are not interested in, in both cases because of the ageism that persists in these settings (Chamberlain & Robinson, 2002; Jacobs, Rasmussen, & Hohman, 1999). It also is important to mention the devastating effect that AIDS has had on the social lives of gay men: over ninety percent of Grossman, D'Augelli, and O'Connell's (2001) sample knew someone who had died of AIDS, in many cases forcing those left behind to 'start over' making new friends (Beeler, Rawls, Herdt, & Cohler, 1999; see also Jones, 2001; Ryan, Hamel, & Cho, 1998; Wierzalis, 2001).

Of course, the existence of informal community networks created by some older lesbians does not guarantee sufficient social support for all lesbians, and neither do the challenges faced by many older gay men necessarily affect all of them equally. Many studies have found evidence of a not-insignificant proportion of the older gay and lesbian community without sufficient social or emotional supports (Gay & Grey, 2006; McFarland & Sanders, 2003; Shippy, Cantor, & Brennan, 2004), especially important because of findings that seniors who are most isolated are at the greatest risk for alcohol dependence, heavy smoking, lack of exercise, and chronic illness (Vaillant, Meyer,



Mukamal, & Soldz, 1998). Isolation or insufficient support can result from a number of factors, including not being partnered (McMahon, 2003; Porter, Russell, & Sullivan, 2003), difficulty establishing a friendship network either after a late coming-out (Beeler, Rawls, Herdt, & Cohler, 1999) or after the deaths of a partner or friends (City & County of San Francisco, 2003; Grossman, D'Augelli, & Hershberger, 2000; Langley, 2001), or encountering barriers either accessing mainstream seniors services (due to homophobia) and/or gay community services (due to ageism; Brotman, Ryan, & Cormier, 2003). These difficulties are compounded for those seniors who are low-income (Greene, 2002; Grossman, D'Augelli, & O'Connell, 2001) or who are living in more isolated, rural environments (Comerford, Henson-Stroud, Sionainn, & Wheeler, 2004; McFarland & Sanders, 2003). Fortunately, according to Jones (2001), "the fear of loneliness seems to be greater than the actual reality" (p.14), and it should not be overlooked that some gay and lesbian seniors actually pride themselves on their lack of implication with the gay community, preferring to participate in other networks rather than associating with others simply because of their sexual orientation (Chapple, Kippax, & Smith, 1998; River, 2006).

#### *Recommendations – The Role of Community Support*

In addition to improving access to formal physical and mental health care for gay and lesbian seniors (discussed by the lead authors in Brotman et al., in press), the amelioration of community social supports offers promising potential to ensure that supportive environments are available and accessible to those who need them most. Most authors have recommended working on two fronts: first, work must be done to assess and eliminate overt and systemic homophobia in mainstream seniors services (Anetzberger, Ishler, Mostade, & Blair, 2004; Brotman, Ryan, & Cormier, 2002; Ramirez Barranti & Cohen, 2000), and second, services and programs should be developed within organisations with specific mandates to serve gay and lesbian seniors (Apuzzo, 2001). A number of well-established organisations already exist in the United States, for example Senior Action in a Gay Environment (SAGE) in New York, New Leaf Outreach to Elders (NLOE) in San Francisco, Gays and Lesbians Older and Wiser (GLOW) in Ann Arbor, Pride Senior Network in New York, and the national Older Lesbians Organizing for Change (OLOC) (cf. Donahue & McDonald, 2005; Kling & Kimmel, 2006; Orel, 2004; Zodikoff, 2006), though nothing comparable currently exists in Canada. The one consistent need expressed within most studies was the demand for more social activities (Chamberlain & Robinson, 2002; Hubbard & Rossington, n.d.; Hughes, 2005; River, 2006), and so any community initiatives that help build friendships and a sense of community while increasing involvement and participation in activities within and without the gay and lesbian community would likely go a long way towards improving the social health of this community (Brotman, Ryan, & Meyer, 2006; Jacobs, Rasmussen, & Hohman, 1999). Although specific needs will vary from person to person depending on their particular situation and context, the one constant may very well be that the next generation of gay and lesbian seniors—having grown up during the gay liberation movement—will not be willing to retreat back into the closet when it comes to having access to programs that best respond to their physical, mental, and social needs as they enter old age (Brotman, Ryan, & Cormier, 2003; Cahill & South, 2002).

#### **4. Findings from Interviews**

Of the 17 interviews we conducted there was a general consensus within the community related to the issues that GL seniors face. This consensus crossed geographical, language, gender and social status differences.

It is clear that there are different levels of efforts being deployed across the country. In some regions there are bureaucrats that are responsible for GLBT issues in their ministries or health boards, in some regions the GLBT community and its organizations work to do sensitivity training within seniors' advocacy and housing organizations. Most of these efforts have been undertaken in urban areas and the respondents had only minimal or anecdotal information about the experiences of GL elders in rural areas.

There was a general consensus that GL elders seek help later than those elders who do not suffer from some form of minority stigma. The literature review makes this point clear and the inability of those exercising leadership roles across the country, both in bureaucracies and in community organizations, is a preoccupation that needs to be addressed. We know that GL elders who live in rural areas are more isolated, but we do not have any measure that enable us to describe that isolation.

Differences were expressed related to gender in almost all regions where we conducted the interviews. It was generally felt that lesbians were more isolated than gay men, having less access to community organizations. As well the fact that gay men had developed, in many cities, support networks related to HIV support and prevention, meant that there were limited services available for men. Women developed supportive services in four of the major centres (Montréal, Toronto, Vancouver, Victoria). However, these services were entirely volunteer in nature.

#### **Knowledge of Social Determinants of Health**

While it was generally recognized that Canada has adopted the Population Health Model, and most Determinants of Health were known by a small majority of respondents, there was confusion about the impact of this policy in their work and in their lives. Many felt that the words were not followed up by policy or funding initiatives, and were quite cynical about the prospects for follow-up on any of these issues. Those who were able to identify priorities within the Population Health Determinants' identified Social Support, Social Environments, and Income and Social Status as, by far, the most important Determinants of Health.

*"I don't how much that is put into practice, it's a nice list but I am not that clear that it really serves much purpose generally, in the general population. And we're talking about older queers, certainly housing is a big one. But there is nothing on that list that relates to sexual orientation. Unless you call it gender I think sexual orientation clearly is a determinant of health. If you are straight you're generally better off, more healthy. If your queer you're less healthy.*

*"Dans les services aussi il faudrait qu'il y ait au moins une ouverture par rapport à qui ils sont et comment ils actualisent leurs vie. Travailler pour eux l'homophobie intériorisée. Quand on a une image négative de l'homosexualité c'est difficile de s'actualiser aussi et d'en être fier. "*

*"When I am trying to capture the things that have to do with heterosexism or homophobia, I try to slide it under the cultural (determinant) because its not spelled out more clearly than that. . . So more on the social environment, and culture, are the ones that come closer to what I am thinking about. I mean all of them can affect anybody and sometimes they are all linked. So I don't see them as entirely separate. If you've been prevented from advancing in employment, you will end up in poverty and you may end up in poor housing, which makes you socially isolated, etc. I don't see them as separate."*

## **Social Support and Social Environments**

The great majority of those individuals and organizations that work with GL elders named social isolation and loneliness as the major challenge in the lives of GL individuals as well as the major obstacle to overcome in attempting to reach out to this population. This loneliness appears to be related to several factors:

They live alone.

They are less connected to their biological families. Still a reality in the lives of younger GLBT people, GL elders tend, because of the age in which they lived their adolescences and became adults, to be more distant from their biological families than their heterosexual peers. This distance can be both physical and or emotional. This has serious implications in their lives, especially as they lose their autonomy. Unable to legalize the same-sex relationships that they are in, due to history and internalized homophobia, and fearful that the biological family will come back into their lives when they are sick, they often do not realize that there are legal options, like powers of attorney, that do not oblige them to name either their sexual orientation or the nature of their relationships, but that do afford them protection in case of inaptitude. This means as well that they do not generally move back into the homes of their biological families. They also do not want to abandon their physical autonomy for the above reasons.

They seek help often when it is too late.

Due to the anticipation and fear of negative experiences in the health and social services system, these elders often hesitate to seek psycho-social evaluations, to seek home-based services.

Their social networks have shrunk with time.

As most respondents tell us their clients are living in progressively smaller social networks, due to the illness, hospitalization, and or death of the members of their social networks. As with most seniors, the possibility of expanding one's network at an advanced age is daunting. With GL seniors, who do not frequent seniors' associations, this task is almost impossible, so they live in smaller and smaller circles.

Professionals who visit them do not ask the right questions or give the right referrals.

It appears that those professionals who are gay or lesbian themselves and working within the public system often become the sole worker for this population.

They are hesitant to go to seniors' organizations.

None of the respondents felt that any non GLBT community organizations or advocacy groups represented the voice of GL elders. Many felt that, at least in a majority of cases across Canada, the GLBT community had little interest in the experiences or needs of GL elders.

They have been conditioned to fear homophobic reactions.

This particular cohort of GL elders has lived experiences that no other generation who follows them will be obliged to face. It is a very particular cohort. Afraid. Invisible. Un-named. They do not label themselves, generally, as those labels have been used to oppress and repress them in their very lifetimes.

*"Je pense que le premier grand risque de personne vieillissantes c'est l'isolement parce que quand on vieillit, par exemple dans la communauté lesbienne, beaucoup de lesbiennes peu âgées, ont rompu les rapports avec leurs familles et ils se sont donc constitués leurs nouvelles familles de lesbiennes amies et amantes et ex\_ amantes, et plus que tu vieillis plus que ces gens\_ là disparaissent à cause de leur santé ou à cause qu'elles sont mortes ou ... en tout cas elles diminuent beaucoup (...)on a fait 35 résidences et on en a spoté, sauf qu'elles ne voulaient pas nous parler, elles ne voulaient pas s'identifier; mais on est sûres qu'elles étaient lesbiennes. Fait que ces lesbiennes\_ là, elles vivent de l'isolement à l'intérieur d'une résidence hétéro parce qu'elle ne vont pas pour aller raconter à une autre... parce qu'il y a quand même une grande... chez les personnes âgées, il y a beaucoup de personnes qui sont quand même discriminatoires envers les lesbiennes. "*

*"I think if you're healthy you are not having to rely on a system in the same way as being unhealthy and having to rely on the system and having a fear about being discriminated. If you have to access health services, mental health, physical health or whatever, you are put in very different position than if you have to access services from*

*a prevention perspective. "*

*"The seniors advocacy groups that I know here are not specifically addressing any of the needs of older LGBT people. They may once in a while think to say : Oh and then there is nothing for older G&L and there is no housing for older G&L. Some of them may think to include that and that's about the limit of how they would see it."*

*"The community groups I encountered don't see the difference. They don't understand that GLBT community can be more isolated and that members of this community are more isolated and have less contact with their families of origin. And they are not sensitive to the needs of the Gay population. "*

*"Plusieurs lesbiennes âgées m'ont raconté des histoires avec leurs docteurs et elles ont été obligées de changer de médecin. Ça va bien jusqu'à temps qu'elles révèlent leur identité et quand elles révèlent leur identité, le service, puis l'accueil n'est plus pareil. Elles se sentent mal. "*

*"we are among the diverse people that are treated badly and so our health is affected.",*

*"Il y a une évidence que les lesbiennes consultent moins les médecins que toute autre personne de la population. Les lesbiennes ont peur d'aller chez les médecins parce qu'elles ont peur de révéler leur identité par exemple. Donc ça ça devient un facteur important au niveau de la santé parce qu'elles attendent qu'elles soient malades pour aller consulter."*

*"If you are straight you're generally better off, more healthy. If your queer you're less healthy . . . "*

*" It's sad because lesbian women are generally underserved and because we are very much more comfortable with a female physician, which means we probably have half the number of physicians that we could've access to."*

*I'd like a requirement that there be more training and education for professionals. So in the schools and in the Licensing bodies. I'd like to see more money put on education. I'd like to see more requirement for services, either specialized or mainstream, to be welcoming and competent in serving LGBT people.*

## **Physical Environments**

Most respondents identified housing as a particular difficulty as well. GL seniors fear losing their homes - as all seniors do - but with specific factors that make their fears

different. Once again, the omnipresence of homophobia in their past lives, the absence of advocacy within seniors' organizations and the fears of how they will be treated once in residential services.

The solution will not be only in providing alternative resources for GL seniors, but also in advocacy, policy and training efforts that will render general housing resources, open to the realities of GL seniors' lives.

***"The seniors advocacy groups that I know here are not specifically addressing any of the needs of older LGBT people. They may once in a while think to say : Oh and then t here is nothing for older G&L and there is no housing for older G&L. Some of them m ay think to include that and that's about the limit of how they would see it."***

### **Specific Health Issues**

Many of the participants noted particular health concerns other than those that are clearly linked to oe Determinant of Health or another. These are also clearly mentioned in the literature as being specific issues within the GL community.

#### **Smoking**

Those who named smoking as an important health issue felt that specific initiatives were needed for both gay men and lesbians, particularly those elders who have been life long smokers. They felt that general population campaigns will not work for an important percentage of the GL population. So far very few specific interventions have been developed in Canada.

#### **Alcohol and Drug Use**

Use of alcohol and drugs was named as another major issue among elder gay men and lesbians. Intersecting with social isolation, distance from the biological family, the lack of specific resources, disappearing social networks, coupled with the sub-group that socializes in bars as their only social expression one can see the various forms of vulnerability that puts this population at risk.

#### **Breast and Cervical Cancer**

Those respondents who work with lesbian elders felt that the various factors that render lesbians vulnerable – isolation, mistrust of the health care system, living alone, little home care resources, less preventive consultations, etc. – also renders them vulnerable to higher rates of breast and cervical cancer.

***"Health is physical, emotional, spiritual... It means we are a whole person. Having said that, in terms of physical health, we know that research has shown that lesbians have***

*a higher incidence of smoking than gay men and higher than the general population, primarily because of our history. (...) Most smoking programs would not take into consideration sexual orientation and a person who's queer who wants to quit smoking, well there is very few places that offer options to access services that take that sexual orientation and gender identity into consideration. "*

*"I will also say that if you have personal health practices like you are someone who has addiction issues or you've been a drinker for many years to cope or you have mental health issues, that is definitely going to affect your option on your health services. "*

*"L'Alcool est souvent présent, mais il y a une prise de risque pour eux "*

*"One thing I do know is that lesbian women tend to have a higher incidence of breast cancer and cervical cancer. That statistic I do know. And the reason for that is because, and know we are kind of talking about a younger cohort, because lesbians are less likely to do the preventive mammograms and the preventive pap tests because they have a hard time finding doctors who understand, appreciate and respect the fact that they are in a lesbian relationships".*

*"Obesity, smoking, drug use. Are they a direct consequence of isolation or vice versa? They are a direct result of homophobia that people have experienced. So people use substances and alcohol and what not to escape that reality."*

## **5. Recommendations**

### **Isolation**

Isolation is the major problem experienced by GL elders, both in the literature and in the lived experience presented to us by our respondents. We recommend a stratified response to this isolation, through

1. The inclusion of this population in social policy provisions emanating from Health Canada.
2. The funding of demonstration projects in every region of Canada in order to develop adequate models of social support and the development of supportive social environments. There will be no lack of community organizations ready to respond to any call for proposals.
3. That a varied approach be used that supports projects in some communities that reach out to men and women, others to women only, others to men only.

## **Adapted Housing**

Models of adapted housing have been developed in different parts of the USA and Canada. Some of these are initiatives of the GLBT community independently; some are the result of collaborations between the public health services and community organizations. The emerging consensus is that there is a need for specific housing services for those GL elders who wish to be in GL environments. It appears, however, that most GL elders will reside in public housing, either because of the lack of other options, or by choice. It is in these housing services that there is an abject lack of information, training or outreach. We recommend that

1. Discussions be undertaken with national bodies which represent housing resources in order to begin the process of making those resources more responsive to inclusion and the needs of GL elders;
2. That several demonstration projects be undertaken in order to provide models of care a) for those elders who are able to live more independently, b) for those elders who require more support in their living environments.

## **Advocacy**

### **Within the GL Community**

Work needs to be done within the broader GLBT community with regards to elders. The very limited resources which have been made available to this community – funding has often been limited to HIV prevention work with gay men – has meant that many health issues have been ignored. Increasingly, GLBT organizations identify aging and the status of elders as priorities, but they are unable to access funding in order to be able to develop supportive interventions.

### **Within Senior's Advocacy Organizations**

In Québec, the Ministerial Commission on Aging, conducted in the fall of 2007, heard several presentations on the lives and needs of GL elders from the broader GLBT community. No mainstream senior's organizations mentioned the existence of GL elders in their presentations. We recommend that the presence of GL elders be brought to the attention of those organizations who should represent the voices of all Canadian elders. Furthermore we recommend that funding incentives be used to incite this move toward inclusion.

## **Training**

### **Within Colleges and Universities**

Within the human sciences programmes in Canadian universities there is a deafening silence related to sexuality and sexual orientation, especially at the two ends of the continuum – youth and elders. Advocacy within professional organizations and



accreditation bodies would facilitate enormously the establishment of models that address the issue of adequate training for young professionals.

#### Within Senior's Organizations

We recommend the development of opportunities for dialogue be developed between mainstream elder's organizations in Canada, both at the federal level and in provinces and cities. Models for these dialogues have been developed in certain cities (Toronto, Vancouver, Victoria) that merit being used nationally and regionally.

#### Continuing Education

That similar to Québec Ministère de la Santé et des Services sociaux's «Pour une nouvelle vision de l'homosexualité», continuing education be offered to those professionals already in the field in order to equip them with the necessary information to appropriately serve the needs of GL elders who are already in their care and to adequately receive new clients who are gay and lesbian.

#### Issues Requiring Specific Initiatives for GL Elders

Loneliness

Alcohol – Drug – Tobacco

Healthy Living

Access to Care / The Right to Adequate Care

#### Research

##### Rural elders

We are aware, anecdotally, of large numbers of GL elders who live in rural areas. There is very little known about their lives and how they access services.

1. We recommend the funding of a research action project that would permit the collection of information on the lived experience of GL elders related to housing, family support, community support, access to services, etc.

#### 6. Conclusion

This scan highlights the clear evidence, in research and on the ground, that gay and lesbian seniors face obstacles which inhibit their access to better health and adequate health services. Spokespersons and stakeholders in this community have been advocating for years that unless specific interventions are undertaken that respect their experiences and history this situation will not improve. We believe that the

recommendations contained herein, if implemented, will begin the process of healing the real damage that has been done to these elders because of their difference.

## 6. Appendix 1: Interview List, Cities and Contacts

### Agencies and Individuals Contacted:

#### **Montréal**

Gérald Julien, Séro-Zéro, animateur du groupe pour hommes 45 ans et plus  
Diane Heffernan, Réseau des lesbiennes du Québec  
Line Chamberland, chercheure, équipe SVR  
ARC – Association des retraités de la communauté  
Glenn Marcotte, TS, CLSC Métro  
Évangeline Caldwell, comité visibilité lesbienne, La Fédération des femmes du Québec  
Kim Kemp, 40 Plus, Montréal  
Beverly, 40 Plus, Montréal

#### **Toronto**

Dick Moore, The Centre, 519 Church St  
Anna Travers, Sherbourne Health Centre, Rainbow Resource Centre  
Mike Saunders, Toronto Housing Authority

#### **The Prairies**

Loretta, Capital Health Region, Edmonton  
Robert Smith, HIV Edmonton

#### **Vancouver-Victoria**

The GLBT Centre, Generations Project, Chris Morrison  
Bob Chapman, Vancouver Coastal Health Authority  
Lesbian Care Society, Victoria  
Prime Timers, Victoria

## 7. Appendix 2: Interview Guide

### **Interview Guide**

This environmental scan is a first step in documenting the current challenges and risks to healthy aging among gay and lesbian seniors, to understand the role of community and voluntary sectors working with gay and lesbian seniors and to identify gaps in order to inform a healthy aging approach that can contribute to the health and well being for this population.

Please consider the following factors when using the questions as guides:

Urban and rural

Women and men

Those who are healthy and do not require care and those who require care

### **Question Poles:**

What do you see as the current challenges and risks to healthy aging among gay and lesbian seniors?

What is the role of community organizations in addressing these health concerns?

Are community organizations in your region addressing the needs of gay and lesbian seniors?

What is the role of the voluntary sector outside of the gay and lesbian community in addressing these health concerns? (eg. Senior Citizens' Lobby Groups, etc.)

Are elder advocacy groups addressing the needs of gay and lesbian seniors in your community?

Canada has chosen a Population Health model in which to frame its health policy both federally and provincially, and has chosen to identify twelve Determinants of Health to prioritize. They are:

- \_ Income and Social Status
- \_ Social Support Networks
- \_ Education
- \_ Employment/Working Conditions
- \_ Social Environments
- \_ Physical Environments
- \_ Personal Health Practices and Coping Skills
- \_ Biology and Genetic Endowment
- \_ Healthy Child Development
- \_ Health Services
- \_ Gender

\_ Culture.

Are these Determinants of Health familiar to you?

Are there Determinants that you would consider to be more important than others in the lives of gay and lesbian seniors, and if so, which and why?

From a policy standpoint, what strategies would you like to see implemented to improve services to gay and lesbian seniors?

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