

# Substance Abuse Treatment and LGBT Issues

## Chapter 1

# An Overview for Providers Treating LGBT Clients

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### What providers will learn from this chapter:

- The epidemiology of substance abuse among the LGBT population
- The types of substances abused
- Definitions of key terms
- Characteristics of LGBT individuals
- How differences in LGBT life experiences may shape the substance abuse issues
- Life cycle issues for LGBT individuals

### Introduction

For substance abuse treatment providers to deliver skilled care to lesbian, gay, bisexual, and transgender (LGBT) clients, they need to be aware of issues specific to the LGBT community. This chapter presents an overview of the use and abuse of substances in the LGBT community and a brief introduction to the concepts of gender identity, sexual orientation, homophobia, and heterosexism.

### Substance Use and Abuse in the LGBT Community

In a discussion of the epidemiology of substance use and abuse among LGBT individuals, the following two questions are of interest to providers:

- What is the epidemiology of substance use and abuse among LGBT individuals?
- Do LGBT individuals use or abuse more substances than heterosexuals or the general population?

**Epidemiology** is the study of the patterns of disease and health problems in populations and the factors that influence these patterns.

**Prevalence** refers to the number of people in a given population who are affected by a particular disease at a certain time; it is frequently expressed in percentages.

**Incidence** refers to the number of new

cases of a disease or condition, such as alcoholism or drug abuse, in a given population over a specified time (such as a year).

Rates of substance use and abuse vary from population to population. The numerous reasons for the varying rates include biological, genetic, psychological, familial, religious, cultural, and historical circumstances. The LGBT population is similar to the general population in that numerous factors predispose its members to substance abuse. However, some clinicians argue that the additional stigma and resulting tension of being a member of a marginalized community such as the LGBT community cause some members of the marginalized community to seek to manage these additional stressors by using mind-altering substances.

The precise incidence and prevalence rates of substance use and abuse by LGBT individuals have been difficult to determine for several reasons. Reliable information on the size of the LGBT population is not available. Scientific studies of LGBT individuals' substance abuse do not always clearly define the difference between substance use and substance abuse, making it difficult to compare studies. Many studies have methodological flaws, such as the use of convenience samples that only infer or estimate substance abuse among the LGBT population. However, several promising studies are under way that, it is hoped, will provide additional information. The Substance Abuse and Mental Health Services Administration's (SAMHSA's) Center for Substance Abuse Treatment (CSAT) will continue to report the results of these studies as they are completed.

To provide background information for this publication, the authors conducted a review of the epidemiological literature, and 16 studies were chosen to highlight the extent of substance use or abuse problems in the LGBT population. The table in appendix D, Studies on LGBT Substance Abuse, presents a

comparison of the studies. Studies were included if they focused on the LGBT population and substance abuse but did not focus primarily on the human immunodeficiency virus (HIV). These studies are considered classics and have been cited in numerous articles about LGBT individuals' substance abuse. The summary is by no means exhaustive; however, it provides the context for exploring the issue and has implications for future research.

Publication dates of articles about the selected studies range from 1970 to 2000. Of the 16 studies, 10 focused primarily on substance abuse in the lesbian population, 3 focused on both lesbians and gay men, 1 focused exclusively on gay men, 1 focused exclusively on men who have sex with men (MSM), and 1 focused on transgender individuals. Eleven of the studies used convenience samples, and five used population-based data. Most of the studies reported on alcohol use.

These studies generally state that gay men and lesbians have greater substance abuse problems than non-LGBT men and women. In seven studies, comparisons between the LGBT population and the heterosexual population could not be made. Studies by Saghir and colleagues (1970); Fifield, DeCrescenzo, and Latham (1975); Lewis, Saghir, and Robins (1982); and Morales and Graves (1983) found that approximately 30 percent of all lesbians have an alcohol abuse problem. Studies that compared gay men or lesbians with heterosexuals (Stall & Wiley, 1988; McKirnan & Peterson, 1989; Bloomfield, 1993; Skinner, 1994; Skinner & Otis, 1996; Hughes & Wilsnack, 1997) found that gay men and lesbians were heavier substance and alcohol users than the general or heterosexual population. From these studies, it is clear that substance abuse treatment is needed and that providers need to know more about this community to provide competent treatment.

## ***Types of Substances Abused***

Over the past several years, the concerns about the epidemic of HIV-related conditions have led to an increased number of studies of both gay and bisexual men and injection drug users. Although LGBT persons use and abuse alcohol and all types of drugs, certain drugs seem to be more popular in the LGBT community than in the majority community.

Woody and colleagues (1999) compared a convenience sample of MSM at high risk for HIV who participated in a vaccine preparedness study with a nationally representative sample of men from the 1995 National Household Survey on Drug Abuse (NHSDA). The study found that these MSM were 21 times more likely to use nitrite inhalants. They were also much more likely (four to seven times) to use hallucinogens, stimulants, sedatives, and tranquilizers than the men in the NHSDA sample. The study also found that weekly use by this MSM sample was 2 times more likely for marijuana, cocaine, and stimulants and 33 times more likely for inhalant nitrites.

A study by Cochran and Mays (2000) found that people with same-sex partners were more likely to use substances than were people with opposite-sex partners. Closer examination of the data (Cochran et al., in press) comparing MSM with heterosexual men and comparing lesbians with heterosexual women showed little difference between MSM and heterosexual male substance abuse but showed that rates of alcohol use were much higher for lesbians than for heterosexual women. For example, lesbians used alcohol twice as often in the past month, were five times more likely to use alcohol every day, were more than twice as likely to get intoxicated, and were four times more likely to get intoxicated weekly than heterosexual women.

Another study of lesbians using self-reported data stated that rates of alcohol use in the

lesbian population were higher than those in the general population, but not as high as rates in other studies, and that the most significant predictor of alcohol use was reliance on bars as a primary social setting (Heffernan, 1998).

## ***Designer Drug Use***

Abuse of methamphetamine, also known as meth, speed, crystal, or crank, has increased dramatically in recent years (Drug Abuse Warning Network, 1998; Derlet & Heischouer, 1990; Morgan et al., 1993; National Institute on Drug Abuse, 1994; Gorman, Morgan & Lambert, 1995; CSAT, 1997b), particularly among gay men but also among male-to-female (MTF) transgender individuals and, increasingly, among some groups of lesbians. What makes the current epidemic so disconcerting is its relationship to the HIV epidemic (Ostrow, 1996; Gorman et al., 1997).

Amphetamines and methamphetamine currently are the most popular synthetic stimulants in the United States, and abuse of them can lead to significant dependence and addiction. The drugs may be drunk, eaten, smoked, injected, or absorbed rectally. They have a half-life of approximately 24 hours. They work by releasing neurotransmitters, and users suffer the same addiction cycle and withdrawal reactions as those suffered by crack cocaine users. These substances increase the heart rate, blood pressure, respiration rate, and body temperature. They cause pupil dilation and produce alertness, a sense of euphoria, and increased energy. After prolonged use, users often experience severe depression and sometimes paranoia. They may also become belligerent and aggressive.

Methamphetamine use appears to be integral to the sexual activities of a certain segment of gay men, especially in some urban communities. The so-called party drugs, such as MDMA (methylenedioxymethamphetamine) (also known as ecstasy or X-T-C), "Special K" or

ketamine, and GHB (gamma hydroxybutyrate), are increasingly popular at dances and celebrations, such as circuit parties and raves.

MDMA is a synthetic drug with hallucinogenic and amphetamine-like properties. The effects are reminiscent of lysergic acid diethylamide-25 (LSD). Ketamine, a white crystalline powder that is soluble in water and alcohol, is a dissociative anesthetic, a synthetic drug that produces hallucinations, analgesia, and amnesia and can cause euphoria. Users can experience impaired thought processes, confusion, dizziness, impaired motor coordination, and slurred speech. Liquid X (GHB) possesses euphoric properties, and overdoses can cause electrolyte imbalances, decreased respiration, confusion, and hypertension, as well as seizure-like activity and vomiting.

Party drugs can impair judgment and increase sexual risk taking. Research has shown a connection between use of nitrite and high-risk sexual behavior (Ostrow et al., 1993), and there is compelling evidence that HIV and hepatitis C infections are linked with methamphetamine use. Studies in several cities indicate that gay and bisexual men who used speed, alone or in combination with other drugs, appear to have much higher seroprevalence rates than either heterosexual injection drug users or gay and bisexual men who do not use these drugs (Harris et al., 1993; Diaz et al., 1994; Gorman, 1996; CDC [Centers for Disease Control and Prevention], 1995; Hays, Kegeles & Coates, 1990; Waldorf & Murphy, 1990; Paul, Stall & Davis, 1993; Paul et al., 1994). This finding is particularly apparent for individuals who inject these drugs and who share needles or injecting equipment. Although most LGBT meth users probably snort, ingest, or smoke the drugs, a sizable number also report histories of injection drug use. Within the substance-abusing population in general, and the LGBT population in particular, injection drug users represent an often hidden and

stigmatized group. Public health efforts have targeted mostly heterosexual injection drug users of heroin. A number of injection drug users inject methamphetamine, and a number of these are LGBT individuals.

Information on the needle hygiene of methamphetamine users or LGBT injection drug users is lacking. Some HIV-positive individuals appear to be self-medicating for depression or specific HIV-related symptoms by using methamphetamine because it reduces lethargy, raises libido, and can be an antidepressant. Mixing these drugs can be dangerous, and some deaths have been documented from using party drugs while taking protease inhibitors.

### Definition of Terms and Concepts Related to LGBT Issues

Understanding how certain terms are used is essential to understanding homosexuality. It is important to recognize the difference between sexual orientation and sexual behavior as well as the differences among sexual orientation, gender identity, and gender role.

**Sexual orientation** may be defined as the erotic and affectional (or loving) attraction to another person, including erotic fantasy, erotic activity or behavior, and affectional needs. **Heterosexuality** is the attraction to persons of the opposite sex; **homosexuality**, to persons of the same sex; and **bisexuality**, to both sexes. Sexual orientation can be seen as part of a continuum ranging from same-sex attraction only (at one end of the continuum) to opposite-sex attraction only (at the other end of the continuum).

**Sexual behavior**, or sexual activity, differs from sexual orientation and alone does not define someone as an LGBT individual. Any person may be capable of sexual behavior with a person of the same or opposite sex, but an individual knows his or her longings—erotic

and affectional—and which sex is more likely to satisfy those needs.

It is necessary to draw a distinction between sexual orientation and sexual behavior. Not every person with a homosexual or bisexual orientation, as indicated by his or her fantasies, engages in homosexual behavior. Nor does sexual behavior alone define orientation. A personal awareness of having a sexual orientation that is not exclusively heterosexual is one way a person identifies herself or himself as an LGBT person. Or a person may have a sexual identity that differs from his or her biological sex—that is, a person may have been born a male but identifies and feels more comfortable as a female. Sexual orientation and gender identity are two independent variables in an individual's definition of himself or herself.

**Sexual identity** is the personal and unique way that a person perceives his or her own sexual desires and sexual expressions. Biological sex is the biological distinction between men and women.

**Gender** is the concept of maleness and masculinity or femaleness and femininity. One's **gender identity** is the sense of one's self as male or female and does not refer to one's sexual orientation or gender role. **Gender role** refers to the behaviors and desires to act in certain ways that are viewed as masculine or feminine by a particular culture.

A culture usually labels behaviors as masculine or feminine, but these behaviors are not necessarily a direct component of gender or gender identity. It is common in our culture to call the behaviors, styles, or interests shown by males that are usually associated with women "effeminate" and to call the boys who behave this way "sissies." Women or girls who have interests usually associated with men are labeled "masculine" or "butch," and the girls are often called "tomboys."

**Transgender** individuals are those who conform to the gender role expectations of the opposite sex or those who may clearly identify their gender as the opposite of their biological sex. In common usage, transgender usually refers to people in the transsexual group that may include people who are contemplating or preparing for sexual reassignment surgery—called preoperative—or who have undergone sexual reassignment surgery—called postoperative. A transgender person may be sexually attracted to males, females, or both.

**Transvestites** cross dress, that is, wear clothes usually worn by people of the opposite biological sex. They do not, however, identify themselves as having a gender identity different from their biological sex or gender role. The motivations for cross dressing vary, but most transvestites enjoy cross dressing and may experience sexual excitement from it. The vast majority of transvestites are heterosexual, and they usually are not included in general discussions about LGBT people.

**Gender identity disorder (GID)** was introduced in the latest edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* (American Psychiatric Association, 1994). Although GID is listed as a mental illness, most clinicians do not consider individuals who are confused or conflicted about their biological gender and their personal sense of their gender identity to be mentally ill. Considerable work needs to be done to augment the small amount of research available on the development of a transgender identity—that is, how a person becomes aware of a sexual identity that does not match his or her biological sex or gender role.

### Estimates of the Number of LGBT Individuals

The true number of people who identify themselves as LGBT individuals is not known. Because of a lack of research focusing on the



LGBT population and the mistrust that makes many LGBT people afraid to be open about their identity, reliable data are difficult to obtain. The popular estimate that 10 percent of the male population and 5 to 6 percent of the female population are exclusively or predominantly homosexual is based on the Kinsey Institute data (Kinsey, Pomeroy & Martin, 1948; Kinsey et al., 1953) addressing sexual behavior. Kinsey proposed the Kinsey Scale, a continuum that rated sexual behavior on a scale from zero to six. Zero represented exclusive heterosexual behavior and six represented exclusive homosexual behavior. The survey reported that 37 percent of American men had at least one homosexual experience after adolescence; 5 to 7 percent had bisexual experiences but preferred homosexual ones; and 4 to 5 percent had homosexual experiences exclusively.

These data illustrate how widespread male homosexual behavior is, not necessarily the number of gay men. The same research indicated that the majority of those surveyed reported behavior in a range Kinsey termed bisexual. Again, the classification is based only on reported behavior. For many minority populations, bisexuality—but not homosexuality—is acceptable (or at least admissible on surveys). For example, in the 1989 Centers for Disease Control and Prevention 8-year review of acquired immunodeficiency syndrome (AIDS) cases among gay or bisexual men, 54.2 percent of African Americans were reported to be bisexual, 44.2 percent of Hispanics were reported to be bisexual, and 11.3 percent of Caucasians were reported to be bisexual.

Michaels (1996) thoroughly analyzed the limited available data and concluded that determining prevalence rates of sexual orientations is extremely difficult because the data are widely disparate. He estimates that in the United States, 9.8 percent of men and 5 percent of women report same-gender sexual behavior since puberty; 7.7 percent of men and

7.5 percent of women report same-gender desire; and 2.8 percent of men and 1.4 percent of women report a homosexual or bisexual identity.

The data on the number of transgender people are even more limited. Some psychiatric literature estimates that 1 percent of the population may have had a transgender experience, but this estimate is based only on transgender people who might have sought mental health services (Seil, 1996).

### Homophobia and Heterosexism

Having a general understanding of heterosexism, homophobia, and antigay bias is important for substance abuse treatment providers working with LGBT individuals. Allport (1952) defined prejudice as a negative attitude based on error and overgeneralization and identified the three interdependent states of acting out prejudice as verbal attacks, discrimination, and violence. Verbal attacks can range from denigratory language to pseudoscientific theories and findings, which serve as a foundation for discrimination and violence. Following this theory, prejudice and discrimination against LGBT individuals is formed, in part, by misinformation such as the following:

- All gay men are effeminate, and all lesbians are masculine.
- LGBT persons are child molesters.
- LGBT individuals are unsuitable for professional responsibilities and positions.
- LGBT persons cannot have fulfilling relationships.
- LGBT persons are mentally ill.

Once negative generalizations are formed about a group of people, some members of the majority group feel that they can treat the

other group differently. As the acceptance of negative stereotypes spreads, discrimination and violence can result.

Heterosexism and homophobia are used to describe the prejudice against LGBT people. **Heterosexism** is a prejudice similar to racism and sexism. It denies, ignores, denigrates, or stigmatizes any nonheterosexual form of emotional and affectional expression, sexual activity, behavior, relationship, or socially identified community. Heterosexism exists in everyone—LGBT individuals as well as heterosexuals—because almost everyone is brought up in a predominately heterosexual society that has little or no positive recognition of homosexuality or bisexuality. Heterosexism supports the mistaken belief that gay men—because they are attracted to men—are in some way like women, and lesbians, in turn, are in some way like men.

**Homophobia**, although a popular term, lacks precise meaning. Coined in 1972 to describe fear and loathing of gay men and lesbians, it also has been used by gay men, lesbians, and bisexuals to describe self-loathing, fear, or resistance to accepting and expressing sexual orientation (Weinberg, 1983). **Antigay bias** is another phrase to describe the first concept, and **internalized homophobia** is another phrase for the latter. Internalized homophobia is a key concept in understanding issues facing gay men, lesbians, and bisexuals in substance abuse treatment.

Examples of heterosexism in the United States include the following:

- The widespread lack of legal protection for individuals in employment and housing
- The continuing ban on lesbian and gay military personnel
- The hostility and lack of support for lesbian and gay committed relationships (except in

Vermont) as seen in the passage of Federal and State laws against same-gender marriages

- The enforcement of outdated sodomy laws that are applied to LGBT individuals but not applied to heterosexual individuals.

Examples of heterosexism in the substance abuse treatment setting are as follows:

- Gay-bashing conversations
- Cynical remarks and jokes regarding gay sexual behaviors
- Jokes about openly LGBT staff members
- Lack of openly LGBT personnel
- Lack of inclusion of LGBT individuals' family members or significant others in treatment processes.

Substance abuse treatment providers should remember that LGBT clients do not know the reaction they will receive when mentioning their sexual orientation. For example, public opinion measures indicate that homosexuality is not widely accepted. In 1996, Gallup Poll data showed 50 percent of respondents reported that homosexuality was unacceptable and only 45 percent found homosexuality an acceptable lifestyle. In addition, Herek (1989) found that as many as 92 percent of lesbians and gay men reported that they have been the target of threats, and as many as 24 percent reported physical attacks because of their sexual orientation.

It is likely that all substance abuse treatment programs have LGBT clients, but staff members may not be aware that they are treating LGBT clients. Most treatment programs do not ask about sexual orientation, and many LGBT people are afraid to speak openly about their sexual orientation or identity. Treatment



programs also may not realize that they have LGBT staff members, who can be a great resource for treating LGBT clients.

### **How Heterosexism Contributes to Substance Abuse**

When treating LGBT clients, it is helpful for providers to understand the effect of heterosexism on their LGBT clients. The role of heterosexism in the etiology of substance abuse is unclear. Heterosexism instills shame in LGBT individuals, causing them to internalize the homophobia that is directed toward them by society (Neisen, 1990, 1993). Some LGBT individuals may use intoxicants to cope with shame and other negative feelings. Some LGBT individuals learn to devalue themselves and value only heterosexual persons instead. The negative effects of heterosexism include the following:

- Self-blame for the victimization one has suffered
- A negative self-concept as a result of negative messages about homosexuality
- Anger directed inward resulting in destructive patterns such as substance abuse
- A victim mentality or feelings of inadequacy, hopelessness, and despair that interfere with leading a fulfilling life
- Self-victimization that may hinder emotional growth and development.

Recognizing that heterosexism is a type of victimization helps the counselor and client draw a parallel with recovery from other types of victimization, whether they are culturally or individually based. It is crucial that counselors and clients recognize that these effects result from prejudice and discrimination and are not a consequence of one's sexuality. It is not surprising to find that many LGBT individuals

in therapy report feeling isolated, fearful, depressed, anxious, and angry and have difficulty trusting others. Meyer (1993) reports that the victimization of gay males in our society results in mental health consequences for individuals. A skilled substance abuse treatment counselor should be attentive to the negative effects that prejudice produces when working with LGBT clients.

### **Perspectives on Homosexuality**

Homosexuality, as a specific category, was not described in the medical or psychiatric literature until the early 1870s. The fledgling psychoanalytic movement regarded homosexuality as a topic of special interest. Sigmund Freud believed a person's sexual orientation, in and of itself, did not impair his or her judgment or cause problems, and Freud set a positive tone when he supported homosexual colleagues in medical and psychiatric societies. Even so, European psychoanalytic organizations did not welcome gay men and lesbians as members in the early years of psychiatry, and many American psychiatrists and psychoanalysts promoted the attitude that homosexuality was a mental disorder.

Bieber and colleagues (1962) proposed that childhood influences and family upbringing were responsible for producing male homosexuality and described the classic combination of a distant, uninvolved father and an overinvolved mother. They did not consider biology or genetics as playing a role. Other psychoanalytic writing also refuted a biological component to female homosexuality, seeing it as caused primarily by early developmental disturbances.

Alfred Kinsey introduced new perspectives on homosexuality with his studies of sexual behavior (Kinsey, Pomeroy & Martin, 1948; Kinsey et al., 1953). Although his studies have been criticized for a variety of reasons, such as poor sampling methods, the studies greatly

increased Americans' awareness of sexuality and the range of sexual behavior.

The psychologist Evelyn Hooker (1957) demonstrated that no discernible differences existed between the psychological profiles of gay men and those of heterosexual men, effectively beginning the debunking of the theory that homosexuality is a mental illness.

Psychiatrist Judd Marmor (1980) recognized that homosexuality could not be explained in a single dimension and helped support exploring the biological, genetic, psychological, familial, and social factors involved in the formation and expression of a homosexual orientation.

In 1973, the American Psychiatric Association, after extensive scientific review and debate, stopped classifying homosexuality as a mental illness. Homosexuality is now seen as a normal variation of human sexual and emotional expression, allowing, it is hoped, a nonpathological and nonprejudicial view of homosexuality as well as of LGBT people. LGBT people and homosexual and bisexual behavior are found in almost all societies and cultures in the world and throughout history (Herdt, 1996). But the degree of tolerance and acceptance of them has varied considerably in different periods of history and from country to country, culture to culture, and community to community. Anthropological studies that have observed homosexual behavior in other cultures may help put homosexuality in global perspective and may contribute to understanding some of the issues facing American LGBT individuals who are from ethnic or cultural minority groups, such as African Americans (Jones & Hill, 1996), Asian Americans (Nakajima, Chan & Lee, 1996), Latinos/Latinas/Hispanics (Gonzalez & Espin, 1996), and Native Americans (Tafoya, 1996).

The genetic and biological contributions to sexual orientation have been studied increasingly in recent years. Unfortunately, the biological studies often grow out of the

confusion between sexual orientation and gender identity. Many studies have tried to demonstrate that physical traits in gay men resemble those of women or have tried to identify traits in lesbians that resemble those of males. These views are based on the belief that, if a man wishes to be with a man, he must somehow be like a woman, and a woman wishing to be with a woman must, in some way, be like a man.

The Kinsey Institute has supported surveys and studies of both sexual behavior and sexual orientation and concluded that homosexuality must be innate, that is, inborn, and is not influenced developmentally by family upbringing (Bell & Weinberg, 1978; Bell, Weinberg & Hammersmith, 1981; Weinberg & Williams, 1974). The studies noted the diversity and variety of gay men and lesbians, recognizing that there was no uniform way to be or become gay or lesbian in our society.

Lesbianism and female homosexuality have also been studied from a nonpathological perspective. Magee and Miller (1998) reviewed these efforts and found no psychodynamic etiologies to female homosexuality and that each lesbian is unique and without stereotypic characteristics.

Studies of intersexual people, that is, people with sexually ambiguous genitalia or true hermaphrodites, are often analyzed. Hermaphrodites have both male and female reproductive organs. These studies ultimately are about gender role expectations and do not contribute to our understanding of homosexuality.

The most promising areas of study involve genetics and familial patterns. Although the gene has not been identified, Hamer and Copeland (1994) have reported a linkage on the X chromosome that may influence homosexual orientation. The genetic and familial patterns studied by Pillard, Bailey,

and Weinrich and their colleagues (Bailey et al., 1993; Bailey & Pillard, 1991; Pillard, 1996) have demonstrated the most consistent and verifiable data. Pillard found that gay men are much more likely to have gay or bisexual male siblings than heterosexual males—based on the incidence of homosexuality—but are not more likely to have lesbian sisters than are heterosexual males. Lesbians are more likely to have lesbian sisters but are not more likely to have gay brothers.

Combined with other twin and heritability studies, this research helps explain the probable genetic substrate of sexual orientation, with different genetic influences for male homosexuality, male heterosexuality, female homosexuality, female heterosexuality, and, possibly, bisexuality. Although the complex set of behaviors and feelings of homosexuality could not be explained by a single factor, a genetic basis seems to be the foundation on which other complex biological, familial, and societal influences work to shape the development and expression of sexual orientation (LeVay, 1996).

### **Perspectives on Bisexuality**

Bisexuality has also existed throughout recorded history. Freud believed in innate bisexuality and that an individual evolves into a heterosexual or a homosexual, rarely a bisexual (Freud, 1963). Many bisexuals still find themselves contending with this lack of acknowledgment that a bisexual orientation can be an endpoint in itself and not just a step toward heterosexuality or homosexuality.

It is helpful for providers to know that the clinical issues facing bisexuals often are problems resulting from the difficulty of acknowledging and acting on a sexual orientation that is not accepted by the heterosexual majority but also not accepted by many gay men and lesbians.

Some people of color in the United States or people from different cultures may define themselves as bisexual, even if they focus exclusively on people of the same sex (Gonzalez & Espin, 1996). This perspective may be their way of coping with the stigma of homosexuality. Reviews that discuss theory and clinical issues include those by Weinberg, Williams, and Pryor (1994); Klein and Wolfe (1985); and Fox (1996).

### **Sexual Orientation Over Time**

Although this chapter presents sexual orientation as belonging to one of three categories—homosexual, bisexual, or heterosexual—clearly sexual feelings, sexual behaviors, and sexual orientation may vary over time. As Kinsey found, sexual behavior ranges over a continuum from sexual activity with people of the same sex exclusively to sexual activity with people of the opposite sex exclusively, and most people's behavior falls somewhere in between. Sexual orientation also follows the same continuum—from sexual interest in people of the same sex exclusively to sexual interest in people of the opposite sex exclusively.

The mapping of sexual orientation over time has not been well studied. It seems that most people have a fairly stable and fixed sexual orientation, once they become aware of their sexual orientation. Nevertheless, some people's sexual orientation may vary. Women's orientation may be more changeable than men's, possibly because of society's homophobia and because men are more uncomfortable with a nonheterosexual identity. Some people may not become fully aware of their orientation for years and may seem to change sexual orientation when, in fact, they are just becoming conscious of their true orientation. This knowledge may help providers support their LGBT client whose confusion about sexual issues is interfering with recovery from substance abuse.

Some types of therapies claim to be able to change a person's sexual orientation. These conversion therapies or reparative therapies are often practiced by religiously based therapists or by some psychoanalysts who still consider homosexuality a mental illness. These therapies treat people who are uncomfortable with being gay, lesbian, or bisexual and—rather than helping an individual become comfortable with his or her inborn and natural sexual orientation—make the individuals even more uncomfortable and ashamed about being different. These attempts to change orientation may result in a temporary change of behavior. A gay man may stop having sex with other men or have sex with women, but his actual sexual orientation, expressed in his sexual fantasies, desires, or thoughts, possibly will not change. Almost all major mental health and medical organizations have condemned these therapies as ineffective and potentially harmful because they make the person feel guilty and ashamed (Haldeman, 1994).

### Assessing Sexual Orientation

If a substance abuse treatment provider is concerned that a client is confused about his or her sexual orientation, some evaluation tools are available to help assess a client's feelings. Coleman (1987) devised a relatively simple assessment tool to help map out or identify the sexual orientation of clients (see exhibit 1–1). The questionnaire considers the combination of sexual behavior, fantasies, feelings, and self-identification that contributes to sexual orientation. This tool may be a useful way to introduce a discussion about sexual orientation with clients who are uncomfortable with the topic. It may also help people understand the complexity of sexual expression and their comfort level with it. However, providers should be sensitive to the individual situation of the client in both administering and interpreting the instrument.

### Life Cycle Issues

LGBT individuals face many of the same issues all people face as they progress through life. However, LGBT youth may have an especially difficult time. During adolescence, teens are under pressure to conform, and extraordinary effort and courage may be required for an LGBT teenager to “come out” to peers and family. Gay and lesbian youth may be subject to sexual abuse or exploitation sometimes related to their insecurity and low self-esteem. LGBT youth may face significant stress in coping with the attitudes of peers, teachers, and parents.

Older adolescent and young adult LGBT people focus on identity development through school, career choices, and sexual exploration and relations. Their social life often revolves around bars or other settings that promote drug and alcohol use (D’Augelli, 1996). When LGBT adolescents come out to their family, the result can range from understanding and support to verbal and physical abuse. Some youth run away from home and live on the streets (Savin-Williams, 1994).

Many LGBT people consider becoming part of a couple an important part of life. Although there are no legal sanctions for such relationships, except in Vermont, the majority of gay people are in relationships, and many are as committed as traditional heterosexual couples (Klinger & Cabaj, 1993). Some LGBT people are parents; they have had or adopted children (Patterson, 1995). LGBT clients belong to a family of origin. Depending on the circumstances, the relationship may be healthy or strained. Some LGBT people create their own family of choice consisting of a close network of friends that serves the needs often met by traditional families. Treatment providers need to consider an LGBT client's partner, children, family of origin, and family of choice when providing care.

**Exhibit 1–1:  
Coleman’s Assessment Tool**

Assessment of Sexual Orientation  
© Eli Coleman, Ph.D.  
1986

Name or Code Number: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

What is your current relationship status:  
(check one box only)

- ☐ Single, no sexual partners
- ☐ Single, one committed partner—Duration: \_\_\_\_\_
- ☐ Single, multiple partners
- ☐ Coupled, living together (Committed to an exclusive sexual relationship)
- ☐ Coupled, living together (Relationship permits other partners under certain circumstances)
- ☐ Coupled, living apart (Committed to an exclusive sexual relationship)
- ☐ Coupled, living apart (Relationship permits other partners under certain circumstances)
- ☐ Other \_\_\_\_\_

In terms of my sexual orientation,  
I identify myself as. . .  
(check one box only)

- ☐ Exclusively homosexual
- ☐ Predominantly homosexual
- ☐ Bisexual
- ☐ Predominantly heterosexual
- ☐ Exclusively heterosexual
- ☐ Unsure

In the future, I would like to  
identify myself as. . .  
(check one box only)

- ☐ Exclusively homosexual
- ☐ Predominantly homosexual
- ☐ Bisexual
- ☐ Predominantly heterosexual
- ☐ Exclusively heterosexual
- ☐ Unsure

In terms of my comfort with my current sexual orientation, I would say that I am. . .  
(check one box only)

- ☐ Very comfortable
- ☐ Mostly comfortable
- ☐ Comfortable
- ☐ Not very comfortable
- ☐ Very uncomfortable


**Continued →**

Source: Coleman, 1987


**Exhibit 1–1:  
Coleman’s Assessment Tool (continued)**

**INSTRUCTIONS:**

Fill in the following circles by drawing lines to indicate which portion describes male or female elements. Indicate which portion of the circle is male by indicating (M) or female by indicating (F).








Example: 

If the entire circle is male or female, simply indicate the appropriate symbol in the circle (M or F).








Example: 

Fill in the circles indicating how it has been up to the present time as well as how you would like to see yourself in the future (ideal).

**UP TO THE PRESENT TIME**

-  Physical Identity  
I was born a biological. . .
-  Gender Identity  
I think of myself as physically. . .
-  In my sexual fantasies, I imagine myself as physically. . .
-  Sex-Role Identity  
My interests, attitudes, appearance, and behaviors would be considered female or male (as traditionally defined). . .
-  Sexual Orientation Identity  
My sexual activity has been with. . .
-  My sexual fantasies have been with. . .
-  My emotional attachments (not necessarily sexual) have been with. . .

**FUTURE (IDEAL)**

-  Physical Identity  
Ideally, I wish I had been born as a biological. . .
-  Gender Identity  
Ideally, I would like to think of myself as physically. . .
-  In my sexual fantasies, I imagine myself as physically. . .
-  Sex-Role Identity  
I wish my interests, attitudes, appearance, and behaviors would be considered female or male (as traditionally defined). . .
-  Sexual Orientation Identity  
I wish my sexual activity would be with. . .
-  I wish my sexual fantasies would be with. . .
-  I wish my emotional attachments (not necessarily sexual) would be with. . .



Older LGBT individuals may experience a sense of loss related to the aging process and associated changes in their physical attractiveness and capacities. This state may be further compounded by the lack of a partner or a legally sanctioned relationship. Consequently, their sense of a purpose and a future may become hazy and may be expressed in emotional and substance abuse problems (Kertzner & Sved, 1996).

Older LGBT people face the same concerns as other older persons regarding living arrangements and loss of loved ones and social supports. These concerns may be exacerbated for some LGBT people by HIV-related losses and limited familial support, that is, not having children and being isolated from their family of origin. Some people in this age group may

need treatment for substance abuse or emotional issues avoided or ignored over the years (Berger & Kelly, 1996).

### Summary

It is hoped that the information in this chapter helps providers improve their ability to provide competent and effective treatment. Treatment can be enhanced by a substance abuse treatment provider who is knowledgeable about the unique needs of LGBT clients. A provider who understands and is sensitive to the issues surrounding sexual and gender identity, homophobia, and heterosexism can help LGBT clients feel comfortable and safe while they confront their substance abuse and start their journey of recovery.

## Chapter 2 Cultural Issues in Working With LGBT Individuals

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### What providers will learn from this chapter:

- What cultural competence is
- How cross-cultural issues affect substance abuse treatment
- What the dimensions of culture are
- Treatment issues that are unique to different ethnic groups
- Perspectives on gay culture

### Introduction

This chapter presents information to help providers understand cultural issues relevant to treating lesbian, gay, bisexual, and transgender (LGBT) clients. To provide culturally competent treatment, providers must possess attitudes that reflect openness to other cultures, values, and beliefs; a willingness to assess and change their own beliefs; and the ability to appreciate diversity. Providers need to know about the social and cultural context in which their clients live and abuse substances and be receptive to information that may differ from their personally held views (CSAT [Center for Substance Abuse Treatment], 1998a).

Providers can play an important role in the healing process of LGBT individuals by being aware of the community, traditions, and heritage of their LGBT clients. The information that follows includes broad generalities intended as starting points for providers in their work with individual clients. It is not intended as a thorough discussion of the topic.

### Definitions of Terms

**Culture** refers to the customary beliefs, social norms, and material traits of a racial, religious, or social group. It affects the group

members' viewpoints: how they act; how they think; and how they see themselves in relation to the rest of the world. Culture is transmitted through language, symbols, and rituals.

**Ethnicity** describes a population or group having a common cultural heritage that is distinguished by customs, characteristics, language, and common history.

**Diversity** refers to differences in geographic location (rural, urban), sexual orientation, age, religion or spiritual practice, socioeconomic status, and physical and mental capacity.

Important reference materials on cultural competency include the following:

- CSAT's publication *Cultural Issues in Substance Abuse Treatment*, 1999b
- CSAT's Technical Assistance Publication (TAP) 21 *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice*, 1998b.

### Cultural Competency Overview

Cultural competency is a set of academic and interpersonal skills that assists individuals in increasing their understanding and appreciation of cultural differences and similarities within, among, and between groups (Woll, 1996). It requires a willingness and an ability to draw on community-based values, traditions, and customs and to work with knowledgeable persons of and from the community in developing focused interventions, communications, and other supports. A culturally competent program is defined by CSAT (1994a) as one that demonstrates sensitivity and understanding of cultural differences in treatment and program design, implementation, and evaluation. Within the treatment setting, cultural competency is a fundamental component that helps individuals develop trust as well as an understanding of the way members of different cultural groups

define health, illness, and health care (Gordon, 1994).

Substance abuse treatment providers may use their understanding of the client and the client's cultural context to develop a culturally appropriate assessment, identify problems, and choose appropriate treatment strategies for the client. A culturally competent model of treatment acknowledges the client's cultural strengths, values, and experiences while encouraging behavioral and attitudinal change. Treatment services that are culturally responsive are characterized by the following:

- Staff knowledge of the client's first language
- Staff sensitivity to the cultural nuances of the client population
- Staff backgrounds representative of those of the client population
- Treatment modalities that reflect the cultural values and treatment needs of the client population
- Representation of the client population in decisionmaking and policy implementation.

These aspects alone do not constitute cultural competency, nor do they automatically create a culturally competent system. Culturally competent systems include both professional behavioral norms for treatment staff and the organizational norms that are built into the organization's mission, structure, management, personnel, program design, and treatment protocols. In other words, culturally competent systems need to implement cultural competency in attitudes, practices, policies, and structures (Mason, 1995).

Interpreting behavior without considering its cultural context can lead to poor, sometimes detrimental, treatment outcomes. The covert prejudice of the treatment staff and language

and cultural differences undermine efforts to help clients recover from substance abuse (CSAT, 1999b). However, if practitioners are to move from accommodation to inclusion in their helping practices, they must alter practices to meet the needs of their clients.

### **Assimilation and Acculturation**

Assimilation and acculturation are key concepts in cultural competency. The extent of a person's assimilation or acculturation influences individual behavior and may affect the treatment outcome. When working with LGBT people from minority populations, providers must assess their level of acculturation and assimilation.

- **Assimilation** is adaptation to a new culture by taking on a new identity and abandoning the old cultural identity.
- **Acculturation** refers to accommodation to the rules and expectations of the majority culture without entirely giving up cultural identity.

The four interpersonal styles represented below may be exhibited by clients in treatment and should be assessed by counselors during substance abuse treatment (Bell, 1981). These styles are fluid, meaning individuals can move among them depending on the context or stage of their development or both.

**Assimilated** individuals consciously or subconsciously reject their culture of origin in favor of their adopted culture. These clients may resist placement in a group with clients of their own ethnicity or may prefer a clinician from their adopted culture.

**Bicultural, or multicultural**, individuals are proud of their cultures and can function in, fulfill their needs through, and be proud of the dominant culture. Their emotional, educational,

economic, and spiritual needs are usually fulfilled in a diverse, integrated living environment that honors two (or more) cultures. A bicultural or multicultural client is likely to be comfortable in any clinical setting with relative ease. However, one of the difficulties of this interpersonal style is cultural or racial schizophrenia (Bell, 1981): the feeling of not belonging to either community. These clients face special challenges that may need to be addressed in treatment.

**Culturally immersed** individuals have rejected mainstream culture, and their emotional and spiritual needs are met exclusively in their ethnic community or in the gay community. The effectiveness of their treatment may depend on the ability of the provider to be supportive as clients work through issues related to being a person from a minority group.

**Traditional** individuals are defined as carriers of the community ethos. They neither overtly accept nor reject their ethnic identity. Traditional persons have most of their emotional, spiritual, and, to some degree, educational needs met through their ethnic community and have limited contact with the dominant culture or any outside communities. Their economic needs are met primarily in the context of the majority culture and sometimes involve power imbalances that increase their distrust of other groups. For traditional individuals, entering into a mainstream treatment program is usually a frighteningly foreign experience that calls for sensitivity by treatment staff.

The heterogeneity of ethnic culture emphasizes the need for providers to appreciate clients' cultural context and individuality. This emphasis allows for more culturally appropriate interventions and focuses on the importance of matching client and provider according to interpersonal styles rather than ethnicity alone.

## General Issues in Cross-Cultural Treatment

Our culture guides how we act and think as well as how we come to understand who we are and how we fit into the world. Cultural norms are rules of conduct that are internalized by the members of the group and embody the fundamental expectations of the group. Cultural rules resemble family rules—often the strongest are the ones not spoken. Because cultural rules are usually reinforced by parents or special people in one's life, the rules are hard to defy. In addition to cultural norms, five general aspects of culture need to be considered if cross-cultural treatment is to be effective. They are as follows:

**Values** of a culture play an important role in determining how one behaves. Cultural values vary among different groups. For example, some cultures admire assertive behavior, but some Asian cultures consider such behavior rude or disrespectful. In American Indian culture, silence is highly valued—a difficulty for counselors who are trained to assess commitment by verbal expression.

**Language** is the primary tool for our work. Certainly, a client whose native language is not spoken in treatment is at an extraordinary disadvantage. All languages are complex, and immigrants find adjusting to the nuances of a new language difficult. The meaning of many words or phrases varies depending on context, tone, audience, and intended message. For some clients, using bilingual services and staff greatly increases the effectiveness of treatment. However, translation into the client's primary language is not enough. Materials or oral translations need to be adapted to be culturally appropriate for the intended audience. Historical factors such as discrimination and how a person interprets another's actions also impact communication and need to be considered. Counselors should verify with the client that the message is understood as meant. This verification should be done in a

sensitive manner that does not embarrass the client.

**Nonverbal behavior** is extraordinarily powerful. Interpretations of touches, gestures, and eye contacts are shaped by personal experience and culture. For instance, a person in a prison community does not use direct eye contact because it is a sign of disrespect in that circumstance. In the Latino culture, touching the person being addressed is a sign of attentiveness. It is important for counselors to be sensitive to a client's style of nonverbal communication and to consider the degree of familiarity and the context of the contact. Counselors should ask clients about any nonverbal behavior they do not understand. If counselors question clients in a nonthreatening way, the clients usually are willing to explain.

**Learning styles** vary among individuals and cultures. Typically, treatment programs use a Western learning style of formal, often written instruction. For example, many treatment centers require that clients read literature from Alcoholics Anonymous and write out the step work without assessing whether the clients understand the information. Nonliterate clients or those with low reading comprehension would be better served if culturally appropriate audiotapes or videotapes also were used. Clients from a cultural group with a tradition of storytelling also may welcome alternative forms of communication and the use of a variety of methods to transmit information.

**Healing** is the essential task of treatment. With all clients, counselors need to create an environment where clients can heal. It is critical for counselors to assess each client's sources of comfort, to understand the individual's beliefs and customs around healing—what will make the client feel better—and to understand the person's definitions of illness and health.

The Western health care tradition tends to compartmentalize health issues and assumes

that healing should be left to those who know best—medical personnel. However, this assumption is being challenged by some people and health care providers who are seeking alternative treatment methods such as folk medicines, acupuncture, herbs, and massage. Some health care providers and patients are also forming new treatment partnerships instead of the authoritarian model of physician-patient. Substance abuse counselors need to determine what the client believes will make him or her healthy and what needs to be included in the treatment plan. This determination is particularly important because what a person believes will make him or her healthy has a great impact on the recovery process. Clients' resistance to a particular treatment method can sometimes be traced to their healing belief system.

### Dimensions of Culture

Many people experience some form of discrimination, prejudice, bias, close-mindedness, or other exclusionary attitudes because of their race, ethnic origin, gender, sexual orientation, religion, or class. Discrimination toward minority groups can come from those of the majority culture; toward other minority groups or the majority culture, from a minority person or group; or toward an LGBT individual, from someone in the majority culture, other ethnic groups, and the individual's own ethnic group.

Little research has been done on the interactions among ethnic diversity, homosexuality, and substance abuse. Providers need to remember that LGBT clients from ethnic minority groups may have additional problems that will affect their recovery from substance abuse. LGBT members of an ethnic minority group need to learn the norms of the mainstream culture, their own minority culture, and gay culture—norms that may conflict. Juggling the demands of these norms may be confusing and problematic, and the substance

abuse treatment provider may need to help the client negotiate the confusing and contradicting norms while the client is in treatment. An LGBT individual may have a stronger connection to his or her ethnic group than to the LGBT community, or the dominant allegiance may be to the LGBT community. It is important that providers invite clients to explain their cultural context and how they feel about their place in society, assess with clients their placement on the continuum from assimilated to traditional, and explore the meaning of these variables in their clients' recovery. It is of utmost importance for counselors to be aware of how their own cultural values, biases, and attitudes influence their practice and how they affect their behavior toward coworkers and clients.

### Introduction to the LGBT Community and Culture

Substance abuse treatment providers need to be aware that LGBT persons do not fit the prevalent stereotype of well-dressed, middle-class urban dwellers; drag queens; or masculinely dressed females. LGBT people live and work in all segments of society. They are from every minority, cultural, racial, and ethnic group. They are members of every nationality, religion, and age group and are from every educational and socioeconomic level. Although some urban centers have populations that are more accepting of LGBT lifestyles than others, and thus are magnets for LGBT persons, LGBT people live in rural, urban, and suburban areas and in every State. LGBT clients can ask for substance abuse treatment services anywhere in the country and not only in large urban areas.

The LGBT minority group differs from other minority groups in that LGBT persons do not come from a common geographic area or have certain physical characteristics in common.



## Gay Culture

There is a lively debate in the LGBT community over what constitutes gay culture. Is it several cultures within one culture? Do lesbian, gay, bisexual, and transgender people each have their own cultures? Gay culture is as diverse as all its members. However, there is no question that many LGBT individuals experience a way of life that is considered a culture. Although lesbian, gay, bisexual, and transgender individuals from different backgrounds experience their communities differently, they share the belief in the legitimacy of their way of life. Substance abuse treatment providers should understand that the gay community possesses common knowledge, attitudes, and behavioral patterns and has its own legacy, argot, folklore, heritage, and history.

Gay culture is different in the degree to which it is submerged within other cultures and in the way that these cultures tend to affect it. LGBT people's behavior is still stigmatized, and because there is usually no way of identifying LGBT people apart from their own disclosure or identification with gay culture, gay culture is essentially hidden in the larger community.

In contrast to how members of ethnic cultures are marginalized, LGBT individuals may receive disapproval and censure from those whom they most trust and rely on—parents, relatives, religious leaders, teachers, and friends. Most members of ethnic minorities can escape discrimination by returning to a supportive family or neighborhood. This is not always true for LGBT persons. When they are growing up, their positive role models are not easy to identify. This isolation sets LGBT minority members apart from ethnic minority group members who are usually in close proximity to other members. The LGBT culture is one that is not developed, taught, or transmitted by families.

Although homosexuality has existed throughout the ages and in many different cultures, gay culture as it is known today began to emerge in 1969, when the New York City police raided a popular gay bar, the Stonewall Inn. At the time, raids of gay bars were conducted regularly with little resistance. However, that night the event erupted into a violent protest as the crowd fought back. The protests that followed, known as the Stonewall Riots, gave birth to the gay rights movement. Before Stonewall, public expression of LGBT life and experience was rare.

The gay rights movement spawned calls for gay pride and civil rights. Since Stonewall, some aspects of gay culture have blossomed. Gay media, books, magazines, movies, newspapers, and Internet sites abound. Attention is lavished on gay heroes—public figures who are “out” and who work to improve the lives of LGBT individuals. Many large companies market their products or services to the lesbian and gay community. Several LGBT organizations exist, and many companies have LGBT employee organizations.

Part of gay culture is a celebration of being gay. Gay pride celebrations are held in June to mark the anniversary of the Stonewall Riots. At gay pride celebrations, the invisible LGBT minority makes itself visible and celebrates its uniqueness, the struggle for civil rights, the cultural gains, and its heroes. The event usually consists of a parade, musical entertainment, and art events showcasing LGBT authors and performing artists and is attended by representatives of LGBT social and service organizations. Gay pride celebrations provide an opportunity for substance abuse treatment providers to reach out to the LGBT community.

An aspect of the debate within the gay community about gay culture involves gay rights. Because public acceptance is important, many LGBT persons want to advance the message that LGBT individuals are no

different from non-LGBT persons. Some LGBT persons worry that highlighting the similarities and the positive aspects of gay culture will mean the loss of that culture as the LGBT community is accepted into mainstream culture. Some believe that the gay community should try to transform mainstream society rather than join it. Another aspect of the debate involves some LGBT individuals who believe there is only one way to be gay and do not honor LGBT persons with other lifestyles or opposing views. Bisexuals have complained that lesbians and gay men do not accept bisexuality as a legitimate sexual orientation but regard it as a developmental phase on the way to acceptance of lesbianism or homosexuality exclusively. Substance abuse treatment providers should keep in mind that this disagreement may be very confusing to clients who are questioning their sexual orientation or to self-identified LGBT clients who may feel unaccepted by the LGBT community because they have a different lifestyle.

**Values.** Compassion and authenticity are important ideals for LGBT individuals. The abilities to invent their own relationships, cultivate the arts, build a community, and create a culture are sources of pride in the LGBT community.

**Language.** Some LGBT individuals disapprove of the words used to describe them, and the reasons can be helpful in understanding LGBT clients. For some LGBT people, the term “homosexual” overemphasizes sexuality and seems to indicate that the sex act is more important to homosexuals than it is to heterosexuals. It also resurrects memories of when homosexuality was considered a psychiatric disorder. Hence, the words “homo,” “bi,” “queer,” or “gay” are preferred by some LGBT persons. However, some LGBT persons are offended by the term “queer.” Some lesbians may prefer to be called dyke or gay, instead of lesbian. Transgender persons may prefer the less clinical term “trans.” It is

important to call a transgender client by his or her preferred name and always to use the gender designation that the client has chosen. Given these conflicting opinions, providers should ask a self-identified LGBT client what he or she prefers to be called. The choice is a conscious and sometimes rather emotional decision and should be honored. A provider’s sensitive use of language can be an important sign of respect and can help create a healing environment for LGBT clients. When clients are confused and questioning their sexual orientation, the provider should be sensitive to the clients’ confusion.

LGBT individuals have a creative vocabulary on the subject of sexual orientation because they may often use code words for safety reasons. For example, a gay man or lesbian uses the following to acknowledge someone with a same-sex preference: one of us, family, member of the church, cousin, colleague, or brother or sister. The vocabulary varies, and providers should listen carefully and ask questions about the meaning and use of unfamiliar terms.

**Nonverbal behavior.** LGBT individuals rely tremendously on nonverbal cues to establish whether the situation is safe for them to be themselves. As they walk into a treatment center, they will be looking for evidence that they are accepted and welcome. Do they see a rainbow-colored flag? A “Straight But Not Narrow” bumper sticker? Is there a mission statement that includes a commitment to honoring diversity or a commitment to treating LGBT clients? Do they see gay or lesbian staff members? Until the LGBT client feels a degree of safety, he or she will be guarded. A provider who is unaware of this may believe that he or she is seeing the client’s real personality when, in fact, the client is on alert and hiding it from the provider. It is important for providers to signal respect, openmindedness, and acceptance by using appropriate gestures and vocabulary.

**Learning styles.** Much of what is taught by institutions and teachers does not reflect the personal experiences of many LGBT people. Experiential learning techniques such as role-plays may be more appropriate, and peers with similar experiences are likely to have influence. Any materials used in treatment that acknowledge the LGBT experience will be more effective than those that do not mention it.

**Healing.** LGBT individuals may distrust the medical establishment and may be somewhat more likely than the general population to rely on the personal experiences of those they trust or other LGBT persons to select providers and treatments.

### **Ethnic Minority Groups**

The cultural norms and beliefs of an ethnic group can have a significant impact on an LGBT person's feelings about his or her sexual orientation or gender identity, his or her ability to express that identity, and how other members of the ethnic group treat the LGBT person. Although an LGBT orientation conflicts with mainstream cultural values, it may be just as, or even more, unacceptable in some ethnic minority groups. Many ethnic groups value strong family ties and traditional gender roles and expect that their children will carry on the family name and traditions through marriage and children. Some families see LGBT behavior as arising from a decadent Western society and as a rebellion against the family and traditional beliefs, instead of as a part of a person's identity. Consequently, LGBT behavior is difficult for family and friends to understand and tends to become invisible.

Some LGBT individuals of color may be accepted by their parents but feel alienated from their ethnic community. Some may distance themselves from their cultural communities and turn to the LGBT community for support and validation. Support groups for LGBT African Americans, Latinos, and

Asian/Pacific Islanders are active in large cities, but many LGBT individuals of color find themselves in predominantly white, middle-class LGBT communities. It is assumed that the LGBT community with its experience of discrimination would be tolerant of diversity. However, ethnic minorities are discriminated against by some LGBT individuals. LGBT people of color may feel they have double minority status that may compound negative consequences such as a poor self-image, low self-esteem, inadequate coping mechanisms, and substance abuse. LGBT ethnic minorities face greater challenges than their counterparts in mainstream society, and it is important for substance abuse treatment providers to validate these experiences and challenges.

### ***American Indian/Alaska Natives***

The number of LGBT individuals in American Indian and Alaska Native communities is not definitely known, although it is believed to resemble the parameters of the dominant population. From self-reports and the small amount of research findings available, American Indians and Alaska Natives in gay or lesbian relationships report a higher degree of bisexuality than do their Caucasian counterparts.

Historically, some American Indian and Alaska Native communities viewed the role of a native person who was different from other community members as having a strong spiritual component. Being different was seen as a result of a spiritual experience and a path chosen by the Creator or the Spirits for that person. Many American Indian and Alaska Native communities used the term "two-spirited" to describe LGBT individuals. Traditionally, American Indian and Alaska Native nations were taught to celebrate the differences and to see all their members as sacred beings fashioned by the Creator. At least 168 of the more than 200 Native American languages still spoken today have terms for genders in addition to male and

female. Many LGBT people prefer the term “two-spirited” because it expresses their sense of combining a male and female spirit. It is also considered empowering for a person to choose what to be called as opposed to accepting a label given by another. This may be particularly true for this group. In the past, the culture, language, and religion of American Indian and Alaska Native people were oppressed by the majority culture. Christian missionaries used their influence in converting many traditional rituals into Christian rituals. Many native children were sent to government-run boarding schools and were prohibited from speaking their native languages and practicing their native customs. Along with erasing traditional roles, the traditional respect for two-spirited people also was diminished.

While American Indian and Alaska Native clients are in treatment, it is important to determine their level of acculturation, their tribal affiliation, and the degree to which their sexual or gender identity is accepted by their tribal community and family. In many communities, being accepted by one’s family is a measure of health and connectedness. If the family has difficulty accepting the client’s sexual orientation, recovery from substance abuse may be hindered. Reintegrating the individual into his or her family may help in the recovery process. Becoming reconnected with family is seen as necessary for health in native tradition. Achieving awareness of one’s sexual orientation or identity may occur in a different way for native men and women than for their non-Indian LGBT counterparts.

**Values.** Some common tribal values are the importance of sharing and generosity, allegiance to one’s family and community, respect for elders, noninterference, orientation to the present time, and harmony with nature. Respect for individual autonomy within the community, respect for family, and honoring the earth are entwined, and each person depends on others for meaning and existence.

Traditional beliefs support the existence of a Supreme Creator and the view that each human has many dimensions such as the body, mind, and spirit. Like humans, plants and animals are part of the spirit world that coexists and intermingles with the physical world.

**Language.** Words are to be honored and not wasted. Language is used to impart knowledge, often through stories. The legends and stories often have specific meanings and involve intricate relationships. Use of symbolism, animism, subtle humor, and metaphors is important. Direct questioning is not as important. Practitioners need to be aware of both their language and nonverbal behavior when communicating with this group.

**Nonverbal behavior.** Their emphasis on observant, reflective, and integrative skills leads American Indian and Alaska Natives to behavior patterns of silence, listening, nonverbal cues, and learning by example. Some traditional natives would view a firm handshake as intrusive and rude; eye contact is used minimally; and a passive demeanor is appropriate.

**Learning styles.** Historically, their survival depended on learning the signs of nature, so observation is central to American Indians and Alaska Natives. Learning is accomplished by watching and listening and through trial and error. Cultural norms and values are passed from generation to generation through rituals, ceremonies, and the oral tradition of story-telling. The relationship with a teacher is important, but trust needs to be established.

**Healing.** Wellness is harmony of the mind, body, and spirit, and native people feel they are responsible for their own wellness. Healing is interconnected with the whole person and rooted in spiritual beliefs connected to the earth and nature. Some traditional practices are the talking circle, sweat lodge, four circles, vision quest, and sun dance and involve community

healers, elders, and holy persons (CSAT, 1999b).

### ***African Americans***

Homophobia in the African-American community is often more intense than in the dominant community. In the past, the sexual orientation of African-American lesbians and gay men was often known by the community although it was not discussed. Many African-American individuals, particularly men, call themselves bisexual instead of gay. Many African-American LGBT individuals operate in separate spheres and may perform community service in the African-American community, but they primarily socialize within the African-American LGBT community. Identifying oneself as an LGBT individual publicly may put an African American at risk for losing his or her most important support system—the African-American community.

Many LGBT African Americans say that they do not feel welcome or comfortable in predominantly Caucasian LGBT settings (e.g., clubs, bars, pride events), and racist incidents have been reported. Diversity in the LGBT service provider community is essential to accommodate for the distrust between African Americans and Caucasians. Many service provider agencies targeting African Americans were formed during the height of the HIV/AIDS epidemic.

Focus groups consisting of African-American gay men and lesbians conducted in California by Michael Browning of Day One in Pasadena, a member of this publication's Steering Committee, clearly stated that they did not want to be called queer and considered it a negative term. Substance abuse treatment counselors need to refrain from using the term, especially if they are working with African Americans.

Focus group members stated that religion remains important to many gays and lesbians in African-American communities, even though some have had negative experiences with organized religious groups. Many treatment programs have some religious context (whether spoken about or not), and focus group members felt that including spiritual activities, music, and practices that are more indigenous to African-American communities would be helpful in treatment.

**Values.** Interpersonal relationships are highly valued, and the identity of African Americans is tied to their group identity. The self is considered an extended self, and this group orientation contrasts with the wider cultural norm of individualism. The community, social organizations, neighborhoods, and kinship relationships provide aid and support. African-American families vary from nuclear to extended. Female-headed households predominate in some socioeconomic levels, but marriage is still highly valued. Rearing children is considered a communal responsibility.

**Language.** Language is passionate and full of action. Dialects and slang are used in some geographic locations and need to be understood by providers. "Same-gender-loving" is a term used by many African-American LGBT individuals. The appropriate form of address is by title (e.g., Ms., Dr., Rev., Mrs.) rather than first name, unless permission is given to use the more informal address.

**Nonverbal behavior.** Body language is expressive and used extensively to help communicate. Movement, thought, and nonverbal behavior are spontaneous, and many African Americans are highly aware of nonverbal cues. Touch is important; however, observing personal space is one key to whether a person feels respected, and providers need to follow the client's lead.



**Learning styles.** Learning styles tend to be relational rather than analytical. Oral communication predominates in knowledge transmission. Tradition is highly valued over the visual and the written word. Teachers and students need to develop a trusting relationship. Storytelling is used to teach about life and pass on cultural values. The use of storytelling and African proverbs can enhance insights into treatment.

**Healing.** Healing occurs through laying on of hands, prayer, herbs, and the like. One is sick when one cannot do for oneself any longer, and recovery from illness usually is seen as possible with the help of God. For many, God and the spiritual community are based in the Christian church and organized religion.

### ***Asian/Pacific Islanders***

Asian/Pacific Islanders consist of more than 60 culturally distinct groups, practice several types of religion, and speak more than 100 languages and dialects. Their degree of acculturation and assimilation varies. The Asian/Pacific Islander cultures have few characteristics in common. For some Asian/Pacific Islander groups, “the traditional Asian/Pacific Islander approach to health and illness centers around balance and harmony. The ultimate goal is to attain a perfect balance among systems of the individual, society, and the universe at large” (Wong et al., 1998). Cohesiveness of the group is an important value, and because of this, shame is a frequently used social constraint to control or deter expressions of homosexual behavior (Wong et al., 1998).

Some Asian/Pacific Islander cultures believe that if one is vigilant in maintaining balance in one’s relationships, then one cannot become ill. It is only when one is out of balance that disease occurs. In addition, prevention as conceptualized by most Asian/Pacific Islanders dictates that, as long as primary prevention behaviors are practiced, there is no reason for

secondary prevention efforts, such as making regular visits to a physician (Wong et al., 1998). Providers need to understand this cultural value and adapt their prevention and treatment efforts accordingly.

**Values.** This culture is heavily based on interdependence, and family is central. The individual is expected to subsume his or her needs to those of the larger group—family, community, or other groups. Varying from one’s prescribed role can cause shame and loss of face for the family. Authority and age are highly respected and honored; thus, there may be discomfort in addressing providers, particularly older ones, by their first names.

**Language.** Some of the languages spoken by Asian/Pacific Islanders do not have words for lesbian, gay, bisexual, or transgender. Without descriptive words, the formation of an LGBT identity may be precluded and an ambiguous social role for LGBT individuals may result. In other words, the behaviors may be practices that lack social legitimacy and may not be discussed. Thus, communication may be indirect, particularly about personal issues or sexual behavior. Initial communication during treatment may need to be indirect with a gradual increase in directness about the issue.

**Nonverbal behavior.** Nonverbal behaviors are as varied as the communities themselves. In some groups, bowing is important, as are related behaviors such as using both hands to present a business card to a colleague, the elderly, and people in authority. Same-sex touching (e.g., holding hands) is not uncommon in most Asian/Pacific Islander cultures; it is a gesture of affection, not sexual feeling.

**Learning styles.** Hierarchical societies support deference to authority (e.g., physicians, health care providers, teachers, the elderly). The learning style is likely to be traditional; information is disseminated or transmitted in one direction, from teacher to student.



**Healing.** Self-reflection through meditation is one traditional way to confront personal issues and increase self-knowledge. Ethics, as outlined by philosophers such as Lao Tzu and Confucius, provide standards for human behavior and regaining a healthy balance. Asian Americans who are Muslim, Christian, or Hindu may have very different beliefs. Eastern medicine is complex, and many recently arrived Asian Americans may still use traditional cures.

### ***Hispanic Americans/Latinos***

Hispanic Americans (also called Latinas and Latinos) are defined as individuals of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish cultures or origins, regardless of their race (CSAT, 1999b). LGBT Hispanics, regardless of the differences among the nationalities represented, have many common values, including strong religious faith, altruism, family values, and spirituality. They contribute greatly to their community, regardless of the fact that they may come from diverse and separate cultural systems and socioeconomic realities.

In treating Hispanic clients, the family is the cornerstone. The support network consists of the family and a host of other individuals who may or may not be related. For new immigrants, the stress of learning a new language, new cultural norms and behavior, and the sense of loss from leaving family and other loved ones behind can be overwhelming.

Homosexuality may be privately acknowledged, but it is usually not discussed openly. Hispanics may be more reluctant to self-identify as LGBT than members of the mainstream culture. The perception of sexuality as an indication of identity is often overridden by identification with the community. Mainstream culture tends to label a person who has a sexual encounter with someone of the same gender as gay, bisexual, or lesbian. In Hispanic

culture, some men who have sex with men do not consider themselves gay if they play the dominant role in the sexual act. When treating Hispanic clients, providers should respect this distinction.

**Values.** Group needs and objectives, family values and ties, and trust (*confianza*) are respected. Traditional values, some of which are rooted in the Catholic faith, are honored. Many Hispanic Americans consider religion central to their lives. Latino/Latina clients appreciate recognition of the emotional, family, and spiritual challenges related to substance abuse problems. Clients likely will maintain a high level of privacy about subjects of a personal nature (illness, addiction, sexual behavior).

In most families, the family respects strong gender roles. Machismo, the strong sense of masculine pride or exaggerated masculinity, and other traditional male attitudes can be barriers to seeking treatment for substance abuse and to coming out. Males are the center of the family, and many gay, bisexual, and transgender men find it difficult to acknowledge their sexual and gender identities.

Drinking is a socially accepted behavior in some families, and young children are allowed to drink beer and tequila as a rite of passage. Caseres and Cortifias (1996) report that for gay Latinos “the bar can be a surrogate home where they can find their other family, who fulfill[s] some of their needs of emotional support in a nonjudgmental context . . . the bar life nurtures, relieves guilt, and becomes an emotional shelter where they can find a new, positive, and valuable world.”

**Language.** Using nonscientific, nontechnical terms and descriptions applicable to the client’s cultural background (Mexican, Colombian, Puerto Rican, etc.) is recommended. The use of Latino, Chicano, or Hispanic differs among groups and communities. An interpreter may be

necessary to successfully treat some Hispanic clients or their families, and bilingual staff members are an excellent resource.

**Nonverbal behavior.** A professional and respectful physical contact, such as shaking hands at every greeting, helps create a safe space for the client. Maintaining eye contact denotes attention and understanding.

**Learning styles.** Family members, especially heads of families, are a source of guidance, counseling, and instruction. It is important to empower individuals to learn about their situation and to know that they can seek support within their own community. It is necessary to remember that for most Hispanic Americans the learning process is based in the context rather than the process. Using a hypothetical third person when giving examples to avoid embarrassment and discomfort about intimate subjects is an effective approach.

**Healing.** Healing is influenced by strong religious beliefs that are often based on traditional Catholicism, although other practices may be followed. Spirituality and religious beliefs are generally very strong and can influence the decisionmaking or behavioral-change processes.

### Summary

The information in this chapter is only a skeletal framework to introduce providers to the complex issues of cultural competency, ethnicity, and gay culture. Providers can help their LGBT clients by understanding their struggle and creating a safe and supportive treatment space. Cultural values and norms are powerful forces, and providers should be mindful that often it is hard for clients to abandon long-held cultural beliefs, even if they are harmful. The experience of expanding their knowledge of the cultural backgrounds of their clients can be rewarding and worthwhile for providers.

## Chapter 3

# Legal Issues for Programs Treating LGBT Clients

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### What providers will learn from this chapter:

- How programs can protect the confidentiality of LGBT clients
- The legal barriers facing LGBT individuals
- The legal issues raised by HIV/AIDS
- What policies programs should adopt to ensure that clients and staff are fairly treated

### Introduction

Lesbian, gay, bisexual, and transgender (LGBT) individuals with substance abuse problems are doubly stigmatized. As substance abusers, they are viewed by many as weak in character and moral fiber. As lesbian, gay, bisexual, and transgender individuals, they are reviled by some as deviant and immoral. They may encounter bigotry from employers, human service workers, criminal justice officials, the general public, and even their own families.

Two Federal (and a number of State) statutes protect recovering substance abusers from many forms of discrimination. However, in most areas of the country, LGBT individuals have no legal protection against discrimination in employment, housing, or access to social services. Protections fought for and won by women, racial minorities, and individuals with disabilities simply are not available for LGBT persons. Disclosure of sexual orientation can lead to an individual's being fired or being denied access to housing and social services—all with legal impunity. LGBT individuals may even lose custody of their children if their sexual orientation becomes known during a custody dispute.

Even in those States that have enacted statutes prohibiting discrimination on the basis of sexual orientation, LGBT individuals have sometimes been denied protection. Little wonder that LGBT individuals regard protecting information about their sexual orientation and substance abuse histories as

<sup>1</sup>Based on original text by Ken South, M.Div., Consultant, Rockville, MD, and Roxanne Kibben, M.A., LAADC, NCAC II, R. Kibben Company, Minneapolis, MN.

critically important. Programs that treat this special population need to be particularly sensitive about maintaining clients' confidentiality, for the consequences of an inappropriate disclosure can be far reaching. (For a compendium of the law regarding discrimination against LGBT individuals, see <http://www.lambdalegal.org>.)

This chapter examines ways programs can safeguard information about clients' substance abuse histories, sexual orientation, and HIV status. It then describes how the lack of legal protection against discrimination can affect LGBT individuals in a variety of areas and how programs can help these clients protect themselves. Finally, the chapter outlines the laws protecting clients with histories of substance abuse and/or HIV/AIDS from discrimination.

### **Protecting the Confidentiality of LGBT Individuals in Substance Abuse Treatment Programs**

#### ***Confidentiality Requirements***

Concerned about the adverse effects stigma and discrimination have on clients in recovery and how stigma and discrimination might deter people from entering treatment, Congress passed legislation (42 U.S.C. §290dd-2) and the U.S. Department of Health and Human Services issued a set of regulations (Vol. 42 of the Code of Federal Regulations [CFR], Part 2) to protect information about clients' substance abuse treatment.

The Federal law and regulations severely restrict communications about identifiable clients by "programs" specializing, in whole or in part, in providing treatment, counseling, and/or assessment and referral services for substance abuse problems (42 CFR §2.11). Although the Federal regulations apply only to programs that receive Federal assistance, this includes indirect forms of Federal aid, such as

tax-exempt status or State or local government funding coming (in whole or in part) from the Federal Government.

The regulations for communications are more restrictive in many instances than, for example, either doctor-patient or attorney-client privilege. They protect any information about an individual who has applied for or received any substance abuse-related assessment, treatment, or referral services from a program. They apply from the time the individual makes an appointment and apply to former clients as well. They apply to any information that would identify the individual either directly or by implication as a substance abuser. They apply whether or not the person seeking information already has that information, has other ways of getting it, has some form of official status, is authorized by State law, or comes armed with a subpoena or search warrant. Violating the regulations is punishable by a fine of up to \$500 for a first offense and up to \$5,000 for each subsequent offense (§2.4).

Programs can find detailed information about compliance with the regulations in Technical Assistance Publication 13 *Confidentiality of Patient Records for Alcohol and Other Drug Treatment* (CSAT [Center for Substance Abuse Treatment], 1999a), available from the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Publications Ordering Web page at: <http://store.samhsa.gov>. What follows is a brief description of some of the regulations' major provisions.

#### ***When May Confidential Information Be Shared With Others?***

The confidentiality regulations permit disclosure without the client's consent in several situations, including medical emergencies, reporting child abuse, and communications among program staff. (For a full discussion of these exceptions, see CSAT, 1999a.)

### **Consent: Rules About Obtaining Consent To Disclose Treatment Information**

The most frequently used exception to the regulations' general rule prohibiting disclosure is client consent. (Parental consent must also be obtained in some States. See below.) The regulations' requirements regarding consent are strict and somewhat unusual and must be carefully followed.

Most disclosures are permissible if a client has signed a valid consent form that has not expired or been revoked (§2.31). To be valid, a consent form must be in writing and must contain **each** of the items specified in §2.31:

1. The name or general description of the program(s) making the disclosure
2. The name or title of the individual or organization that will receive the disclosure
3. The name of the client who is the subject of the disclosure
4. The purpose or need for the disclosure
5. How much and what kind of information will be disclosed
6. A statement that the client may revoke (take back) the consent at any time, except to the extent that the program has already acted on it
7. The date, event, or condition upon which the consent will expire if not previously revoked
8. The signature of the client (and, in some States, his or her parent)
9. The date on which the consent is signed (§2.31(a)).

A general medical release form, or any consent form that does not contain all of the elements

listed above, is not acceptable. (See the sample consent form in exhibit 3–1.)

A number of items on this list deserve further explanation and are discussed under the bullets below.

- ***The purpose of the disclosure and how much and what kind of information will be disclosed***

These two items are closely related. All disclosures must be limited to information that is necessary to accomplish the need or purpose for the disclosure, and this purpose or need must be specified on the consent form. It would be improper to disclose everything in a client's file if the recipient of the information needs only one specific piece of information.

Once the purpose or need has been identified, it is easier to determine how much and what kind of information will be disclosed, tailoring it to what is essential to accomplish the specified need or purpose. That, too, must be written into the consent form.

As an illustration, if a client needs to have his or her participation in counseling verified in order to be excused from school early, the purpose of the disclosure would be "to verify treatment so that the school will permit early release," and the amount and kind of information to be disclosed would be "times and dates of appointments." The disclosure would then be limited to a statement saying, "Susan Taylor (the client) is receiving counseling at XYZ Program on Tuesday afternoons at 3 p.m."

- ***The client's right to revoke consent***

The client may revoke consent at any time, and the consent form must include a statement to this effect. Revocation need not be in writing. If a program has already made a disclosure prior to the revocation, acting in reliance on the client's signed consent, it is not required to try

**Exhibit 3–1:**  
**Consent for the Release of Confidential Information**

I, \_\_\_\_\_, authorize  
(Name of client)

\_\_\_\_\_  
(Name or general designation of program making disclosure)

to disclose to \_\_\_\_\_  
(Name of person or organization to which disclosure is to be made)

the following information: \_\_\_\_\_  
(Nature of the information, as limited as possible)

☐ I understand that the program will NOT be disclosing information about my sexual orientation.

☐ I understand that the program will be disclosing information about my sexual orientation.

\_\_\_\_\_  
(Client's initials)

The purpose of the disclosure authorized herein is to: \_\_\_\_\_

\_\_\_\_\_  
(Purpose of disclosure, as specific as possible)

I understand that my records are protected under Federal regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

\_\_\_\_\_  
(Specification of the date, event, or condition upon which this consent expires)

\_\_\_\_\_  
(Signature of client)

/ \_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of parent, guardian, or authorized representative when required)



to retrieve the information it has already disclosed.

The regulations also provide that “acting in reliance” includes the provision of services while relying on a consent form permitting disclosures to a third-party payer. (Third-party payers are health insurance companies, Medicaid, or any party other than the adolescent’s family that pays the bills.) Thus, a program can bill the third-party payer for services provided before the consent was revoked. However, a program that continues to provide services after a client has revoked a consent authorizing disclosure to a third-party payer does so at its own financial risk.

- ***Expiration of consent form***

The form must also contain a date, event, or condition on which it will expire if not previously revoked. A consent must last “no longer than reasonably necessary to serve the purpose for which it is given” (§2.31(a)(9)). Depending upon the purpose of the consented disclosure, the consent form may expire in 5 days, in 6 months, or in a longer period.

The consent form does not have to contain a specific expiration date but may instead specify an event or condition. For example, if an adolescent has been placed on probation at school on the condition that she attend counseling at the program, the consent form can be drafted to expire at the completion of the probationary period. Or, if a client is being referred to a podiatrist for a single appointment, the consent form should stipulate that consent will expire after he or she has seen “Dr. X.” (See below for further discussion about making referrals.)

- ***The signature of the client (and the issue of parental consent)***

A minor must always sign the consent form in order for a program to release information even

to his or her parent or guardian. The program must get the signature of a parent, guardian, or other person legally responsible for the minor in addition to the minor’s signature only if the program is required by State law to obtain parental permission before providing treatment to a minor (§2.14).

In other words, if State law does not require the program to get parental consent in order to provide services to a minor, then parental consent is not required to make disclosures (§2.14(b)). If State law requires parental consent to provide services to a minor, then parental consent is required to make any disclosures.

Note that the program must always obtain the minor’s consent for disclosures and cannot rely on the parent’s signature alone. (For a full discussion of this issue and what programs can do when minors applying for treatment refuse to consent to parental notification in those States requiring parental consent to treatment, see “Legal and Ethical Issues,” in Treatment Improvement Protocol 32 *Treatment of Adolescents With Substance Use Disorders* (CSAT, 1999c).

Where LGBT minors are concerned, the issue of parental consent can be a particularly delicate matter. Minors in States requiring parental consent for treatment can specify on the written consent form that their sexual orientation will not be disclosed to parents (see exhibit 3–1).

- ***Required notice against redisclosing information***

Once the consent form has been properly completed, there remains one last formal requirement. Any disclosure made with patient consent must be accompanied by a written statement that the information is protected by Federal law and that the recipient cannot further disclose or release such information unless permitted by the regulations (§2.32).

This statement, not the consent form itself, should be delivered and explained to the recipient of the information at the time of disclosure or earlier. (Of course, a client may sign a consent form authorizing a redisclosure.)

### ***Using Consent Forms***

The fact that a client has signed a valid consent form authorizing the release of information does not mean that a program must make the proposed disclosure, unless the program has also received a subpoena or court order (§§2.3(b)(1); 2.61(a)(b)). In most cases, the decision whether to make a disclosure authorized by a client's signed consent is up to the program, unless State law requires or prohibits a particular disclosure once consent is given. The program's only obligation under the Federal regulations is to refuse to honor a consent that is expired, deficient, or otherwise known to be revoked, false, or incorrect (§2.31(c)).

In general, it is best to follow this rule: Disclose only what is necessary, for only as long as is necessary, keeping in mind the purpose for disclosing the information.

- ***Using consent forms to seek information from collateral sources***

Making inquiries of families, partners, schools, employers, doctors, and other health care providers might, at first glance, seem to pose no risk to a client's right to confidentiality. But it does.

When a program that offers assessment and treatment for substance abuse asks a family member (including a parent), partner, employer, school, or doctor to verify information it has obtained from the client, it is making a disclosure that the client has sought help for substance abuse. The Federal regulations generally prohibit this kind of disclosure unless the client consents.

How then is a program to proceed? The easiest way is to get the client's consent to contact the family member (including a parent), partner, employer, school, health care facility, etc. In fact, the program can ask the client to sign a consent form that permits the very limited disclosure that he or she has sought assessment or treatment services in order to gather information from any one of a number of entities or persons listed on the consent form. Note that this combination form must still include "the name or title of the individual or name of the organization" for each collateral source the program may contact. If program staff are making inquiries by telephone, they must inform the parties at the other end of the line orally and then by mail about the prohibition on redisclosure.

Of course, the program should never disclose information about the client's sexual orientation to a collateral source, unless the client specifically consents to disclosure to that particular person or agency. The consent form provided in exhibit 3-1 allows the client to choose whether to consent to disclosure of this information.

- ***Using consent forms to make periodic reports or coordinate care***

Programs serving LGBT individuals may need to confer on an ongoing basis with other agencies, such as mental health or child welfare programs. Again, the best way to proceed is to get the client's consent (as well as parental consent when State law requires). Take care in wording the consent form to specify the purpose of the communication and the kind and amount of information to be disclosed. For example, if the program needs ongoing communications with a mental health provider, the "purpose of the disclosure" would be "coordination of care for Simon Green" and "how much and what kind of information will be disclosed" might be "treatment status, treatment issues, and progress in treatment."

If the program is treating a client who is on probation at work and whose continued employment is contingent on completing treatment, the “purpose of disclosure” might be “to assist the patient to comply with the employer’s mandates” or to “supply periodic reports about attendance,” and “how much and what kind of information will be disclosed” might be “attendance” or “progress in treatment.”

Note that the kinds of information that will be disclosed in these two examples are quite different. The program might well share detailed clinical information about a client with a mental health provider if that would help in coordinating care. Disclosure to an employer should be limited to a brief statement about the client’s attendance or progress in treatment. Disclosure of detailed clinical information to an employer would, in most circumstances, be inappropriate.

The program should also give considerable thought to the expiration date or event the consent form should contain. For coordinating care with a mental health program, it might be appropriate to have the consent form expire when treatment by either agency ends. A consent form permitting disclosures to an employer might expire when the client’s probationary period ends.

Programs should exercise great care about sharing information about clients’ sexual orientation. Disclosure of such information might be therapeutically important when a substance abuse program is coordinating a client’s care with a mental health provider. It would not be appropriate to disclose this information to a client’s employer. Programs should get clients’ consent in writing before making any disclosures about sexual orientation.

- ***Using consent forms to make referrals***

Programs treating LGBT individuals may need to refer clients to other health care or social

service agencies. The program can, of course, give the client the name and telephone number of an outside gynecologist, psychologist, or training program and allow him or her to initiate the call. However, if a staff member at the program makes the call to set up an appointment, he or she must keep in mind that such a call may result in disclosure that the client has a substance abuse problem. If the staff member identifies the client as attending a substance abuse treatment program, directly or by implication, the referral requires the client’s consent in writing (as well as parental consent in States requiring it).

Unless the client has consented, the program should not disclose the client’s sexual orientation when making a referral.

### ***HIV and Confidentiality***

Almost all States now have laws protecting information about individuals’ HIV status. The laws vary widely in the strength of the protection they offer. All allow for disclosure of HIV-related information in certain circumstances. Administrators should educate themselves about the HIV confidentiality protections offered by their individual States.

### ***Discrimination Against LGBT Individuals***

In much of the United States, discrimination against individuals because of their sexual orientation is legal. Although some States have extended their laws against racial and gender discrimination to cover discrimination on the basis of sexual orientation, in most places LGBT individuals can be denied employment or fired, barred from housing, and excluded from health and social services.

LGBT individuals are disadvantaged legally in other areas as well. In most States, same-sex couples in a committed relationship are prohibited from marrying. This means that same-sex partners must make special

arrangements if they wish to bequeath their assets to each other after death. Few jurisdictions provide unmarried partners of employees the health insurance benefits married partners take for granted; even fewer require private employers to offer unmarried partners these benefits. Partners may have difficulty visiting their loved ones in hospitals that have “family only” policies. LGBT individuals are often denied the right to adopt children.

Because of the lack of protection under the law, LGBT individuals may suffer severe or painful consequences if their sexual orientation becomes known. They risk losing custody of their own children in disputes with former spouses or families of origin because of their sexual orientation. (A diagnosis of substance abuse can be yet another strike against them in such cases.) In addition, LGBT individuals can be discharged from the military if their sexual orientation becomes known.

Thus far, only one State has enacted legislation that recognizes what it terms “civil union” between two individuals of the same sex. The statute was passed in response to a decision of the Supreme Court of Vermont (*Baker v. State of Vermont*) finding that the State’s denial of marriage licenses to same-sex couples “effectively excludes them from a broad array of legal benefits and protections incident to the marital relation, including access to a spouse’s medical, life, and disability insurance, hospital visitation and other medical decisionmaking privileges, spousal support, intestate succession, homestead protections, and many other statutory protections.” The court held that “the State is constitutionally required to extend to same-sex couples the common benefits and protections that flow from marriage under Vermont law.”

The Vermont Supreme Court did not order the State to offer marriage licenses to same-sex couples. Rather it required the State legislature

to “craft an appropriate means of addressing this constitutional mandate [through any one] potentially constitutional statutory scheme from other jurisdictions [that provide] an alternative legal status to marriage for same-sex couples, impose similar formal requirements and limitations, create a parallel licensing or registration scheme, and extend all or most of the same rights and obligations provided by the law to married partners.” Ultimately, the State legislature chose to enact a “civil union” (cu) statute, and same-sex couples in Vermont have already been “cu’ed.” (It remains unclear whether other States will recognize such unions between individuals who travel to Vermont for the purpose of being cu’ed.)

The Vermont Supreme Court based its decision squarely on the common benefits clause of the Vermont constitution, a provision it interpreted as offering stronger protection to Vermont citizens than the Federal equal protection clause. The advantage of the court’s resting its decision on the Vermont constitution is that the U.S. Supreme Court cannot review or overturn the decision. The disadvantage is that other States lacking a similar clause are less likely to adopt the court’s reasoning.

For up-to-date information on the laws regarding discrimination against LGBT individuals, see <http://www.lambdalegal.org>.

### ***What Can Be Done To Help LGBT Clients?***

There are a number of ways that programs can adjust their policies and procedures to protect clients, educate them, and help them deal with the discrimination they may face.

#### **1. Confidentiality**

Programs should establish written policies that ensure that information about sexual orientation is confidential. The policy should prohibit disclosure of such information to anyone outside the program, unless the client

consents. Any exceptions to this rule should be approved in advance by the program director.

## 2. Caution on Self-Disclosures

As part of the recovery process, substance abuse treatment programs often encourage clients to acknowledge to others that they have abused alcohol and drugs. Of course, disclosure of this information is not always advisable. While there are laws protecting alcoholics and former drug abusers from discrimination in employment, housing, and access to health care (see below), it is not always easy to enforce those legal protections. Clients should be advised to think carefully before disclosing information about their substance abuse histories.

LGBT clients should also be cautioned to think carefully before disclosing their sexual orientation to others. Such disclosures will rarely be advisable unless clients are fairly sure how the information will be received. Because LGBT clients often have no legal protection against discrimination on the basis of sexual orientation, they should continue to share this information only with those they are confident will respect them and their privacy.

## 3. Education

Programs should educate staff and clients about State and local laws and regulations regarding LGBT persons. Some jurisdictions have enacted statutes protecting LGBT individuals from some forms of discrimination. Other jurisdictions have enacted statutes designed to make life more difficult for LGBT individuals. The confidentiality afforded HIV-related information also varies from place to place. Programs should use the resources listed at the end of this chapter to educate themselves and their clients about LGBT legal issues. The Web site maintained by the Lambda Legal Defense and Education Fund is particularly informative.

## 4. Legal Inventory

Programs can help their clients review their employment, marital, and parental statuses and assess what steps they might take to protect themselves and their rights.

Example 1: Barbara A., a 23-year-old lesbian, is contemplating a divorce. She has three young children and very much wants to retain custody. She worries that her spouse will use her sexual orientation (and/or treatment history) when the issue of child custody arises.

The program should encourage Barbara to share information about her sexual orientation and substance abuse treatment with her attorney. Depending on Barbara's relationships with her spouse and the children's grandparents, her attorney may advise her to consider seeking a negotiated custody agreement. Information about her sexual orientation (and substance abuse history) is less likely to be used against Barbara in this context than during a heated court battle.

Example 2: Harry B. is in a committed relationship with Stephen C. Harry is worried about what might happen if his high blood pressure causes him to have a stroke. What if he becomes unable to make decisions about his own medical care? He feels very strongly that he would not want to prolong his life following a massive stroke. He wonders whether Stephen will be allowed to make medical decisions for him.

The program can help Harry explore the options available to him, which may include (depending upon State law) signing "advance directives" about his health care and/or signing a legal document appointing Stephen his proxy, enabling him to make health care decisions should Harry become incapacitated. This legal document is often called a "health care proxy" or a "medical power of attorney."



Example 3: Ellen W. and Jean C. have grown old together. Ellen has a considerable fortune she inherited from her father; Jean has few assets. Ellen wants to make sure Jean will inherit her property.

State law generally controls rules of inheritance. However, in most (although not all) instances these rules can be overridden once an individual makes a will naming a beneficiary or establishes a trust for the benefit of a named individual. In this respect, LGBT individuals are no different from heterosexuals who are unmarried and have only distant blood relatives. They, too, must make a formal will or set up a trust if they do not want a third cousin to inherit their assets.

#### 5. Respect for LGBT Clients

Programs treating LGBT individuals should take steps to ensure that staff and other clients respect the privacy, safety, and humanity of this population.

- Programs should screen staff members to ensure that they are willing to work with LGBT individuals. Written descriptions of job responsibilities should include treatment of LGBT individuals.
- Program rules should require that clients exhibit respect for one another without regard to race, gender, religion, national origin, or sexual orientation. Programs should establish grievance procedures for clients who want to complain about violation of the rules. All complaints should be handled promptly.
- Programs should treat the partners of LGBT clients as they do members of traditional families. Many LGBT clients are alienated from their families of origin and will not want them to visit. However, visits by a partner may be welcomed.

For a comprehensive list of “Standards of Practice for Provision of Quality Health Care Services for Gay, Lesbian, Bisexual, and Transgendered Clients,” see the Web site maintained by the Gay, Lesbian, Bisexual, and Transgender Health Access Project at <http://www.glbthealth.org>.

#### 6. Program Safety for LGBT Individuals

All clients should be informed at admission that the program will not tolerate sexual harassment or sexual overtures between persons of the same or different gender. Programs should establish effective grievance procedures and respond to any violations of the rules promptly.

Written personnel policies should include prohibition of harassment in the workplace, including harassment of LGBT staff by other staff and sexual harassment between persons of the same (or different) gender. Programs should establish effective disciplinary procedures and respond to complaints promptly.

Programs treating minors should be particularly attentive to this issue, as an incident involving a minor can result in serious legal consequences. The minor’s parents may sue a program that is negligent in this area, and child protective services may intervene if there is an allegation of abuse.

#### 7. Affirmative Action/Cultural Competency

Providing effective treatment for LGBT individuals requires programs to make every effort to employ LGBT individuals in visible jobs. Personnel policies should include a nondiscrimination hiring clause that encompasses LGBT persons (see chapter 14, Policies and Procedures), and programs should offer domestic partner benefits whenever possible.

## Do LGBT Individuals in Substance Abuse Treatment Have Any Legal Protections?

Yes, in areas unrelated to sexual orientation, they do. The Federal Rehabilitation Act (29 U.S.C. §791 *et seq.* (1973)) and the Americans with Disabilities Act (ADA) (42 U.S.C. §12101 *et seq.* (1992)) prohibit discrimination against individuals with “disabilities,” a group defined as including individuals who are alcoholics or have a history of drug abuse. Together, these laws prohibit discrimination based on alcoholism or a history of drug abuse in the services, programs, or activities provided by:

- State and local governments and their departments, agencies, and other instrumentalities (29 U.S.C. §794(b) and 42 U.S.C. §§12131(1) and 12132)
- Most providers of “public accommodations,” including hotels and other places of lodging, restaurants and other establishments serving food or drink, places of entertainment (movies, stadiums, etc.), places the public gathers (auditoriums, etc.), sales and other retail establishments, service establishments (banks, beauty shops, funeral parlors, law offices, hospitals, laundries, etc.), public transportation depots, places of public display or collection (museums, libraries, etc.), places of recreation (parks, zoos, etc.), educational establishments, social service centers (day care or senior citizen centers, homeless shelters and food banks, etc.), and places of exercise and recreation (42 U.S.C. §§12181(7) and 12182).

The Rehabilitation Act and ADA (Rehabilitation Act and key implementing regulations: 29 U.S.C. §793 and 29 CFR Part 1630; §794(a), (b)(1), (b)(3)(A) and 45 CFR Part 84; Americans with Disabilities Act and key implementing regulations: 42 U.S.C. §§12111(2) and (5) and 12112 and 28 CFR Part 35, Subpart C, and 29 CFR Part 1630) also provide

protection against discrimination by a wide range of employers, including:

- Employers with Federal contracts worth more than \$10,000
- Employers with 15 or more employees
- Federal, State, and local governments and agencies
- Corporations and other private organizations and individuals receiving Federal financial assistance
- Corporations and other private organizations and individuals providing education, health care, housing, or social services and parks and recreation sites
- Labor organizations and employment committees.

The Rehabilitation Act and ADA also classify individuals with HIV/AIDS as individuals with disabilities and prohibit employers, government agencies, and places of public accommodation from discriminating against them on the basis of seropositivity. Because gay men, other men who have sex with men, and injection drug users constitute the largest portion of persons diagnosed with AIDS in the United States, this protection is important. For a detailed discussion of the scope of protection offered and how these statutes have been applied in cases of individuals with HIV/AIDS, see Treatment Improvement Protocol 37 *Substance Abuse Treatment for Persons With HIV/AIDS* (CSAT, 2000), available at SAMHSA’s Publications Ordering Web page. Many States also have laws protecting people with HIV/AIDS from discrimination. Local HIV/AIDS and gay and lesbian advocacy groups and resource centers are often able to provide information and advice about both Federal and State laws in this area.

These laws can be helpful to LGBT clients and the programs treating them. If a program refers a client to a vocational rehabilitation training program or a dentist and he or she is rejected because of a history of drug abuse or HIV positivity, there is legal recourse. Programs should also be aware that they, too, are most likely covered by these laws; for example, they may not discriminate against clients with HIV/AIDS or against job applicants or employees with HIV/AIDS or histories of substance abuse.

(Note that ADA specifically excludes “transvestism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairments, and other sexual behavior disorders” from the definition of “disability.” Psychoactive substance use disorders resulting from current illegal use of drugs are also excluded.)

### Case History #1

Bill is a 41-year-old African-American man who has applied for admission to an inpatient alcohol treatment facility. Bill’s history of substance abuse goes back 20 years but includes several years of sobriety and active participation in Alcoholics Anonymous. He is in a committed relationship with Harold (36), his partner of 5 years. Bill’s wife died of a drug overdose 3 years ago, and he has custody of his two young children, Melissa (6) and Philip (4). The children live with Bill and Harold in their rented townhouse. Bill’s late wife’s parents have never accepted him and have always blamed Bill for their daughter’s drug problems.

Bill has been teaching seventh grade English for the past 10 years. Only a very few colleagues in the school system know about his sexual orientation and his relationship with Harold. Bill was referred to the treatment facility by the school district’s Employee Assistance Program (EAP); his employer-provided Health Maintenance Organization (HMO)-based health insurance will cover his treatment. He must satisfactorily complete treatment to retain his job. Bill has signed a form consenting to disclosures about his progress in treatment to the district’s EAP.

### What legal issues does this case present?

- 1) Disclosures of treatment information to the district’s EAP: Bill should sign a consent form that complies with 42 CFR Part 2 so that the facility can release information to the district’s EAP about his progress in treatment. The consent form should be limited to disclosure of general assessments of Bill’s progress in treatment. Giving the EAP detailed treatment information would not be appropriate and should not be authorized by the consent form Bill signs. There should be no disclosure of any information about Bill’s sexual orientation or his living arrangements. Public school systems are generally reluctant to employ an openly LGBT person. Disclosure of this information could result in Bill’s losing his job (and his health insurance). Bill should sign a consent form that gives him the option of permitting or prohibiting disclosure of this information (see exhibit 3–1).

Continued →

- 2) Disclosures of treatment information to the district's HMO: The HMO will require information about Bill's need for treatment in order to make a decision about covering that treatment. It will also demand that the facility update the information periodically. Bill must sign a consent form to permit the program to disclose information to the HMO. Disclosures to the HMO should be as limited as possible, but this may prove difficult. Many managed care organizations require programs to submit detailed information periodically before they will authorize continued treatment (or benefits). Bill has every reason to be concerned that his admission to treatment may trigger a flow of information that might, through school reviews of personnel or HMO records, result in his losing his job. The Federal rules prohibit HMOs from redisclosing information to the district, but there is no assurance that the HMO will refrain from doing so. Therefore, and although this can be difficult, there should be no disclosure of any information to the HMO about Bill's sexual orientation or his living arrangements. Bill should sign a consent form that gives him the option of permitting or prohibiting disclosure of this information (see exhibit 3-1).
- 3) Disclosure of information about Bill's sexual orientation to his in-laws: Disclosure could spark an attempt to challenge Bill's custody of his children. In many States, the combination of Bill's sexual orientation and his history of alcohol abuse could be used by relatives to try to wrest custody from him. If Bill's in-laws do file a court case seeking custody and their attorney issues a subpoena for Bill's treatment records, the program can, working with Bill's attorney, ask the court to issue an order restricting the scope of the information the program will be required to provide. For detailed information on dealing with subpoenas and court orders, see Treatment Improvement Protocol 24 *A Guide to Substance Abuse Treatment for Primary Care Clinicians* (CSAT, 1997a), available from SAMHSA at 1-877-726-4727.

#### **What policy issue does this case present?**

How will Harold be listed on the intake form: as "spouse" and/or next of kin?

Facilities may set their own individual policy about how they treat life partners. At the very least, programs should allow clients to sign a consent form specifying whom the program can call in emergencies.

#### **Case History #2**

Denise is a 16-year-old white female who entered an inpatient treatment program after being hospitalized twice: once for alcohol poisoning and once after a suicide attempt. Denise's parents are working professionals with a comfortable income and large home in the suburbs. Denise has been living at home but does not get along with her two older sisters or her younger brother. She has been habitually truant.

Denise has confided in her counselor that for some time she has been having a hard time with her attraction to and feelings about other girls. Denise characterizes her parents as homophobic and is terrified about what might happen if they find out. Once, when her father found her watching an episode of the TV program "Ellen," he screamed at her: "Why would you want to watch that disgusting smut? I will not have that stuff in my house!"

Denise has signed a consent form permitting her counselor to speak with her parents about her substance abuse treatment.

After Denise has been in the program for a month, a staff member discovers her acting out sexually with another girl.

**Continued** 

### What legal issues does this case present?

- 1) Does the facility have to tell Denise's parents about her sexual attraction to other girls? No. Denise has consented to communications with her parents about her substance abuse treatment. Denise's fears about her parents' reaction may be entirely realistic. Disclosure of this information to Denise's parents at this time would certainly destroy any therapeutic relationship developing between Denise and her counselor. Such disclosure may also be a violation of professional ethics.

Now that Denise's counselor knows Denise's concern, she could ask her to sign a new consent form that specifically requires the program to withhold information about her sexual orientation from her parents (see exhibit 3-1).

- 2) Can Denise's counselor discuss her discovery with other facility staff? Yes, the counselor can discuss her discovery with other program staff. The Federal confidentiality regulations contain an exception permitting communication of information between or among program staff members who have a need for the information in connection with their treatment responsibilities.
- 3) Should Denise's counselor discuss her discovery with other staff? Yes, the counselor should tell other staff, including the program director, about her discovery. The sexual acting out may have affected either Denise or the other girl, and failure to disclose it might create a legal risk for the program.
  - If one girl makes an unwanted advance to another girl, the program has a responsibility to help the victimized child. The information is important to the other girl's treatment counselor. He or she should be working with the girl to help her cope with this experience.
  - The information is also important to the program director. If the other girl was an unwilling target or participant, her parents might sue the program for failing to protect their child. Moreover, if such an incident is swept under the rug, the aggressor may act out again, in which case the program could be put in real jeopardy.

### What policy issues does this case present?

- 1) Program rules regarding client behavior. If the program does not have rules about sex between clients, it should adopt rules now. If the program does have rules, the treatment staff and the program director should discuss whether the acting out violated any program rules and, if so, what the program should do.
- 2) Preventive measures. The program director should consider whether the program can take additional steps to ensure such incidents do not occur in the future.



### Case History #3

Frankie is a 66-year-old retired postal worker who has been in and out of 12-step programs and outpatient treatment for 10 years. This will be his first inpatient treatment episode. Frankie came to the intake session with Janice, his female partner of 16 years. The couple lives together in a home they purchased 12 years ago. They are not legally married, but their friends and family consider them husband and wife. They have two grown children (one each from previous marriages) and five grandchildren. Frankie expects that Medicare will pay for his treatment. Janice works for the city and is covered by the city's HMO plan.

After intake, Frankie is settled in a room with another male patient. On Frankie's first night at the facility, a nurse observes that Frankie has female genitals. Frankie's roommate demands that he be moved out of the room. The nurse has told her supervisor that she's not going to work "with that 'weirdo' in Room 112."

#### What legal issues does this case present?

- 1) Who is responsible for the cost of Frankie's care? Since Frankie and Janice are not legally married, and cannot be, Janice is not responsible for the cost of Frankie's treatment. Janice may want to support part of the costs of treatment, but there is no legal requirement that she do so, and unless her employer provides health benefits to domestic partners, her HMO will not contribute.
- 2) Will Medicare cover Frankie's treatment if his declared gender is not in accord with his biological sex? Ask Frankie whether Medicare identifies him as male or female. If he gives a different gender from what appears on the original Medicare application, there may be problems with payment.
- 3) Who is considered "next of kin"—Janice? or Frankie's child? Since Frankie's and Janice's relationship is not State sanctioned, Frankie's child is considered his next of kin. However, if Frankie would prefer to name Janice as his next-of-kin for visiting and emergency-notification purposes, the program should respect his wishes.
- 4) Can the program fire staff who refuse to work with Frankie because he is transgendered? Yes. Unless the staff person is protected by a union contract with a provision covering this situation, he or she can be fired at any time, unless the action is taken because he or she is female, a member of a minority group, or disabled. In the United States, most employment is "at will," which means that either the employer or employee can end the relationship at any time and for any reason, unless that reason violates one of the civil rights statutes discussed above.

#### What policy issues does this case present?

- 1) What policies should the program have in place to ensure that LGBT individuals are treated fairly? Programs should have written policies in place that require staff to be willing to treat all clients without regard to race, gender, disability, or sexual orientation. Job descriptions should make treatment of clients (regardless of their status) an integral part of the responsibilities of each position. Staff should be screened before hiring to ensure they are willing to abide by the program's treatment rules and should be required to attend educational and sensitivity training about LGBT individuals.
- 2) Should the program move Frankie away from his objecting roommate? Yes. No one should have to endure a hostile roommate. Moving Frankie avoids a difficult situation and helps with his treatment. With Frankie's consent, the program should conduct a sensitivity session to educate clients about transgendered individuals as well as those who are lesbian, gay, or bisexual.

## Recommendations

The following are some recommendations for improving substance abuse treatment for LGBT clients.

1. Improve knowledge among staff members about the laws affecting LGBT individuals with substance abuse histories. These include:
  - a. Federal and State antidiscrimination laws protecting individuals with disabilities that apply to alcoholics and individuals with histories of drug abuse
  - b. Federal and State antidiscrimination laws protecting individuals with disabilities that apply to individuals with HIV/AIDS
  - c. Federal confidentiality laws and regulations
  - d. State laws protecting HIV-related information
  - e. State and local laws that apply to LGBT individuals.
2. Ensure that staff members respect LGBT clients by:
  - a. Establishing written job descriptions that require treatment of all clients without regard to their sexual orientation
  - b. Screening out job applicants who express overt bias
  - c. Establishing clear, written program policies requiring equal treatment of clients without regard to their sexual orientation and enforcing program policy through a disciplinary process
  - d. Providing staff members with training to increase their awareness of and sensitivity to LGBT issues
  - e. Establishing a procedure for clients to complain about bias.
3. Ensure that clients respect LGBT individuals by:
  - a. Establishing program rules requiring respect for clients without regard to their race, gender, religion, national origin, or sexual orientation
  - b. Providing clients with education and information about LGBT individuals
  - c. Establishing grievance procedures for clients wishing to lodge complaints
  - d. Enforcing program rules promptly.
4. Ensure that LGBT staff and clients are safe while attending the program by:
  - a. Establishing personnel policies prohibiting harassment in the workplace, including harassment of LGBT staff by other staff and sexual harassment by persons of the same or a different gender
  - b. Informing clients at admission that the program does not tolerate sexual harassment or sexual overtures or activities by persons of the same or a different gender
  - c. Enforcing the rules promptly
  - d. Establishing grievance procedures for both staff and clients who may wish to complain about harassment and responding promptly to complaints.

5. Take all steps necessary to ensure the confidentiality of information about clients' substance abuse treatment as well as their sexual orientation by:
  - a. Providing staff with training about the Federal confidentiality regulations
  - b. Establishing written policies about the confidentiality of information about sexual orientation and instructing staff about those policies
  - c. Educating clients about the importance of respecting the confidentiality of their fellow clients.
6. Establish personnel policies that attract and retain LGBT staff by:
  - a. Actively recruiting such individuals
  - b. Offering such individuals' partners the same benefits offered married couples.
7. Educate LGBT clients about:
  - a. The confidentiality protections they enjoy (and those they lack)
  - b. The antidiscrimination laws that protect them, as well as the ways in which their rights are not protected
  - c. The steps they can take to protect themselves.

## Resources

### *Confidentiality of Substance Abuse Treatment Records*

*Confidentiality of Patient Records for Alcohol and Other Drug Treatment.* Technical Assistance Publication (TAP) 13 (CSAT, 1994b), 36 pp. BKD156.

This guide provides an overview of Federal alcohol and drug treatment confidentiality laws and regulations as well as options for dealing with a wide variety of situations. The appendix includes sample forms for patient consent and qualified service organization agreements. (Although the printed version of this publication is currently out of stock, it can be viewed and printed at <http://store.samhsa.gov>.)

*Checklist for Monitoring Alcohol and Other Drug Confidentiality Compliance.* TAP 18 (CSAT, 1996), 52 pp. PHD722X.

This TAP is a reference for the substance abuse treatment provider on maintaining and protecting patient confidentiality and records.

*Welfare Reform and Substance Abuse Treatment Confidentiality: General Guidance for Reconciling Need To Know and Privacy.* TAP 24 (CSAT, 1999d), 40 pp. BKD336.

This report provides guidance for alcohol and drug treatment providers on resolving confidentiality issues that arise in the context of welfare reform.

*Legal Issues Associated With Development and Implementation of a Provider-Sponsored Managed Care Organization.* Volume 6 (SAMHSA, 1998), 65 pp. BKD296.

This publication summarizes the legal issues that substance abuse treatment service and mental health providers address in organizing provider-sponsored managed care organizations (MCOs) and implementing managed care programs through contract negotiation and the delivery of services and care through provider contracts.

Legal Action Center  
153 Waverly Place  
New York, NY 10014  
Ph: 800-223-4044  
<http://www.LAC.org>

The Legal Action Center is the only law and policy organization in the United States that fights discrimination against people with histories of addiction, AIDS, or criminal records and advocates for sound public policies in these areas. The center provides:

- Legal services, including impact litigation
- Policy advocacy and research
- Training, technical assistance, and education.

### *LGBT Rights*

*A Legal Guide for Lesbian and Gay Couples (10th Ed.)* (Curry et al., 1999).

This manual outlines the differences between legally married couples and same-sex partners.

Advocates for Youth  
1025 Vermont Avenue, NW, Suite 200  
Washington, DC 20005  
Ph: 202-347-5700, Fax: 202-347-2263  
<http://www.advocatesforyouth.org>

Advocates for Youth (formerly Center for Population Options) is dedicated to creating programs and promoting policies that help young people make informed and responsible decisions about their sexual and reproductive health. It provides information, training, and advocacy to youth-serving organizations, policymakers, and the national and international media. Advocates for Youth also sponsors the Youth Resource Web site at <http://www.amplifyyourvoice.org/youthresource> (for LGBT youth).

American Civil Liberties Union (ACLU)  
132 West 43rd Street  
New York, NY 10036  
Ph: 212-944-9800  
<http://www.ACLU.org>

The American Civil Liberties Union is a nonprofit, nonpartisan, 275,000-member public interest organization devoted exclusively to protecting the civil liberties of all Americans and extending those rights to groups that have traditionally been denied them. It files court cases to expand and enforce individuals' civil rights and educates legislatures and the public on a broad array of issues affecting individual freedom in the United States.

ACLU Lesbian and Gay Rights Project  
125 Broad Street  
New York, NY 10004  
Ph: 212-549-2627

The goal of the ACLU Lesbian and Gay Rights Project is equal treatment and equal dignity for lesbians, gay men, and bisexuals. That means even-handed treatment by the government; protection from discrimination in jobs, housing, hotels, restaurants, and other public places; and fair and equal treatment for lesbian and gay couples and families.

Human Rights Campaign (HRC)  
919 18th Street, NW  
Washington, DC 20006  
Ph: 202-638-4160, Fax 202-347-5323  
<http://www.hrc.org>

HRC is the largest national lesbian and gay political organization. Its mission is to create an America where lesbian and gay people are assured of basic equal rights and where they can be open, honest, and safe at home, at work, and in the community. With a national staff and volunteers and members throughout the country, HRC:

- Lobbies the Federal Government on gay, lesbian, and AIDS issues
- Educates the public
- Participates in election campaigns

- Organizes volunteers
- Provides expertise and training at the State and local levels.

Lambda Legal Defense and Education Fund  
120 Wall Street, Suite 1500  
New York, NY 10005-3904  
Ph: 212-809-8585, Fax: 212-809-0055  
<http://www.lambdalegal.org>

Lambda is the Nation's oldest and largest legal organization working for the civil rights of lesbians, gay men, and people with HIV/AIDS.

National Center for Lesbian Rights (NCLR)  
870 Market Street, #510  
San Francisco, CA 94103  
Ph: 415-392-6257, Fax: 415-392-8442  
<http://www.NCLRights.org>

NCLR is committed to advancing the rights and safety of lesbians and their families through litigation, public policy advocacy, free legal advice and counseling, and public education. NCLR also provides representation and resources to gay men and bisexual and transgendered individuals on key issues that affect lesbian rights.

National Gay and Lesbian Task Force (NGLTF) (Main office)  
1700 Kalorama Road, NW  
Washington, DC 20009-2624  
Ph: 202-332-6483, Fax: 202-332-0207  
TTY: 202-332-6219

National Gay and Lesbian Task Force (Policy Institute)  
121 West 27th Avenue, Suite 501  
New York, NY 10001  
Ph: 212-604-9830, Fax: 212-604-9831  
<http://thetaskforce.org>

NGLTF is a leading progressive civil rights organization that has supported grassroots organizing and advocacy since 1973. Since its

inception, NGLTF has been at the forefront of every major initiative for lesbian, gay, bisexual, and transgender rights. In all its efforts, NGLTF works to strengthen the gay and lesbian movement at the State and local levels while connecting these activities to a national vision of change.

Servicemembers Legal Defense Network  
P.O. Box 65301  
Washington, DC 20035-5301  
Ph: 202-328-3244, Fax: 202-797-1635  
<http://www.sldn.org>

On July 19, 1993, the Clinton administration announced a new policy regarding gays in the military. Dubbed "Don't ask, don't tell, don't pursue," the policy was intended to stop military officials from asking troops about their sexual orientation, end witch hunts, and stop harassment of lesbian and gay service members. Suspect service members still face an untimely end to their careers. Most service members do not realize that the new policy affords little protection or privacy for lesbian and gay personnel, and most service members do not know what their legal rights are under the new policy.

Gender Education & Advocacy  
<http://www.gender.org/>

Gender Education & Advocacy is a civil rights group seeking to secure and safeguard the rights of all transgender individuals.

*Queer Resources Directory*  
<http://www.qrd.org>  
Queer Legal Resources  
<http://www.qrd.org/qrd/www/legal>

The *Queer Resources Directory* contains tens of thousands of files about various topics of interest to LGBT individuals. It bills itself as having one of the most extensive collections of materials devoted to LGBT legal issues on the Internet. The collection includes:



- Tables listing the important legal cases dealing with LGBT and AIDS issues for each year from 1992 to the present
- Case and issue archives by subject
- Statewide gay rights statutes and same-gender marriage resources
- *Lesbian/Gay Law Notes*, edited by Professor Arthur Leonard, a monthly summary of the cases important to gay/lesbian and HIV/AIDS jurisprudence
- *National Journal of Sexual Orientation Law*, an electronic legal journal devoted to sexual orientation and the law
- QueerLaw and QueerLaw-Digest, with information about companies with nondiscrimination policies that include sexual orientation; companies and organizations that provide domestic partner benefits; States that criminalize sexual acts between people of the same gender; State laws on age of consent for sexual acts between people of the same gender; and sodomy and age-of-consent laws worldwide
- Lists and links to groups that work on legal issues of interest to LGBT individuals.

Gay, Lesbian, Bisexual and Transgender  
Health Access Project  
JRI Health  
100 Boylston Street, Suite 860  
Boston, MA 02116  
Ph: 617-988-2605  
Fax: 617-988-2629  
<http://www.glbthealth.org>

The Gay, Lesbian, Bisexual and Transgender Health Access Project is a collaborative, community-based program funded by the Massachusetts Department of Public Health. The Project's mission is to foster the development and implementation of comprehensive, culturally appropriate, quality health promotion policies and health care services for gay, lesbian, bisexual, and transgendered people and their families.

## Chapter 4

# Overview of Treatment Approaches, Modalities, and Issues of Accessibility in the Continuum of Care

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*Mickey Smith, LGSW, C.A.C., Whitman-Walker Clinic, Washington, DC*

### What providers will learn from this chapter:

- The special issues that need to be addressed in working with LGBT individuals
- The levels of care and the types of treatment that appear to work best for LGBT individuals
- The major issues of accessibility related to substance abuse treatment for LGBT populations
- How a program can be made accessible for LGBT populations

### Introduction

This chapter advises providers on approaches, modalities, and accessibility in the continuum of care relevant to the lesbian, gay, bisexual, and transgender (LGBT) populations seeking substance abuse treatment services. Although the issues discussed may be similar to those of the larger population, some differences exist. This chapter provides information about accessibility and attributes of programs that are helpful for LGBT clients.

Substance abuse treatment for LGBT individuals is the same as that for other individuals and primarily focuses on stopping the substance abuse that interferes with the well-being of the client. However, some LGBT clients will need to address their feelings about their sexual orientation and gender identity as part of their recovery process. For some LGBT clients, this will include addressing the effects of internalized homophobia. Clinicians sometimes see relapses in LGBT persons with lingering negative feelings about their sexual orientation or gender identity.

Substance use, especially alcohol use, is woven into the fabric of the lives of many LGBT individuals. The greater use and presence of alcohol and drugs in settings where LGBT people socialize (in conjunction with the denial produced by the use of these substances) may help to explain the greater predisposition to substance abuse among LGBT individuals.

Even if the LGBT individual is open about his or her identity, it is virtually impossible to deny the effects of society's negative attitudes, which can result in feelings of doubt, confusion, fear, and sorrow (Diamond-Friedman, 1990). Often referrals or appropriate treatment are difficult to secure due to the lack of understanding of these issues by treatment program administrators and staff. Finding a program that can both address LGBT clients' treatment needs and be supportive of them as individuals can be very difficult.

Members of the LGBT community often face problems in traditional health care systems and are stigmatized within programs by staff and other clients (Mongeon & Ziebold, 1982). Service providers should develop a basic understanding of how they can best serve these populations to help ensure successful treatment outcomes. In addition, due to the multicultural and varied backgrounds of LGBT clients, treatment approaches and modalities may need to be tailored to meet the needs of these individuals.

The growing body of literature on working with LGBT substance abusers can help clinicians understand the issues and improve treatment (Cabaj, 1996; Finnegan & McNally, 1987; Gonsiorek, 1985; Ziebold & Mongeon, 1985).

## Approaches

Abstinence-based and treatment-readiness approaches to substance abuse disorders are the two major approaches presented in this chapter. For the purpose of this publication, treatment readiness refers to the level of readiness that individuals may exhibit relating to changing alcohol and drug use behaviors. When undergoing treatment for substance abuse, LGBT individuals have many of the same issues as the larger population, but they may have additional issues as well. LGBT clients may be coping with coming out; their sexual orientation and gender identity; societal

stigmas; HIV/AIDS; death and dying; discrimination; same-sex relationships; and homophobic family members, employers, and work colleagues. At times, these issues have a negative impact on a person's ability to change his or her alcohol and drug use patterns and other harmful behavior.

Providers need to understand that a part of substance abuse recovery for many LGBT individuals is accepting themselves as gay, lesbian, bisexual, or transgender and finding a way to feel comfortable in society.

## Levels of Care

Levels of care refers to the intensity and duration of services being provided by a program to clients, including inpatient, residential, therapeutic, partial hospitalization or day treatment, intensive outpatient, outpatient, aftercare and followup, and monitoring services.

LGBT substance abusers should be assessed to determine the range of services and levels of care they require. The type of drug and the amount used by a client, the danger of a medically complicated withdrawal, the difficulty with withdrawal and craving, and the need to be away from social and psychological stressors will help a counselor determine the level of care a client needs. Whatever the planned treatment, it should be LGBT sensitive and supportive.

Although they abuse alcohol and some of the same substances as non-LGBT substance abusers, certain LGBT individuals may abuse other drugs that influence the level and duration of care they need. For example, methamphetamine abuse is nearly epidemic in gay men in some parts of the United States (Freese et al., 2000). Abuse of this drug often results in strong cravings and frequent relapses and may require extensive and highly focused treatment.

Outpatient care will serve the vast majority of LGBT substance abusers, just as it does non-LGBT substance abusers. Many larger urban communities have residential programs for LGBT people as well as LGBT-supportive inpatient or outpatient recovery programs.

## Continuum of Care

The continuum of care refers to continuing available services and may include provision of additional services while individuals are in the program; ongoing support and services after discharge (regardless of treatment completion); followup and monitoring activities; and outreach, recruitment, and retention. Some of these services may be different for LGBT clients due to factors such as the health status of the clients or their partners, their living arrangements, the type and stability of their employment, their work hours, their level of openness about their sexual orientation/sexuality, and their experience with previous service providers or systems.

## Accessibility

Due to the homophobia and discrimination they experience, LGBT individuals may find it difficult, and sometimes uncomfortable, to access treatment services. Substance abuse treatment programs are often not equipped to meet the needs of this population. Heterosexual treatment staff may be either uninformed about LGBT issues, insensitive to their concerns, or antagonistic toward such individuals. These attitudes may be based on misperceptions or personal beliefs. A harmful result of this insensitivity is that some professionals or other clients may falsely believe that an LGBT person's sexual orientation/gender identity caused his or her alcohol and drug use. One's sexual orientation/gender identity should not be viewed as in need of changing. Such factors become barriers when the LGBT population seeks access to appropriate treatment.

Some LGBT individuals may express difficulty in participating in non-LGBT focused treatment, stating that heterosexuals may not understand LGBT issues and problems. This can be problematic for the treatment staff, but it does not have to impede services. This attitude may be a defense mechanism, or the person may have experienced problems with heterosexual treatment providers in the past. Whatever the cause, it should be managed in a therapeutic manner. Encourage individuals to discuss previous experiences or why they have these feelings or attitudes toward heterosexuals. It is also important for counselors not to assume that they know why such statements are made or that they completely understand these experiences. Be sensitive to the LGBT individual's experience and facilitate these issues within a therapeutic context.

Often negative feelings or attitudes are based on real experiences and should be acknowledged as such. Making the program accessible to the LGBT community may require some changes. Programs that use observers to administer urine screens need to consider the clients' concerns and ask which gender observer they prefer. Staff may not know what gender the client considers herself or himself, and this could result in uncomfortable situations.

If possible, designate a separate, non-gender-specific toilet and shower facility for some LGBT clients, particularly in residential treatment settings. Transgender individuals may be in the process of change or may be living as the gender opposite the one they were born with, which may result in these individuals using rest rooms different from what one would expect.

Heterosexual staff and clients should not assume that LGBT individuals are any more likely to flirt or act out sexually than their heterosexual counterparts. Rules regarding sexual interactions, flirting, and dating in treatment settings should be the same for LGBT persons as for heterosexual individuals.

## Degrees of LGBT Sensitivity

In addition to addressing issues of accessibility, it is important for program administrators and staff to create a supportive environment for LGBT individuals. The impact on the client of anti-LGBT bias and internalized homophobia should be considered when developing the treatment plans of LGBT people with substance abuse problems. Few programs provide education to staff about LGBT people, and many programs may be unaware that they have LGBT clients. Some LGBT clients may be too frightened to come out during treatment or feel they have been given permission to be open about their sexual identity (Hellman et al., 1989). Staff attitudes are crucial in helping clients feel comfortable and safe; training counselors about homosexuality will help clients feel safe.

Substance abuse treatment programs can be rated on a spectrum from LGBT-hostile to LGBT-affirming. Exhibit 4–1, which was adapted from Neisen (1997), provides a brief overview of the components identified on the spectrum.

It is hoped that only a few programs are openly hostile toward LGBT people; it is essential that any LGBT individuals seeking help for substance abuse problems are not treated at these programs. Unfortunately, many substance abuse treatment programs are unaware of the importance of sexual orientation and operate as if everyone is heterosexual—unaware that LGBT people exist. In such settings, LGBT people most likely will not talk about their sexual orientation or gender identity and will not be able to integrate their sexuality and acceptance of a gay, lesbian, bisexual, or transgender identity into recovery. Internalized homophobia/transphobia and coping with anti-LGBT societal bias most likely will not be discussed.

Some substance abuse treatment programs may be **LGBT tolerant**, that is, aware that LGBT people exist and use their services. Such awareness is usually due to an LGBT staff member. Even so, accepting one's sexual orientation and dealing with homophobia most likely will not be addressed.

**LGBT-sensitive** programs are aware of, knowledgeable about, and accepting of LGBT people. Many well-established programs are training staff about LGBT concerns to make them LGBT sensitive. The material in this document is part of that effort. LGBT-sensitive programs acknowledge the existence of LGBT people and treat them with respect and dignity. These programs usually care for LGBT people in the same way that they treat other clients but recognize the difficulties and challenges facing LGBT people in recovery. Some programs may also have specific therapy groups for LGBT people.

Fewer programs are **LGBT affirmative**—that is, they actively promote self-acceptance of an LGBT identity as a key part of recovery. These programs affirm LGBT individuals' sexual orientation, gender identity, and choices; validate their values and beliefs; and acknowledge that sexual orientation develops at an early age. An LGBT-affirmative program, the Pride Institute, released data showing a very successful treatment rate when acknowledging one's sexual orientation is considered a key factor in recovery (Ratner, Kosten & McLellan, 1991). At a 14-month followup with verified reports, 74 percent of all patients treated 5 or more days abstained from alcohol use continuously, and 67 percent abstained from all drugs. These data can be compared with data from four similar, sometimes LGBT-sensitive but non-LGBT-affirmative treatment programs with unverified reports taken at followups ranging from 11 months to 24 months after treatment, which had abstinence rates of 43, 55, 57, and 63 percent.

**Exhibit 4–1:  
LGBT Sensitivity Model**

<b>Anti-LGBT Treatment</b>	<b>Traditional Treatment</b>	<b>LGBT-Naive Treatment</b>	<b>LGBT-Tolerant Treatment</b>	<b>LGBT-Sensitive Treatment</b>	<b>LGBT-Affirming Treatment</b>
No LGBT sensitivity	No LGBT sensitivity	No LGBT sensitivity	Minimal LGBT sensitivity	Moderate level of LGBT sensitivity	Highest level of LGBT sensitivity
Antagonistic toward LGBT individuals	No realization that there are LGBT clients	Realization that there are LGBT clients	Recognition that there are LGBT clients	Several clients and/or staff are open with their LGBT identity	Program primarily targets LGBT population
Treatment focuses exclusively on heterosexuals and excludes LGBT clients	No acknowledgment or discussion of LGBT issues; it is assumed everyone is heterosexual	As an agency, has not yet begun to address the special issues of the LGBT population	Some staff may verbalize that it is okay to be an LGBT individual; however, such discussions are limited to individual sessions	Several workshops and/or groups focus on LGBT issues; they may have LGBT groups or a “track” for LGBT issues; groups are generally mixed	All workshops specifically for LGBT clients; workshops and groups affirm the LGBT individual, have LGBT-specific materials, etc.; groups and workshops are not mixed with heterosexuals
No specific LGBT treatment components	No specific LGBT treatment components	No specific LGBT treatment components	No specific LGBT treatment components	Some specific LGBT treatment components	All treatment components are LGBT specific

Adapted from Neisen, 1997

### **Specific Issues**

Substance abuse and sexual identity formation, which includes awareness and acceptance of sexual orientation and gender identity, are often enmeshed for many LGBT people. Some counselors and clinicians working with LGBT clients’ substance abuse see addressing these issues as essential to recovery, and failure to do so may result in a difficult recovery process.

Substance abuse treatment programs that are LGBT sensitive are more likely to have more successful outcomes with LGBT clients.

Exhibit 4–2 presents principles of care that are appropriate for any client. Program administrators and staff need to be aware of issues that may be specific to the LGBT population with respect to the continuum of care, including outreach, identifying the extent of alcohol and drug use, and discharge planning.



## Exhibit 4–2: Principles of Care

Principles of care that should be part of any substance abuse treatment program for LGBT populations are listed below. These principles are adapted from a mental health care practical guide to developing programs for working with people living with or affected by HIV/AIDS (Acuff et al., 1999).

### ***Be flexible and client centered***

Clients will present with a wide range of substance use and psychosocial needs. While some clients may benefit from group modalities, others may need individual counseling or may benefit from supportive treatment. To meet the individual's needs, services need to be flexible but consistent and thorough.

### ***Be coordinated, integrated, and comprehensive***

Service systems should establish formal linkages and networks to enhance service coordination and integration. Likewise, providers working in a multidisciplinary setting should use a team approach to meet each client's needs.

### ***Be consistent with each client's cultural needs and expectations***

Programs may need to employ multilingual and multicultural staff as well as individuals representing LGBT populations. Sensitivity training is essential for staff members who are not culturally matched with the client base.

### ***Promote self-respect and personal dignity***

Effective service delivery depends on recognizing an individual's self-worth and contributions to his or her community. Society and the traditional health care system, along with substance abuse treatment programs, typically may have stigmatized LGBT clients and left them with little sense of self-respect or dignity. Programs must ensure that staff and the service delivery system do not stigmatize the clients further.

### ***Promote healthier behaviors***

Service providers can work with clients to practice healthier behaviors, to practice safer sexual behaviors, to strengthen supportive relationships, and to comply with medication regimes for HIV and psychotropic communities—or other professionals and agencies may provide positive examples for clients currently in treatment or receiving services.

### ***Empower persons in substance abuse treatment to make decisions in collaboration with the service provider***

Service providers must not assume that they know what is best for individuals but must include clients in treatment planning. All segments of the community, including consumer and advocacy groups, should be involved in the process of establishing, delivering, and improving services.

### ***Reduce barriers to services for hard-to-reach populations***

LGBT populations are varied, which can cause difficulties in reaching segments of the community. Individuals may be homeless, work as street hustlers/prostitutes, be in jail/prisons, or come from a variety of cultural/ethnic backgrounds, thus creating the need to develop effective outreach and retention mechanisms.

### ***Develop and deliver services that are clinically informed and research based***

It is important not to assume that services that are effective for the larger population will be as effective or appropriate for the LGBT populations; clinical issues often are different and need to be acknowledged and treated. Evaluations of current clinical services for the LGBT community may need to be undertaken, or research from other such undertakings can be used to develop appropriate services.

### ***Work to create a treatment/recovery community***

Programs can play a role in developing a community of individuals, agencies, and organizations that work in partnership to develop a treatment/recovery community. Making use of individuals who have successfully completed treatment (alumni), individuals in the recovery communities, or other professionals and agencies may provide positive examples for clients currently in treatment or receiving services.

Identifying the extent of alcohol and drug use is an issue that is important to all individuals entering substance abuse treatment regardless of their sexual orientation. Traditional assessment forms may need to be modified or redeveloped for the LGBT populations to include more inclusive language (refer to Coleman's Assessment Tool in chapter 1).

Without culturally competent training, the assessor may be uncomfortable and miss biopsychosocial information important to effective treatment planning. Also, collecting collateral information may be different for the LGBT population: Some LGBT clients may not have close relationships with their family of origin; it may be clinically appropriate to gather collateral information from a partner and close friends (who may be identified by clients as their family of choice). However, it cannot be assumed that all LGBT clients are estranged from their families of origin. Many have supportive and close families. It may be helpful to include these individuals in treatment to expand clients' recovery support system.

### ***Special Assessment Questions***

In formulating a treatment plan for LGBT individuals with a substance abuse problem, some additional factors may need to be assessed. Following are a sample.

- Determine the individual's comfort with being an LGBT person. Evaluate the person's comfort level with his or her sexuality and expression of sexual feelings. If the person is a transgender individual, determine his or her level of comfort with, and acceptance of, that identity.
- If appropriate, determine the stage where the individual is in the coming-out process (whether as a gay, lesbian, bisexual, or transgender person). Learn about his or her experience and the consequences of coming out.
- Determine the extent of the individual's support and social network, including whether there are any current relationships or past relationships and the individual's relationship with his or her family of origin.
- Determine whether there are any health factors of concern, including the individual's HIV status.

The substance abuse counselor can ask the same questions about alcohol or drug use as he or she uses for non-LGBT individuals. Specific information about the patterns of, and situations involved in, the use of alcohol and drugs by LGBT individuals can be helpful in planning treatment and preventing relapse. For example:

- Look at the most recent alcohol and drug use: Was it with family, friends, a significant other, a lover, or a date? With work colleagues? Where was it? At a circuit party? Alone? At a sex club or bathhouse? At a lesbian, gay, bisexual, or transgender bar or at a straight bar?
- Is there current or past intravenous or injection drug use? If so, what drugs are used? Are amphetamines (speed, crystal, crank) used? Are amphetamines used to enhance sexual intensity?
- What is the frequency of the alcohol and drug use? Does it correlate with the socializing?
- What is the drug of choice—the drug the client enjoys or seeks most? What does it seem to do or accomplish? Provide relaxation? Provide freedom from guilt? Enhance sexual behavior?
- If the client has a significant other, does that person believe there is a problem? Does he or she have his or her own substance abuse problems?

- Has the client had legal problems due to his or her use of alcohol and drugs, including driving under the influence? Has the client ever had legal problems related to sexual behavior or police harassment?
- Has the client ever been attacked or assaulted (gay bashed) because he or she was thought to be an LGBT person?
- Has the client had social problems or lost partners, family, or friends because of alcohol and drug use? Has there been domestic violence? Was it by a same-sex lover?
- Has the client had treatment in the past for substance abuse? If so, was his or her sexual orientation or sexuality discussed?
- What is the longest time the client did without alcohol and drug use, and what allowed that to happen?

### Modalities

Typical modalities for substance abuse treatment include individual, group, couples, and family counseling, but LGBT individuals can face other unique problems if they are treated by traditional programs through group, couples, or family modalities.

The group modality may be difficult for LGBT individuals if heterosexism/homophobia is demonstrated by staff and other group members. Groups should be as inclusive as possible and should encourage each member to discuss relevant treatment issues or concerns. If a group combines heterosexuals and LGBT individuals, provide sensitivity training relating to LGBT issues and concerns; ensure that all clients are aware that groups will be mixed. Placing LGBT individuals in therapy groups with homophobic clients may lead to difficult situations and/or hostility toward the LGBT individuals.

Staff need to ensure that LGBT clients are treated in a therapeutic manner and should provide a strong verbal directive that homophobia and hostility will not be tolerated. If it does occur, staff must take strong action on behalf of LGBT clients. LGBT clients should not be required to discuss issues relating to their sexuality or sexual orientation in mixed groups if they are uncomfortable. On the other hand, in a mixed group setting led by adequately trained, culturally competent, and LGBT-supportive staff, LGBT clients may have the powerful experience of gaining acceptance and affirmation from peers. The acceptance and care that can come from members of groups could be healing for LGBT persons.

Often, intensive programs provide groups for special populations (e.g., women, professionals, those with HIV/AIDS, racial/ethnic minorities) to address their multidimensional needs (CSAP [Center for Substance Abuse Prevention], 1994). If a program has enough LGBT clients, it may start an additional or separate group for them. This may provide a safe or more cohesive venue for discussing issues specific to LGBT clients. However, attendance should be voluntary. When LGBT- or gender-specific groups are held, therapists should regularly direct attention to safe-sex practices and sexual feelings about and experiences with same-sex individuals.

Family counseling can be difficult due to issues relating to the client's sexual identity/orientation, substance abuse, and, in some cases, HIV/AIDS diagnosis, which have caused distance and alienation. LGBT clients are more likely to seek support for their partners if they view the program as LGBT sensitive.

If a program provides treatment primarily through an individual modality, many of these issues may not be relevant. Providing one-to-one services may decrease the difficulty of mixing heterosexual and LGBT clients in treatment groups and decrease the likelihood

that heterosexism/homophobia will become an issue. LGBT individuals will be able to discuss issues revolving around their sexual orientation/identity without fearing that non-LGBT individuals will be hostile, will be insensitive, or will minimize LGBT issues.

### ***Discharge planning***

Specific concerns related to the discharge planning process for LGBT clients may include an enhanced analysis of their social support, their living arrangement/environment, their employment status or type of employment, and ongoing issues that clients have identified related to their sexual orientation/identity. Social support involves the amount of support available to clients, which can increase their likelihood of remaining abstinent or in recovery. Social support often includes the family of origin and family of choice (e.g., sexual partner, friends, or others) and should focus on individuals who support clients' efforts to create such significant changes. LGBT individuals may live in an environment that is not conducive to their ongoing abstinence/recovery (e.g., they have a partner or roommate who actively uses alcohol and drugs, or they live in close proximity to drug dealers or open air drug markets). Although these issues or concerns may be similar to those individuals from the larger population may face, it is important to assess and provide appropriate referrals for LGBT clients. Clients' employment status or type of employment may also interfere with their ongoing abstinence/recovery. Specific issues may be the type of work the individuals perform (e.g., bartender, sex industry worker) or status (e.g., not in stable employment, disabled). Issues related to their sexual orientation/identity may interfere with their recovery after discharge if ongoing support or counseling is not provided to meet needs identified by clients.

### ***Aftercare/Recovery***

Aftercare and support for recovery may be a problem, depending on the geographic location and any difficulties the client may have expressed concerning acceptance of his or her sexual orientation (there may be no LGBT-sensitive counselors or programs in the client's community).

Twelve-step recovery programs and philosophies are, of course, the mainstays in recovery and in staying clean and sober. As an organization, Alcoholics Anonymous (AA) clearly embraces LGBT individuals as it embraces anyone concerned about alcohol problems and has literature specifically for LGBT individuals. Although open to all, AA meetings involve a random group of people and may reflect the perceptions and prejudices of those individuals and the local community and not be supportive of openly gay members (Kus, 1989). Many communities now have LGBT-specific AA, Narcotics Anonymous (NA), and Al-Anon meetings. Many LGBT people, however, mistakenly link AA and religion and resist attending since many religious institutions denounce or condemn homosexuality. For example, because of the moral condemnation of some religious bodies, references to a higher power or God in the 12-step model may, in fact, create fear of prejudice rather than assurance of support. While AA advises same-sex sponsors, recovering LGBT individuals require some flexibility, in that same-sex sponsorship may create problems. Many times AA respects this need. In locations where they are available, counselors should consider exposing their LGBT clients to LGBT-specific 12-step meetings so that any problems or issues relating to those meetings can be addressed while the clients are in treatment.

Some groups similar to AA have formed to meet the needs of LGBT people, such as Alcoholics Together. Many large cities sponsor

“roundups”—large, 3-day weekend gatherings focused on AA, NA, lectures, workshops, and alcohol and drug-free socializing. Some LGBT people entering recovery, however, may not have come out publicly or may not feel comfortable in such meetings, especially if a discussion of sexual orientation was not part of the early recovery process.

Twelve-step programs such as AA and NA recommend avoiding emotional stress and conflicts in the first 6 months of recovery. However, for LGBT persons, the risk of a relapse may be increased if they cannot begin to work through these issues. Discussions about sexual orientation and learning to live comfortably as an LGBT person are essential for recovery, even if these topics are emotionally stressful.

On the other hand, waiting 6 months to deal with this issue may be helpful. The client will have the increased confidence that 6 months of sobriety brings as well as a clear head. Just like many other people in recovery, LGBT individuals may find some of the suggestions and guidelines of AA, NA, and some treatment programs difficult to follow. Giving up or avoiding their old friends, especially fellow LGBT substance users, may be difficult when clients have few other contacts. Staying away

from bars, parties, or circuit parties may be difficult if those are their only social outlets. The counselor may need to provide special help on how not to drink or use drugs in such settings or, better yet, help clients find social environments that support recovery. Clients will need to learn how to adjust to clean and sober socializing, without the use of alcohol or drugs to hide their social anxiety.

Many localities now have LGBT health, mental health, or community centers, almost all of them with a focus on recovery and substance abuse treatment. National organizations, such as the National Association of Lesbian and Gay Addiction Professionals, the Association of Gay and Lesbian Psychiatrists, the Gay and Lesbian Medical Association, the Association of Lesbian and Gay Psychologists, the National Association of Alcoholism and Drug Abuse Counselors’ LGBT Special Interest Group, and National Gay Social Workers, may help with appropriate referrals.

Additional things the newly sober client should learn are how to have safer sex while clean and sober, how to deal with the damaging effects of substance abuse on employment and relationships, and the adjustment to recovery couples must make that will heal the client and avoid the negative impact of codependent relationships.



### Case Example

Ruth is a 47-year-old African-American lesbian living in a large midwestern city. She is currently in an inpatient substance abuse treatment program that is gay sensitive. She has talked openly about being lesbian, and her partner of the past 25 years has been part of the treatment program.

Ruth was admitted for help with her crack cocaine use. She grew up in a very poor part of the city but had developed supports and strengths at her local Baptist church. Ruth and her mother went to regular services and many social functions, and she developed many friendships. She did well in school and liked sports. She was surprised one day in the ninth grade when she read a story about a lesbian teacher and felt a sudden awareness of sexual feelings for other women. She went home to talk about it with her mother, who said she should talk to the minister. When Ruth told him about her feelings, he became very upset, said she was an abomination before God. Although some clergy are LGBT supportive, this minister asked Ruth's mother to keep Ruth away from the church until she "recovered her senses." Ruth's mother agreed.

Very upset and confused, Ruth ran away from home. She became homeless and discovered that she could escape her feelings by using crack cocaine. To get money for food and drugs, she began to work as a streetwalker. At a special celebration for a homeless center a few years later, she met a city worker who happened to be black and lesbian. They formed an improbable relationship, and her partner brought Ruth off the streets and into a loving living arrangement. In the last 25 years, Ruth went back to school and worked as a substance abuse counselor. She has been clean and sober most of that time. She relapsed recently after her mother died and the old minister refused to let her attend the funeral in her old Baptist church.

Her lover was still supportive but was getting frustrated and angry. The lover had a history of severe depression and was treated with psychotherapy and medications; she again sought help from a therapist. That therapist convinced the lover to bring Ruth in for couples counseling. After being suspended from work for absenteeism, Ruth finally agreed. The therapist helped Ruth accept that she had relapsed and that she needed to get clean and sober. The couple's therapy work was suspended while Ruth entered an out-of-town inpatient treatment program. Ruth said she was too embarrassed to seek help locally since she might run into her fellow counselors and current or former clients.

### Suggested Interventions

This case presents a unique situation but touches on several important themes: treatment level, location, and type; racism and homophobia; mental health or emotional stresses and relapse; and religion. A counselor working with Ruth will have many challenges.

- Relapse is possible at any time. LGBT people in long-term recovery may be very embarrassed about relapsing and use that as an excuse to avoid 12-step or other interventions. LGBT substance abuse counselors may feel that they have even fewer treatment options, especially if they wish to preserve a sense of personal confidentiality. In Ruth's case, the out-of-town location may not have been necessary from a clinical point of view (that is, the treatment at a local site may have been just as good as the site chosen), but the client accepted the intervention and referral. Since getting back on the path of recovery is so important, this concession made perfect sense.
- Relapse can be triggered by many things. Though nothing like a death or a reaction to prejudice causes the substance abuse, the emotional reaction to such events may be the trigger that brings on a relapse. Ruth will have to face several emotional challenges in her early recovery, and her substance abuse counselor will need to help her pace the rate at which she confronts the issues to help her remain clean and sober. The death of her mother, the homophobia of her church, her concern about the effect of her behavior on her lover, her return to work, and revisiting her own internalized homophobia all will be part of her long-term recovery.
- Religion and spirituality may play a very important part in recovery from substance abuse for many LGBT people. If the client's church is an issue, the counselor may need to help the client find an LGBT-accepting church or a different church branch. Some organized religious groups and churches have congregations for LGBT people. Most religious groups will have some LGBT-sensitive, if not even openly LGBT, clergy who may be very helpful. Counselors will need to know the difference between religion and spirituality and help the LGBT client understand that difference. Such a client may find spiritual comfort even if he or she cannot find religious comfort.
- Psychotherapy usually does not work for substance abusers who are actively using. In Ruth and her lover's case, couples therapy would probably not have been helpful. The therapist was very aware of the need to recognize this fact and used the couple's meetings to help the lover shape an intervention, which led to Ruth beginning treatment. After Ruth is clean and sober for several months, the couple could start therapy if it is still needed. Meanwhile, the lover can continue to seek the help she needs to manage her own depression.
- Ruth herself will also need to see how much of her life has been affected by racism and homophobia. If it has not been explored in past counseling, it will need to be looked at to help shore up her recovery. In the same way that not acknowledging the effects of homophobia may make relapse more likely, so, too, will not addressing the impacts of racism.
- Since the lover is so involved in Ruth's life and recovery, she should play a role in the early recovery process. Ruth's inpatient treatment counselor will need to include her just as she would the significant other of a non-LGBT person.