

# **Best Practices Report #4:**

**Standards for Culturally Responsive Services for Sexual and Gender Variant Clients and Communities: Substance Abuse Treatment and Prevention Programs in California**

Produced by LGBT Constituency Committee and LGBT TRISTAR,  
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## **INTRODUCTION AND RATIONALE**

Substance abuse treatment agencies provide a vital service to society, helping people with alcohol, drug, tobacco, and other addictions to recover their lives. Prevention of alcohol and drug abuse saves lives, families, and communities, reduces the costs of treating chronic substance abuse problems, and reduces the prevalence of many associated problems such as HIV/AIDS, school failure, crime, and violence. As the substance abuse field matures, there is growing awareness that clients and communities are diverse, and that some personal identities are stigmatized, resulting in a great deal of “minority stress” that creates a disproportionate health burden for some communities. Minority stress refers to the additional burden laid on top of daily stressors and stems from the social invalidation, rejection, harassment, and violence experienced by many lesbian, gay, bisexual, and transgender (LGBT) individuals, as well as for some people who do not adopt these labels for themselves, but have same-sex desires or whose gender expression varies from the norm. Minority stress can stem from feeling different and alienated as a child, being rejected by family and friends, experiencing violence from peers, harassment from strangers, job discrimination from employers, and rejection or pressure to change from religious institutions, to name just a few of the traumas experienced by many LGBT people (Meyer, 2003; Eliason, Dibble, DeJoseph, & Chinn, 2008). Fortunately, the majority of LGBT individuals has strong social support and positive coping strategies, and do not resort to alcohol, drugs, or tobacco to self-medicate stress. Some, however, do succumb to substance abuse and dependence with potentially serious consequences. Most research indicates that LGBT people have higher rates of substance use and dependence/addiction than the general population (Cochran & Mays, 2000; Cochran, Mays, et al, 2007; Drabble & Trocki, 2005; Garofalo et al., 2007; Hughes et al., 2006; Mays et al., 2002; McKirnan & Peterson, 1989; Reback & Simon, 2001; Russell, 2006; Skinner & Otis, 1996; Stall et al., 2001; Xavier et al., 2007 [partial list]).

Because of the higher frequency of alcohol and drug problems in LGBT people, they may appear in substance abuse treatment programs at a higher frequency than their numbers in the general population (Cochran, Sullivan, & Mays, 2003; Copeland & Sorensen, 2001). LGBT people may also show different patterns, consequences, and triggers for use than the general population (Hughes & Eliason, 2002). In particular, internalized shame and guilt stemming from negative societal attitudes about LGBT people (also called minority stress or internalized oppression) may underlie substance abuse for many LGBT clients (Amadio, 2006).

Without standards of care and training about LGBT issues, many LGBT clients will experience the same types of harassment, discrimination, or invalidation when they access substance abuse services as they experience elsewhere in society, potentially hindering their recovery (Cochran, Peavy, & Cauce, 2007; Eliason, 2000; Eliason & Hughes, 2004). The California ADP LGBT Constituent Committee offers these standards as a starting point to improve the quality of services for LGBT clients in the state of California. The standards

outlined here are consistent with the ADP's Cultural Competency Quality Improvement Project that presents strategic goals for the state for 2008-2010.

The LGBT standards were derived from:

- a) Review of the research literature;
- b) Review of standards from other related disciplines, and from recommendations made in substance abuse treatment and prevention-related materials; and
- c) Knowledge of California substance abuse treatment and prevention systems based on clinical experience and long-term advocacy efforts by Constituency Committee members.

### **Brief History and Review of the Literature**

LGBT people have been involved in substance abuse treatment since the beginning. In 1937, the first openly gay man asked to join Dr. Bob Smith's AA group in Akron, and in 1939, Marty Mann became the first woman and first lesbian member of AA (Brown & Brown, 2001). She went on to found the National Council on Alcoholism. Californians have been leaders in the substance abuse treatment and recovery movements from the beginning. In 1965, San Francisco had two AA groups known to be mostly gay, and in 1968, the first officially recognized gay AA group in the nation started in a church on Fell St. Los Angeles had its first gay AA group in 1969, Alcoholics Together, and in 1976, the first ever national conference for gay AA members was held in San Francisco. Today there are more than 1800 LGBT AA/NA groups that meet every week in the United States (Borden, 2007).

The first study in the U.S. of alcohol use among gay populations was done in 1975 by Lillenne Fifield and colleagues through the Los Angeles Gay and Lesbian Center. Although the study was seriously flawed by relying heavily on bar patrons and bar employees as respondents, the report was widely disseminated and brought much needed attention to the problem of substance abuse in gay men and lesbians. Other research soon followed, confirming that LGBT people were more likely than the general population to have problems related to drug, alcohol, and tobacco use (e.g. Bloomfield, 1993; McKirnan & Peterson, 1989; Skinner & Otis, 1996).

In the 1980s, the HIV/AIDS crisis prompted increased funding for the study of the linkages between substance use and risky sexual behaviors, thus, much research focused on men who have sex with men (recent examples include Halikitis, et al., 2007; Stall et al., 2001). One result of this research was the conclusion that substance abuse treatment is an effective method of HIV prevention (e.g. Shoptaw & Frosch, 2000). Greater understanding of HIV/AIDS and more recently, substance abuse practices prevalent within subsets of the LGBT population, such as methamphetamine use among gay and bisexual men, have resulted in a broadening of the substance abuse treatment and prevention agendas for the state.

Considerable research has examined tobacco use among LGBT communities as well, finding rates that are about double among LGBTs compared to heterosexual individuals (e.g.

Tang et al., 2005). There is also evidence that alcohol and tobacco industries target LGBT communities (Smith et al., 2005) through use of LGBT-specific messages and images in advertising and through sponsorship of LGBT community events.

In 1992, the state of California Department of Alcohol and Drug Programs created the LGBT Constituent Committee. This committee, like the women's and community of color constituent committees advises the ADP administration on contemporary issues. In 1995, a technical assistance (TA) contract was approved to support the work of the committee and provide training and assistance to individual providers in the state around LGBT issues. The current TA contract is held by Gil Gerald and Associates under the project name of LGBT-TRISTAR. Over the years, the LGBT Constituent Committee and TA contract have conducted town hall meetings, developed position papers, and held a prevention conference (1996). In 2004, a report entitled, "Invisible Californians" was released, outlining the state of affairs for LGBT individuals with substance use disorders.

In 2007, Gil Gerald and Associates conducted a needs assessment, surveying 63 AOD providers and completing phone interviews with eight individuals. They found that:

- only 19% of agencies collect data about sexual orientation and gender identity. Cal-OMS does not include this information and only San Francisco and Los Angeles counties require this data.
- 24% of agencies do not conduct outreach or marketing to LGBT communities.
- one-third of agencies had done no service enhancements for LGBT clients in the past three years and nearly 70% had no plans to do much improvements in the next three years.
- only 8% had services specifically for gay men with methamphetamine dependence.
- most agencies had little understanding of the concept of transgender.

Are LGBT people with substance use disorders being adequately served in our state? We cannot answer this question without data, and since statewide reporting mechanisms have no questions about sexual orientation and gender identity, there is little data to assess treatment needs. Data from the California Quality of Life survey (Grella et al., 2009) reported that heterosexual men (34%) and women (50%) were more likely to seek substance abuse treatment if they needed it than were gay/bisexual men (30%) or lesbian/bisexual women (40%). However, for the subset that had both mental health and substance use disorders, 80% of gay, bisexual, and lesbian individuals sought treatment, compared to 71% of heterosexual women and 68% of heterosexual men. It appears, in California at least, that LGB people will be found in substance abuse treatment programs.

A national study of treatment programs across the United States identified that only 7% had any services tailored for LGBT populations (Cochran et al., 2007) suggesting that most LGBT people in need of treatment will seek it in mainstream programs without LGBT expertise.

We also have limited knowledge about what happens when LGBT people enter treatment. They face the same stereotypes and potential for negative treatment in substance abuse treatment facilities because of the lack of training and lack of standards for care (Cochran, Peavy, & Cauce, 2007; Eliason, 2000; Eliason & Hughes, 2004). It appears that many LGBT Californians remain invisible and underserved by the states' substance abuse treatment and prevention resources.

This brief review indicates that there is a need for standards of care for LGBT clients and communities. Having standards sets minimum criteria for agencies to meet in terms of changing the organizational climate and training staff. The rest of this document outlines those minimal standards for provision of culturally and linguistically appropriate services for LGBT individuals, beginning with a brief discussion of terminology (language).

## **Terminology**

The language used to refer to sexuality and gender is constantly changing, and preferred terms vary by age group, ethnicity, geographic region, and other factors. We acknowledge that this confusion about terminology can be disturbing, but clients are likely to appreciate substance abuse professionals' efforts to be inclusive and will help them with the appropriate terminology for their communities. We will not discuss slang, since that is the most dynamic and fluid, but will instead define the broader terms used in these standards.

**Sexual orientation.** This term refers to a person's core sexual attractions, and is thought to have a biological basis. Sexual orientation is on a continuum from exclusively attracted to people of the other sex to exclusively attracted to people of the same sex, with many points in between.

**Sexual identity.** Identities are the labels that people use to describe themselves. The sexual identities most often identified in the literature are heterosexual, lesbian, gay, and bisexual. Sexual identities may not be totally consistent with sexual orientation or behavior. For example, a woman with attractions to both men and women may label herself as a lesbian and choose not to act on the attractions to men. A man may label himself as heterosexual, yet have significant same-sex experiences. A person may be bisexual by nature (sexual orientation) but be in a committed relationship with one person, and never have a sexual relationship with someone of the other sex/gender. Some people do not use any labels, or describe their sexuality as "queer" or "fluid." Other reasons for not using labels may include ethnic or culture differences in understandings about sexuality and gender, religious beliefs, fear of losing family or children if labels are used, confusion about what label fits best, and a multitude of other factors.

**Gender identity.** This term refers to one's sense of self on the continuum of maleness and femaleness. The majority of people have a gender identity that flows from their physical bodies: male bodied persons labeling themselves as men and female-bodied persons as women. For some people, there is a lack of connection between the physical body and the psychological gender. Some of those individuals use the label of transgender or transsexual.

**Gender expression.** Everyone expresses their gender in the ways that they dress, accessorize, wear their hair, act in public, and communicate with others. When someone varies from the expected appearance or behavior from the social norms for their perceived gender, people notice and sometimes punish them for this variation. Gender expectations are strong in western societies and most people are coerced into following the stereotypes that stem from their physical bodies.

**Terms to avoid.**

The term *homosexual* is rarely used by people in the LGBT community anymore. It is the term imposed on the community by the medical establishment in the past. Lesbian, gay, bisexual, and transgender (LGBT) are terms of the communities own choosing. Within many LGBT communities and among individuals, other terms are preferred, such as "two spirit" among many American Indian individuals, "same-gender loving" among many African Americans, and "queer" among many youth.

*Sexual preference* is the phrase most often used by anti-LGBT campaigns and implies that LGBT people could change their sexuality or gender if they tried hard enough.

Any slang term should be avoided by substance abuse professionals, even if those terms are used by clients (queer, fag, dyke, punk, etc).

## **Overarching Principles**

These standards of care are based on a set of core values adopted by the LGBT Constituency Committee:

**Respect:** All clients or recipients of an agency's services are of equal value and deserve respect.

**Individuality:** Stereotypes harm all people by reducing them to some narrow set of characteristics. All clients are unique individuals. Equal access to treatment does not mean that all clients or communities have the same needs, thus may receive different services or interventions according to unique characteristics.

**Sexual health:** All clients are sexual beings and the majority of clients of any sexual orientation or gender identity have sexual issues or problems related to their substance use and abuse. Staff members in treatment agencies need training about the best ways to take a sexual history and about effective ways of discussing sexuality with clients.

**LGBT-responsive:** All agencies can and should be LGBT-responsive. This means that the agency meets the minimum standards outlined here. Some agencies may go further and provide LGBT-specific services.

**Safety:** The first concern of all clients is safety. All agencies should strive to provide physical, emotional, and spiritual safety for all clients, including LGBT clients. To feel safe, marginalized group members need to feel that they are being seen by treatment providers.

## THE STANDARDS

These standards were culled from our review of the research literature, clinical and policy experience, and review of relevant standards from other regions or disciplines, including:

- The American Psychological Association's *Guidelines for Psychotherapy with Lesbian, Gay, & Bisexual Clients* (2000).
- SAMHSA's *A provider's introduction to substance abuse treatment for lesbian, gay, bisexual, and transgender individuals* (2001).
- The Boston Department of Health's GLBT Health Access Project: *Community Standards of Practice for Provision of Quality Health Care Services for Gay, Lesbian, Bisexual, and Transgendered Clients*.
- The Gay & Lesbian Medical Association's *Guidelines for creating a welcoming environment*.
- California Department of Alcohol and Drug Programs Cultural Competency Quality Improvement Project: Goals and Objectives

### **Standard #1: Agency policies and procedures are inclusive of LGBT staff, clients, and communities.**

Background: Most agencies are heterosexist, meaning that there is no indication in their daily operations that some of the staff, clients, and communities they serve are LGBT. This erasure of a significant portion of the population is invalidating and dehumanizing. The first step an agency can take is to examine their policies and procedures for evidence that LGBT people exist and are addressed in the agency documents. This standard complies with ADP's Culturally and Linguistically Appropriate (CLAS) standards about organizational supports.

#### **Action Steps:**

1. Policies to review for inclusive language include:



- Nondiscrimination policies or human rights statements
- Client or patient rights statements
- Agency mission statements
- Employee benefits policies
- Confidentiality policies
- Sexual harassment policies

2. Recommendations about language for forms;

- Human rights/nondiscrimination and client rights policies: include “sexual orientation and gender identity” along with other protected classes such as age, sex, race/ethnicity.
- Mission statements: commitment to diversity, social justice, inclusivity.
- Benefits policies: include domestic partners for health care benefits, family leave, and other employee benefits.
- Confidentiality: include in the agency procedures manual a statement that staff members honor the confidentiality of LGBT clients and ask their permission to record information about sexuality and gender on official agency records.
- Sexual harassment: make sure that the policy is sufficiently broad to include same-sex harassment.

**Standard #2: Staff members at substance abuse treatment or prevention agencies receive LGBT basic training as part of their larger diversity training experiences, and receive appropriate supervision to provide inclusive services. Staff members who provide poor quality care are appropriately sanctioned.**

Background: We receive very little accurate information about LGBT people or issues in professional training (Eliason, 2000; Eliason et al., 2008), leaving most professionals with the same level of misinformation and stereotypes as the general population. Some people have negative attitudes about LGBT people that stem from this lack of accurate information. Others may have negative attitudes based on deeply-seated value systems, similar to the systems that sustain racism, sexism, and other forms of oppression. All individuals need to learn how to provide quality services to all clients and communities regardless of their personal beliefs. In a field where the stigma of drug abuse is such a problem, all professionals must be committed to reducing any further stigma based on sexuality, gender, age, race, class or other personal identifications. This standard is consistent with ADP’s CLAS standard about ongoing education.

**Action Steps:**

1. When the agency schedules staff training for the year, ensure that at least one program includes LGBT issues. If possible, ensure that all staff members providing direct services to clients receive basic training in LGBT issues, and that some staff members, at minimum clinical supervisors, receive more advanced training.
2. Agency policies about staff conduct should include language about the sanctions for violating the respect and dignity of clients or staff members.

***Standard #3: Written forms and documents, and oral language used in assessment and interventions are inclusive and respectful of LGBT people.***

Background: State and national standards for treatment call for culturally and linguistically appropriate services. In terms of LGBT communities, language has often been used to exclude or demonize LGBT individuals. Written documents such as client brochures, intake forms, and outreach materials, and oral language used in assessments and interventions set the tone for inclusion or exclusion. If the first ten minutes of entering the door to a treatment facility consists of filling out a form that has no place for clients to indicate their primary identities, relationships, or families, the client is likely to feel invalidated or on the defensive. If group facilitators only talk of heterosexual relationships and husbands and wives, clients in same-sex relationships may be silent if they are unsure if they are included. If staff members are overheard making jokes about LGBT people, or allow derogatory language in the dining room, the LGBT clients may feel unsafe. Words are important, and being as broadly inclusive in written and oral language of all people and communities is critical.

**Action Steps:**

1. Examine all written documents for inclusion of LGBT people and communities. Add inclusive language if it is not there.
2. Conduct peer observations of client history-taking sessions and group therapy or support to identify areas where these situations can be made more inclusive of LGBT people or communities, and discuss these issues in staff meetings, retreats, and clinical supervision sessions.
3. Confront staff members and clients who make anti-LGBT comments—these comments are unacceptable in a professional work environment.

***Standard #4: The climate of the substance abuse treatment and prevention agencies is welcoming and inclusive of all clients.***

Background: An adage in health care settings is, First, do no harm. Much of the climate of an agency is found in the language used, as noted in Standard #3. But climate goes beyond the words. Research on LGBT patients in medical settings suggests that many LGBT people are hyper-vigilant, looking for signs of acceptance (Eliason & Schope, 2001; Hitchcock & Wilson, Stevens, 1998). These signs of acceptance include magazines and pamphlets, signage, posters on the walls, the kind of books on the counselors' shelves, and the body language of staff members. Are other clients or staff members openly LGBT and accepted when they speak of LGBT issues? One of the biggest predictors of success in substance abuse treatment is related to the relationship between counselor and client (Hubble et al., 2002). If the counselor uses inappropriate language, shows exclusionary behaviors, or is visibly uncomfortable, the client may be harmed.

**Action Steps:**

1. Ask LGBT people from the local community to assist your agency to conduct a 'walk-through' of the agency to help you identify places where the environment can be more welcoming;
2. Download client education pamphlets for your reception or waiting areas (the CDC has fact sheets and brochures about men who have sex with men; the Gay and Lesbian Medical Association has patient-centered information). Have a hand-out listing local LGBT community resources, such as LGBT AA/NA meetings or LGBT community centers.
3. Post a client rights statement that includes sexual orientation and gender identity in a prominent area.
4. Subscribe to local LGBT newsletters or newspapers.
5. In client orientations to group treatment, or in new client information packets, state that derogatory language and discriminating behaviors that are disrespectful of any group of people will not be tolerated.

***Standard #5: Substance abuse treatment and prevention agencies shall create linkages with local LGBT communities and use appropriate referral sources and resources for their LGBT clients.***

Background: Different communities have different needs. Substance abuse treatment and prevention agencies need to have contacts within the local communities to best serve their clients, including linkages with communities of color, faith-based organizations, agencies that serve youth and elders, and LGBT-specific groups. LGBT community leaders might be found in

LGBT social service agencies, LGBT community centers, LGBT-specific AA, NA or other recovery support groups and networks, business owners, and a variety of other places.

### **Action Steps:**

1. Find out about your local LGBT community by asking questions such as: Are there gay bars in your city? How many? Where? Who owns them? Are there LGBT community organizations or social service agencies? LGBT AA or NA groups? What are the substance use patterns in the community? Does your agency have a reputation in the LGBT community?
2. Ask LGBT people in recovery to serve on the board of directors, be mentors/sponsors, serve on committees and task forces, help you do an LGBT community needs assessment, and generally serve as advisors and resources for your agency.
3. Advertise job openings in the LGBT local community. CLAS Standard #2 requires that "recruitment, retention, and promotion {efforts}...represent the demographic characteristics of the service area." Many LGBT communities have newspapers, newsletters, or websites where you can post job openings and other information.

### **Conclusions**

This document outlines minimal standards for providing culturally and linguistically appropriate services for LGBT clients and communities, and is consistent with ADP's commitment to diversity and provision of quality services to all Californians. Agencies that would like to exceed the minimal standards may request further training and technical assistance from the state Office of Alcohol and Drug Programs through their cultural and linguistic competency training mechanism.

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## Appendix A: Examples of Inclusive Language

### Sex/Gender

One item that has been cognitively tested with youth and found to be successful is (Scout, 2008):

Sex/Gender

- Male
- Female
- Transgender male to female
- Transgender female to male
- Transgender, do not identify exclusively as male or female
- Not sure

Other alternatives are:

Were you born male, female, or another sex?

Do you currently identify as male, female, or another identification? (Note: If you have many transgender clients in your agency, include transgender as an option, or list both male-to-female transgender and female-to-male transgender)

Are you comfortable with your gender at this time?

### Sexual Identity

The following item has undergone testing and found to be successful (Scout, 2008):      Do you

consider yourself to be:

- Heterosexual or straight
- Gay or lesbian
- Bisexual

Another alternatives is:

Do you identify as heterosexual or straight, gay, lesbian, bisexual, or another identification?



**Sexual Behavior**

Are you sexually active with women, men, both, or neither? (usually attach a time frame to this question, such as “currently,” “in the past year,” “in the past five years,” or “in your lifetime.”)

**Relationships**

Add to list of marital status: domestic partner and same-sex marriage to reflect legal relationship status. If not married, do you have any legal documents to protect your relationship that we should note in our records?

Is your partner a man, woman, or another identification?