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Delivering LGBT-sensitive substance use treatment to sexual minority women

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Abstract

Epidemiologic studies have consistently found elevated rates of alcohol and other substance use among sexual minority women (SMW), and despite calls for “LGBT-specific” services and culturally-tailored interventions, few such services exist. This study involved qualitative interviews with directors from substance use treatment programs (N=10) about how they addressed the needs of SMW. Strategies implemented primarily focused on creating a safe and welcoming environment for sexual minority clients. Findings highlight challenges involved in meeting the treatment needs of SMW and provide guidance to researchers and service providers on how to improve the quality of care for them.

Keywords

lesbian; sexual minority women; substance use treatment; cultural sensitivity

A growing body of research from large-scale epidemiologic studies has found that sexual minority women (SMW; e.g., lesbian, gay, bisexual women) may be at heightened risk for hazardous drinking and alcohol-related problems (Drabble, Midanik, & Trocki, 2005; Drabble, Trocki, Hughes, Korcha, & Lown, 2013) as well as drug use (Cochran & Cauce, 2006; Operario et al., 2015; Trocki, Drabble, & Midanik, 2009) and substance use disorders

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(Cochran, Ackerman, Mays, & Ross, 2004). For instance, using data from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), McCabe and colleagues (2009) found that for lifetime alcohol dependence, lifetime drug dependence, and lifetime dependence on any substance, odds of meeting criteria for these disorders were 2–3 times greater for SMW compared to non-sexual minority women. The increased odds generally held regardless of how sexual orientation was measured (i.e., by identity, attraction, or behavior).

A variety of factors have been posited to increase risk for and co-occur with substance use disorders within this population. Minority stress is generally defined as excess stress to which individuals from stigmatized social categories are exposed as a result of their social position (Meyer, 2003). Distal and proximal social stressors may include prejudice, discrimination, interpersonal violence, internalized stigma, and anticipation of maltreatment (Institute of Medicine, 2011), experiences found to be more commonly reported among sexual minorities than heterosexuals (Mays & Cochran, 2001). Further, among SMW, substance use disorders often co-occur with a host of other enmeshed and mutually reinforcing health conditions that increase the complexity of substance use disorders and represent a larger public health syndemic (Coulter, Kinsky, Herrick, Stall, & Bauermeister, 2015; Singer, 2009). Compared to heterosexual counterparts, SMW have been found to be at increased risk for victimization and mental health problems (Cochran, Sullivan, & Mays, 2003; Drabble et al., 2013; Hughes, McCabe, Wilsnack, West, & Boyd, 2010; Kerridge et al., 2017; Mereish, Lee, Gamarel, Zaller, & Operario, 2015; Wilsnack, Kristjanson, Hughes, & Benson, 2012) as well as other conditions that increase risk for health problems like cigarette smoking (Fallin, Goodin, Lee, & Bennett, 2015; Gruskin, Greenwood, Matevia, Pollack, & Bye, 2007; Trocki et al., 2009; Ward, Dahlhamer, Galinsky, & Joestl, 2014) and obesity (Boehmer, Bowen, & Bauer, 2007; Bowen, Balsam, & Ender, 2008; Struble, Lindley, Montgomery, Hardin, & Burcin, 2010).

The increased prevalence of hazardous drinking and other substance disorders among SMW increases the importance of accessing substance use treatment that can effectively address the complexity of their service needs. Studies that have examined help-seeking among SMW have found that they are more likely to access treatment than heterosexual women (Drabble et al., 2005)—differences that persist even after adjusting for factors that may increase the likelihood of accessing services (Cochran et al., 2003; McCabe, West, Hughes, & Boyd, 2013). However, studies examining their experiences in treatment have documented a number of shortcomings in the quality of care received. For instance, Matthews and colleagues (Matthews, Selvidge, & Fisher, 2005) found that sexual minorities reported that their addiction counselors engaged in supportive and otherwise LGBT-affirmative behavior with them only some of the time, and Senreich (Senreich, 2009) found that sexual minorities reported lower levels of connection and satisfaction with their substance use treatment than did heterosexuals. Studies have also documented gaps in counselor education regarding the experiences of sexual minorities and negative or ambivalent attitudes held by substance use counselors (Cochran, Peavy, & Cauce, 2007; Eliason, J., 2000; Eliason & Hughes, 2004).

Studies on outcomes of sexual minorities in substance use treatment relative to heterosexuals are notably lacking, particularly pertaining to sexual minority women (Green & Feinstein,

2012). One study using data collected from entrants to publicly-funded treatment programs between 1992–1997 in the National Treatment Improvement Evaluation Study found that there was no main effect for sexual minority status on outcomes after all other individual, organizational, and social and health service variables were controlled. However, several interactive effects between sexual orientation and service use were found, suggesting that the kinds of services received while in treatment may differentially effect outcomes depending on sexual orientation (Hardesty, Cao, Shin, Andrews, & Marsh, 2012).

To better address the needs of sexual minority clients, there have been calls for LGBT-specific substance use treatment services (Hicks, 2000; Stevens, 2012) as well as culturally-tailored or culturally-adapted interventions (Talley, 2013). LGBT-specific services generally refer to special groups or programs for members or segments of the LGBT community. While there are examples of such (Rowan & Faul, 2011), Cochran et al. (Cochran, Peavy, & Robohm, 2007) found that only 12% of treatment programs in the US listed in the SAMSHA National Directory of Drug and Alcohol Abuse Treatment Programs in 2003 reported that they offered specialized services for LGBT clients. When researchers contacted these programs, only 7% of them, representing 62 programs within the US, could identify a service specifically for LGBT clients. Another approach to meeting the needs of sexual minorities accessing treatment is through the delivery of culturally-tailored/adapted interventions. Culturally-tailored/adapted interventions deliver empirically supported treatments to a target population but modify materials and messages to observable characteristics of the population or alter the intervention to specifically address how cultural, social, psychological, environmental, and historical factors may influence substance use (Resnicow, Soler, Braithwaite, Ahluwalia, & Butler, 2000; Talley, 2013). As mentioned previously, few studies have examined outcomes of sexual minorities, particularly among SMW, and limitations of extant research prevent conclusions about the relative impact of LGBT-specific or adapted interventions for sexual minorities (Green & Feinstein, 2012).

Concurrent with efforts to better define and investigate specialized services/programs or culturally-tailored/adapted interventions, there have been growing calls to enhance LGBT cultural competence among substance use treatment providers (Stevens, 2012; Taliaferro, Lutz, Moore, & Scipien, 2014). Cultural competence with respect to meeting the treatment needs of sexual minorities speaks to addressing treatment providers' attitudes, knowledge, and skills as well as creating a culturally competent clinical environment more generally (Boroughs, Bedoya, O'Cleirigh, & Safren, 2015; Van Den Bergh & Crisp, 2004; Wilkerson, Rybicki, Barber, & Smolenski, 2011). These efforts have been advanced through materials developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) to identify guiding principles of recovery (Substance Abuse and Mental Health Services Administration, 2012) and to raise awareness among substance use treatment providers about treatment needs unique to LGBT clients (Center for Substance Abuse Treatment, 2012). These efforts are also reflected in the broader definition of culture in the enhanced Culturally and Linguistically Appropriate Services (CLAS) Standards which specifically identify gender identity and sexual orientation as cultural elements relevant to the Standards (Office of Minority Health, 2013).

Despite significant gains in knowledge regarding the treatment needs of SMW and calls to improve substance use treatment experiences for them, it is unclear how these efforts have altered the practices of treatment providers. To help in better addressing the needs of SMW, particularly with respect to hazardous and harmful drinking, the aim of this qualitative study was to describe strategies used by substance use treatment programs to address the needs of SMW. Qualitative techniques can provide insight that is not available through quantitative techniques primarily because they can provide rich and detailed descriptions of phenomena being studied as well as participants' perceptions of the phenomena simultaneously (Becker, 1996; Denzin & Lincoln, 2000). These techniques may be particularly useful in studying organizations, like treatment programs, because they can gather nuanced information on aspects of organization behavior and policies as well as broader information on organizational culture. Moreover, qualitative data collection techniques are well accepted in organizational settings because "most people like talking about their work – whether to share enthusiasm or to air complaints – but rarely have the opportunity to do so with interested outsiders" (King, 2004, p.21).

Method

Sampling and Recruitment

This study was conducted in Northern California from 2016–2017 and recruited a random sample of representatives from substance abuse treatment programs (N=10) using the SAMHSA Treatment Locator. Programs were considered eligible for the study if they were: (1) located in one of nine San Francisco Bay Area Counties; (2) indicated they were a substance use facility that provided substance use treatment; (3) served adult female clients; (4) reported offering special groups or programming specifically tailored for LGBT clients. Of the 412 facilities in the nine San Francisco Bay Area counties, 155 facilities had a primary focus of substance use services and provided substance use treatment. A total of 133 of these served female clients, and only 25 of these programs reported offering a program or group specifically tailored for LGBT clients. To reach our target sample of 10 programs, we needed to randomly sample 16 programs. Directors of 4 programs declined participation (too busy, uninterested). One sampled program no longer treated female clients and another sampled program was determined to be ineligible because the director had been interviewed for a sibling program. It should also be noted that one sampled program was replaced with a sibling program (that was not part of the 25 but was actively trying to develop LGBT-specific programming) because the sampled program only treated adolescents. Representatives from sampled programs provided verbal informed consent and received \$30 for their participation.

Data Collection Procedures

Interviews with program representatives were conducted in person at the program facility. In one program, both the Program Director and Clinical Supervisor participated in the interview. These interviews were audio-recorded and generally lasted 40–60 minutes. The semi-structured interview guide covered topics pertaining to the nature of services provided at the program, the treatment needs of SMW accessing services at the program, and services provided to address those needs. Representatives were also asked obstacles encountered in

meeting the needs of SMW and what they viewed as most helpful in providing treatment that was responsive to the needs of SMW.

Data Analyses

Audio recordings were professionally transcribed verbatim according to pre-determined conventions (O'Connell & Kowal, 1999) and information that might identify participants was redacted. Further, all transcripts were independently reviewed for accuracy by project staff. Transcripts were analyzed using the framework approach (Ritchie, Spencer, & O'Connor, 2003). Closely related to thematic (Braun & Clarke, 2006) and qualitative content analysis (Morgan, 1993), the framework approach involves a series of interconnected stages that allows for a constant refinement of themes facilitating the development of robust conceptual frameworks (Gale, Heath, Cameron, Rashid, & Redwood, 2013; Smith & Firth, 2011). Initial codes were developed from the topic areas addressed in the interview guide, and coding subcategories were created through discussions with study team members about the nature of participant responses. Transcripts were independently coded by two team members, and any discrepancies were discussed until consensus was achieved. NVivo software (QSR International, 2015) was used to organize transcripts for coding, to facilitate retrieval of coded passages to refine and illustrate common themes, and to tally both how often a particular theme was mentioned and the number of different speakers who mentioned each theme. Passages used to exemplify themes were identified by participant identification number to track the representation of as many participants as possible.

Results

Table 1 displays the characteristics of the substance use treatment programs and treatment program representatives recruited into the study. Half of the ten programs provided residential treatment, four provided outpatient treatment, and one provided residential treatment with outpatient aftercare. Of the eleven representatives who participated in interviews, the majority were female (82%); five could be characterized as a director of the program, five could be characterized as director of the clinical services provided, and one was a senior counselor who was involved in programming for segments of the LGBT population.

Although programs were recruited into the study because they were listed as offering special groups or programming specifically tailored for LGBT clients in the SAMHSA Treatment Locator, only two programs offered LGBT-specific groups, and these groups were not specific to sexual minority women. However, all programs employed a variety of strategies to address the needs of their SMW clients, with most of these strategies focused on creating a safe and supportive environment for sexual minority clients. Program representatives also described factors that they saw as critical to being able to provide this care, such as these strategies being congruent with their overall treatment philosophy and supported throughout the organizations, as well as barriers to providing LGBT-specific services.

Setting the stage.

Representatives from five programs talked about ways in which they structured the physical environment to be non-stigmatizing and welcoming to their sexual minority clients. These strategies ranged from more generic ones like ensuring that the “environment does not reek of the downside of drug use” (Program 1013) to intentionally displaying signals to acknowledge the LGBT community. As one program representative described, “it’s funny because there’s little hints all over, that unless you are looking for them, you don’t know. But queer folks will see it, and they are like, ‘Okay, cool.’” She continued to add that her program did this to affirm that “This is a safe place for you to explore what you need to explore, and we want to walk with you through your journey” (Program 1018). Programs also talked about other things they did to accommodate sexual minorities, particularly transgender clients. As one representative noted, “We don’t have men and women’s restrooms here. We have people restrooms and whatever restroom is open, you are welcome to use it” (Program 1014).

Staffing and training.

Representatives from all programs talked about the importance of staffing to meet the needs of sexual minority clients. This included ensuring that the diversity in their clientele was reflected in the diversity of their staffing. As one representative from a program that did have a specialized group recounted, “...even though I am [the] Director, the reason I am doing the LGBT group is because I am the one gay person who can be there at the time the group is” (Program 1002). Program representatives also talked about ensuring that their staff had the skills and training necessary to provide treatment to sexual minorities. One program representative noted that “Registration is not enough. Certification is a mandate” (Program 1013). Another representative described that “We have a CVS training, which is culture, values, and safety, and so everybody is orientated to this. It’s one of the main sort of pieces when people come into our agency. They come from lots of other places, and they might have learned different things or have different ideas about AOD [alcohol and other drug treatment]” (Program 1001).

Creating a LGBT-affirmative environment.

Representatives from all programs also talked about what they did to ensure their sexual minority clients felt supported in their program, particularly during the intake/assessment and treatment planning stages of treatment to, as one program representative noted, “understand our clients so we can best support them” (Program 1019). As one program representative explained, “Part of the intake process is [that] we do ask about gender identification and sexual preference,” and added that, “It’s not anything that’s judged. It’s simply a matter of understanding you and your needs and who you are as a unique individual, and it’s just part of information gathering for the intake process” (Program 1011). Program representatives also talked about how they used this information to ensure that their program addressed these needs. As one representative commented, “...if we have a transwomen, and she identifies that way, that’s where she is gonna sleep, that’s who she tells us who she is, that’s what we are gonna call her. We don’t care whatever else we have on a paper that says this, that, and the other...” (Program 1014). Programs also talked about other

ways in which they endeavored to address client needs. As one representative explained, “So one thing we do have is the ability to provide the patients with the clinician profile that they are hoping for. So we do ask the question, ‘do you have any preferences?’ and if people say, ‘I would like a lesbian clinician’ or ‘I want a gay male therapist,’ then we do that” (Program 1016).

Referral and linkage.

Six program representatives discussed addressing the needs of their SMW clients through referrals and linkages to outside programs. As one representative noted about his program which encourages residents to attend outside 12-step meetings, “I will introduce them to an LGBT meeting myself, so that they can get a sponsor” (1005). A representative from another program explained that, “...we are not the ‘know all, do all.’ I think that’s really the important thing ‘cause some people want to know it all and do it all. We can’t do that, but we can offer the safe place, and we can continue to maintain the working relationships with those other community providers, you know, as a safe residential treatment program for LGBT and transwomen. We can do that” (Program 1014). It should be noted that having access to outside resources to address the needs of sexual minority clients as well as a more diverse staff recruiting pool and greater awareness of the importance of addressing the needs sexual minorities was seen as being facilitated by operating in the Bay Area. As one representative noted “...because we are in the Bay Area, because we have got a significant number of gay staff...I think there is a lot of familiarity with gay people, so I think it’s demystified” (Program 1002).

Treatment Philosophy.

Only two of the sampled program offered LGBT-specific groups. However, many programs recognized the importance of having specialized groups to facilitate safety and support because “what happens for the lesbian, the bisexual, the person who is questioning is very different than the person who is heterosexual and has never questioned themselves” (Program 1001), and all programs described strategies they used to address the needs of their sexual minority clients. Yet some program representatives insisted that “We treat them just like everybody else” (Program 1012). While this sentiment, in part, reflected ensuring that sexual minorities were not in any way stigmatized or treated unfairly, this sentiment also reflected overarching commitments to treatment approaches and philosophies that were seen as consonant with these strategies and therapeutic for all clients. For example, in talking about how their program operating as a therapeutic community (TC) ensured that sexual minorities accessed the care they needed, one representative noted, “it’s that thing about one-stop shopping at a TC. You can cover it all, or you’re not a TC” (Program 1005). Programs that were grounded in culturally-informed and transformational healing approaches or that operated with gender-responsive and trauma-informed approaches, particularly in residential settings, talked about ensuring that sexual minorities were “not feeling shamed or embarrassed” (Program 1011) and ensuring that they felt like a member of a family and part of a community. As a representative from one program put it, “...we welcome people within the community, within the family. Everybody is welcome. We are just friendly” (Program 1018). A representative from an outpatient program expressed a similar sentiment about the environment fostered within their program. As this

representative put it, “I respect your difference. I honor and respect your need. If I missed anything, I need you to feel empowered enough to respectfully tell me what I missed. And you have every right to expect me to respectfully capitulate or adjust, adapt. I ask you to give me benefit of the doubt. I’m working with you and not against you. That’s the level of user-friendliness that we lead with here. Whether our population core is female LGBT, or whether they are gay transgender men, or whether they are straight up gay, male, or female” (Program 1013).

Organizational commitment.

Not only were strategies implemented to address the needs of SMW described as being consonant with overall treatment approaches and philosophies, these strategies were seen as being supported at the organizational level as well. Representatives from nine programs discussed this. With respect to ensuring diversity in staffing, one representative noted that, “It’s a number one value here. It’s diversity and that happens from the CEO to the staff, and so it’s just really important” (Program 1014). Representatives also discussed organizational commitment with respect to cultural competency trainings: “...our model is practice from bottom to top and back. So from the person that’s doing maintenance to our counselors to admin to our board members, everyone gets the training” (Program 1018). This commitment also applied to trouble-shooting and problem-solving. As a representative from one program noted, “...there is a trust in management where you can have the hard conversations that might be uncomfortable, and we might not get an answer today, but we’ll at least kick it around and try and figure something out. So I think that’s key.” This representative added that “... we want to serve, we want to serve the LGBT community. And when I say serve, not just take them in, but really give them some quality program” (Program 1001).

Lingering Barriers.

Although programs were implementing a variety of strategies to address the needs of SMW clients and discussed organizational commitment to doing so, representatives from six programs discussed barriers to better addressing the needs of SMW who entered their programs. Representatives from five programs noted that having limited numbers of SMW at any one time prevented them from providing services that might be specifically tailored to this segment of the LGBT community. As a representative from one program explained, “...if we were serving more of the population--with two or three or more clients, we would definitely have a group specialized for them if it would help them to feel more welcome and serve them better” (Program 1019). Funding for additional staff, group-room space, and specialized training were also discussed by representatives from five programs as barriers to better addressing the needs of SMW. For example, a representative from one program explained that, “I think would be nice if I had a sexual minority staff member...But I don’t expect that to happen with our money” (Program 1005). A representative from another programs talked about “dynamic tension between the core services and having a specialty resource” (Program 1002) and how specialty services are often dependent upon having staff available to deliver them without taking away from other services currently being provided.

Discussion

This study sought to describe the strategies used by substance use treatment programs to address the needs of SMW clients. These strategies focused on creating a safe and welcoming environment by structuring the physical setting to project inclusivity, staffing the program to affirm diversity, individualizing treatment planning to address the specific needs of clients with services provided at or outside the program--all strategies found to be essential to creating a culturally competent environment for sexual minority clients (Rowan & Faul, 2011; Wilkerson et al., 2011) and reflected in SAMHSA's guiding principles of recovery (Substance Abuse and Mental Health Services Administration, 2012) and the enhanced CLAS Standards (Office of Minority Health, 2013). It should be noted that programs in this study included both residential and outpatient facilities and representatives described a range of different treatment philosophies and approaches. However, these strategies were seen as congruent with these philosophies and approaches and were reinforced throughout the organization, suggesting that what is beneficial for SMW clients is universally valued and beneficial for all clients.

Representatives from the recruited programs also noted a number of critical barriers to addressing the needs of their SMW clients. These barriers included having limited numbers of SMW clients in their programs at any one time, which prevented them from providing specialized groups. They also cited funding for such services and staff to deliver them. Taken together, these findings highlight progress made to increase awareness about the importance of addressing the unique treatment needs of SMW and underscore ongoing challenges in doing so. This "mixed bag" nature of findings is not dissimilar to those found regarding the evolution and current state of LGBT-specific health services in the US. In their survey of LGBT community health centers, Martos and colleagues (Martos, Wilson, & Meyer, 2017) identified over 200, but also found that they were concentrated within urban hubs and coastal states and entirely absent in 13 states.

In recent years, a number of advances have been made with respect to both defining (Boroughs et al., 2015) and measuring cultural competence with sexual minority clients (Crisp, 2006). However, efforts to define components (Shelton, 2016; The Joint Commission, 2010) and delineate a spectrum of LGBT-sensitive treatment (Neisen, 1997) have not crystalized into a measure of organizational LGBT cultural competence. Shelton's Treatment Agency Audit (Shelton, 2016, pp287–291.) provides a useful framework to develop such a measure, which could be used to assess the effects of trainings and policies to enhance LGBT-sensitivity. Studies examining the substance use treatment outcomes among sexual minorities, particularly among SMW, are woefully lacking. However, a measure of organizational LGBT cultural competence included in studies examining the outcomes of SMW accessing treatment could be used to validate the value of LBGT cultural competence and identify aspects of cultural competence critical to favorable outcomes.

A number of key limitations should be noted with respect to the generalizability of our findings. Most prominently, treatment programs were recruited from the San Francisco Bay Area—an area with high concentrations of individuals identifying as LGBT (Newport & Gates, 2015) and with a long history of advocacy for LGBT rights (Lipsky, 2006). However,

the greater prevalence of sexual minorities combined with greater awareness of their needs make our findings of continued challenges even more pressing for other regions of the country. Finally, we only conducted interviews with a random sample of ten substance use treatment programs. On the basis of the interviews conducted, however, our findings indicate that we reached theoretical, thematic, as well as data saturation (Saunders et al., 2017). Moreover, our ten programs represent a randomly sampled 40% of the universe of programs in the San Francisco Bay Area meeting study criteria.

Conclusions

Epidemiologic studies have consistently found elevated rates of alcohol and other substance use among SMW and, although studies have also found that they are more likely than their heterosexual counterparts to access substance use treatment, they often present in treatment with unique challenges and additional service needs. Despite calls for “LGBT-specific” services and culturally-tailored interventions, few such services exist. Significant advances have been made in defining LGBT cultural competence, but this study illustrates that challenges to providing LGBT-sensitive treatment to SMW remain. Measures of organizational LGBT competence are needed to assess the effects of trainings and policies to enhance LGBT-sensitivity. Such measures used in studies examining the outcomes of SMW in substance use treatment could be used to validate the value of LGBT cultural competence and identify aspects of cultural competence critical to favorable outcomes.

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Table 1.**Sample Characteristics**

	n	%
Treatment Programs (N=10)		
Modality		
Residential	5	50%
Outpatient	4	40%
Residential & Outpatient	1	10%
Currently Provided an LGBT-specific Group	2	20%
Staff Member Position (N=11)		
Program Director/Executive Director/CEO	5	45%
Medical Director/Clinical Supervisor	5	45%
Counselor	1	9%
Staff Member Gender (N=11)		
Male	2	18%
Female	9	82%