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Meeting the Needs of Lesbian, Gay, and Bisexual Clients in Substance Abuse Treatment

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Rates of substance misuse and disorder remain much higher among lesbian, gay, and bisexual (LGB) individuals relative to heterosexual individuals (McCabe, Hughes, Bostwick, West, & Boyd, 2009). LGB individuals also experience higher rates of minority-based mistreatment, such as discrimination and victimization, compared to heterosexual individuals. Discrimination (McCabe, Bostwick, Hughes, West, & Boyd, 2010) and victimization (Hughes, McCabe, Wilsnack, West, & Boyd, 2010) have been shown to be related to higher rates of substance use among LGB individuals and may account for the poorer and physical health outcomes observed among LGB individuals (Dilley, Simmons, Boysun, Pizacani, & Stark, 2010).

While substance abuse treatment remains an important tactic for reducing substance use and related impairment, it is important to consider factors that could impact whether or not LGB individuals benefit from these services. For instance, LGB individuals may encounter negative LGB bias from providers within substance abuse treatment settings (Cochran, Peavy, & Cauce, 2007). They may also seek out services at a treatment center advertising LGB specific services, only to find that no such services exist (Cochran, Peavy, & Robohm, 2007). LGB individuals are also less likely to carry adequate health care coverage relative to heterosexual individuals (Buchmueller & Carpenter, 2010), which may serve as a barrier to accessing treatment or following treatment recommendations for extended care services.

Despite these potential barriers, studies have shown that LGB individuals are more likely to seek substance abuse treatment compared to heterosexual individuals (McCabe, West, Hughes, & Boyd, 2013). Past research also indicates that LGB individuals seeking substance use treatment have higher rates of co-occurring mental health diagnoses (Lipsky et al., 2012), greater substance use severity, and past-year use of medical services (Cochran & Cauce, 2006), when compared to heterosexual individuals. Programs and providers can provide better services for LGB individuals if they are more aware of the specific mental and

physical health needs of LGB individuals seeking substance use treatment, and understand best practices when it comes to meeting the needs of LGB clients. Thus, further work is needed to understand the unique health care needs of LGB individuals seeking substance use treatment. So far this research had been limited to the state of Washington, where sexual orientation data was collected as part of state database requirements (Cochran & Cauce, 2006).

The Study

The goal of our study was to identify differences in mental and physical health care needs between LGB and heterosexual individuals in substance abuse treatment. We did so by examining records collected within a publicly-funded substance abuse treatment system in San Francisco. Based on previous research, we expected that LGB individuals would have higher rates of mental and physical health problems, and would be using mental and physical health services at greater rates than heterosexual individuals.

Data for this study were released to us by the Department of Public Health in the County of San Francisco. We used deidentified patient admission and discharge information for patients served between 2007–2009 from all substance abuse treatment programs in the county that received any government funding. A single treatment episode was selected for each patient, and could include multiple types of treatment including residential, detox or outpatient treatment. Clients included in the current study were those who provided information regarding sex (i.e., male or female) and sexual orientation. People who reported transgender identity were not included in this study, though data on transgender individuals are reported in a separate study (Flentje, Heck, & Sorensen, 2014). We examined the substance use patterns of the LGB individuals within this same sample in Flentje, Heck, & Sorensen (2015), as well as in the original article where we published the results reported here.

Substance abuse treatment programs provided client admission data to the County of San Francisco where it was compiled. Upon admission, clients entering substance abuse treatment were asked about substance use, mental health, and physical health. Specifically, they were asked if they

- Had a prior mental health diagnosis
- Had taken prescribed medication for mental health
- Were receiving mental health treatment
- Had a recent mental health assessment
- Had been in a hospital or psychiatric facility for mental health
- Experienced physical health problems
- Were receiving physical health care
- Had a recent physical health assessment

- Had gone to the emergency room (ER)
- Stayed in the hospital overnight for a physical health problem

We made our comparisons separately for men and women, comparing gay, lesbian, and bisexual individuals (considered as separate groups) to heterosexual individuals. We used logistic regression, and covaried age, race, and ethnicity, and reported statistically significant differences for analyses where $p < .01$.

Participants

In all, 13,211 participants were included in our study. Participants were 38.10 years old on average ($SD=13.48$), and over 90 percent of participants were age eighteen or older. Of the 9,330 male participants, 8,318 identified as heterosexual, 797 identified as gay, and 215 identified as bisexual. Among the 3,881 female participants, 3,452 identified as heterosexual, 156 identified as lesbian, and 273 identified as bisexual. The sample was racially diverse: 37 percent African American, 36 percent Caucasian, 16 percent “other race,” 6 percent Asian American/Pacific Islander, 5 percent “multiple races,” and 1 percent Native American/Alaskan Native race; with 18 percent of the sample reporting Hispanic/Latino ethnicity (Flentje, Heck, et al., 2015).

Results

LGB men and women reported higher rates of mental health diagnoses and current mental health prescription medications compared to heterosexual clients. Specifically, 65 percent of gay men and 61 percent of bisexual men reported mental health diagnoses, while only 27 percent of heterosexual men had a prior mental health diagnosis. Among women, 51 percent of lesbian women and 56 percent of bisexual women had prior mental health diagnoses, while only 38 percent of heterosexual women reported having a mental health diagnosis. For men, 49 percent of gay men and 36 percent of bisexual men were taking prescribed medications for mental health, while only 14 percent of heterosexual men were taking these medications. Among women, 33 percent of lesbian women and 32 percent of bisexual women were taking mental health medications, while only 22 percent of heterosexual women were taking these medications.

Gay and bisexual men and bisexual women were more likely to be receiving mental health treatment; there were no differences between lesbian women and heterosexual women. Further, gay men and bisexual women were more likely than heterosexual men and women, respectively, to have undergone a recent mental health assessment. Lastly, gay men were more likely than heterosexual men to have recently been in a psychiatric hospital or facility.

Physical Health Problems and Service Utilization

Gay men were more likely than heterosexual men to report physical health problems in the previous thirty days (32 percent versus 22 percent), but this difference was not evident for bisexual men. Bisexual women were more likely than heterosexual women to report physical health problems (31 percent versus 24 percent), but there was no difference between lesbian

and heterosexual women. Gay and bisexual men and bisexual women were more likely than heterosexual counterparts to be receiving health care, but there were no differences observed between lesbian and heterosexual women. Seventy percent of gay men and 58 percent of bisexual men were receiving health care, compared to 34 percent of heterosexual men. Fifty four percent of bisexual women reported receiving health care compared to 43 percent of heterosexual women. Gay men were more likely to report a recent physical health assessment, but there were no differences between bisexual men, lesbian women or bisexual women when compared to heterosexual counterparts. LGB status was not predictive of ER visits nor hospital stays among males or females.

Discussion and Recommendations

In this study we found that sexual orientation is a predictor of mental and physical health status, and that important mental and physical health disparities exist among LGB individuals in substance abuse treatment. LGB individuals experienced higher rates of previous mental health diagnoses and more LGB individuals reported taking psychiatric medications. In addition, gay and bisexual men and bisexual women were more likely to also be receiving mental health treatment. Our findings suggest that LGB individuals would benefit from both continuity of care within substance abuse treatment, and treatment that is responsive to the co-occurring mental health needs.

More than half of all lesbian and bisexual women entered treatment with a mental health diagnosis, highlighting the importance of attending to co-occurring mental health within this population. The rates of previous mental health disorders among gay and bisexual men were also notable, as nearly two-thirds of gay and bisexual men entered treatment with a mental health diagnosis. The need for treatment addressing both substance use and co-occurring disorders is therefore extremely relevant for one-half to two-thirds of LGB people seeking substance abuse treatment services, and is an imperative and not a complementary service among this population.

Gay men and bisexual women reported more recent physical health problems compared to heterosexual individuals. Gay and bisexual men and bisexual women were more likely to be receiving health care, but only gay men were more likely to have had a recent physical health assessment. This suggests that physical health care continuity may need increased attention for this treatment population.

In contrast to previous research (Cochran & Cauce, 2006), LGB individuals seeking substance abuse treatment did not report higher rates of recent ER visits or hospital overnight stays. It is possible that substance-use-treatment-seeking individuals in San Francisco are at higher risk for ER visits (which ranged from 10 to 14.5 percent of participants across all sexual orientations) and hospital overnight stays (which ranged from 3.3 to 7.7 percent of participants across sexual orientations) overall, irrespective of sexual orientation. It could also reflect that within San Francisco, it may be easier for LGB individuals to access other health care services, thus circumventing the need for emergency department use in order to access regular health care.

Finally, we found higher rates of mental health treatment utilization among all LGB groups, with the exception of lesbian women. This is consistent with previous research documenting treatment utilization among LGB individuals in general (Grella, Greenwell, Mays, & Cochran, 2009). It is unknown if access to mental health care is easier for LGB individuals within California. However, it is possible that within San Francisco, an area with a track record for the moving forward the gay rights movement (Armstrong, 2002), disclosure and barriers to access to care are removed or greatly reduced for LGB individuals. Providers working in other locations should consider barriers to seeking care among LGB individuals, and whether access to mental health care is feasible within their locations. Regarding barriers to care, research has shown that lesbian and bisexual women who disclose their sexual orientation report greater satisfaction with their providers (Mosack, Brouwer, & Petroll, 2013) and are more likely to utilize health care services (Bergeron & Senn, 2003) compared to those for whom sexual orientation remains undisclosed. Decisions about whether or not to disclose are linked to openness and individuals' comfort level with their providers (Bergeron & Senn, 2003) and, as such, is something that can be fostered within client-provider interactions.

Recommendations for Care

The differences in mental and physical health in our study suggest that additional screening, training, outreach, and integration of health care services are warranted in order to meet the needs of LGB individuals in substance use treatment. Given the disparities reported here, it is essential that providers offer services that are inclusive of LGB individuals, and that services are provided in a manner that is affirming of LGB individuals and responsive of their unique health care needs. Consistent with this imperative, the following recommendations are provided.

Assess for Sexual Orientation at Intake

We recommend that providers inquire about their clients' sexual orientation during the intake process (Heck, Flentje, & Cochran, 2013). This may reduce the likelihood of encountering uncomfortable misunderstandings early on, such as misidentifying the gender of a clients' romantic partner. Questions about sexual orientation should be included on intake paperwork, though it is recommended that multiple options are provided to clients on intake paperwork (e.g., lesbian, gay, bisexual, something else), or that paperwork includes an open-response option to allow patients to write in their sexual orientation (Bradford, Cahill, Grasso, & Makadon, 2012).

Asking about sexual orientation should be accomplished in a manner that facilitates healthy and supportive provider-client dialogue (Mosack et al., 2013). That is, providers who query about sexual orientation in person should remain sensitive to the needs of clients, and do so from a place of affirmation and respect for clients' sexual orientation, presenting concerns, and other intersecting identity statuses (SAMHSA, 2012)—for example, their roles as employees, students, parents, children, and other aspects of their identity, such as race, ethnicity or gender. In other words, providers working with LGB individuals should maintain an appreciation for the unique needs of LGB clients while avoiding the pitfall of

reducing them to their sexual orientation, stereotyping, or over-/underemphasizing the role of sexuality in one's conceptualization and treatment plan. For example, providers should not confuse LGB orientation with pathology, or infer the presence of pathology given an LGB client's sexual orientation.

As suggested by the results of this study, providers should practice good judgment while working with LGB clients in order to gather relevant health information while maintaining respect for the people sitting across from them. Providers working with LGB individuals should also remain mindful of the possibility that they have not had their health care needs met sufficiently in the past, and might have experienced minority stress within substance use treatment settings (Cochran, Peavy, & Robohm, 2007). Providers who are aware of this are better poised to provide a corrective health care experience for LGB clients, which might promote treatment adherence and positive treatment outcomes. Providers who are trained to have competency in working with LGB individuals and communities may be better prepared to assess clients in an affirmative manner.

Train Staff and Counselors

There are many ways that providers can increase their competency in working with LGB clients. Free training options include on-demand webinars through the Fenway Institute, and reasonably priced Continuing Education credit options through organizations such as the National Association of Social Workers or American Psychological Association. There are also numerous print resources for providers interested in learning more about working with LGB clients, including a manual from SAMHSA on providing substance abuse treatment for lesbian, gay, bisexual, and transgender individuals, which is free and available online (SAMHSA, 2012).

Counselors may also benefit from familiarizing themselves with guidelines provided through counselor and psychological organizations. Providers are also encouraged to familiarize themselves with training opportunities offered through local LGB advocacy organizations and academic institutions. Important learning objectives may include distinguishing between sexual orientation, gender, and gender expression (SAMHSA, 2012); the effects of minority stress on LGB individuals' health and treatment outcomes; and approaching care with an LGB-affirmative stance in order to maximize therapeutic gains and minimize the likelihood of contributing to minority stress and associated mental and physical health consequences.

Create an Inclusive and Affirming Treatment Environment

Creating an inclusive treatment environment might include having brochures, magazines or literature that is relevant to LGB individuals in lobbies and waiting areas (SAMHSA, 2012). Even something as simple as a small rainbow flag or sticker can serve as a cue that the environment is welcoming to the LGB community. In addition, outreach efforts at community-based LGB events, college campuses or LGB community spaces may be used to reach members of the LGB community who might directly or indirectly benefit from substance abuse treatment. Outreach in communities could help substance use programs to reach this population and let LGB individuals know the program is both interested in the LGB community and trained to provide appropriate care, triage or referrals.

Coordinate Physical and Mental Health Care

Substance use treatment providers are in an excellent position to coordinate and integrate physical and mental health care for LGB clients. Integrating mental (Grella & Stein, 2006) and physical (Drainoni et al., 2014) health care into substance use treatment; as well as LGB-specific interventions into existing substance use treatment settings (Senriech, 2010) can be beneficial. Our study also found that LGB clients are more likely to enter treatment already on psychiatric medications, and therefore may benefit from integrated psychiatric care. Expected advantages of health care integration for LGB clients include:

- Not having to repeatedly disclose sexual orientation to new providers
- Better coordination of care and simultaneous treatment of comorbid mental and physical health conditions that might otherwise complicate substance use treatment
- Greater support for client treatment adherence and follow through

Providers are essential in the role of enhancing continuity of care for LGB individuals in substance abuse treatment. Their role could include counseling efforts such as providing motivational enhancement interventions to those who need it in order to access mental and physical health care.

Collect Sexual Orientation Data in Electronic Health Records

In order to improve existing services and research efforts, we also recommend collecting sexual orientation data in electronic health records (EHRs; Cahill & Makadon, 2013), as sexual orientation can be an important predictor of physical and mental health in treatment settings. Sexual orientation has been successfully added to EHRs and studies have found that asking about this in standard clinical practice is acceptable to patients (Cahill et al., 2014). Asking about sexual orientation and including it in EHRs may help treatment clinics to understand their client population better (e.g., to inform needs assessment and quality improvement efforts), and could lead to the development of specialized services for LGB clients, which could improve overall care (SAMHSA, 2012). Further, having this information available in EHRs may promote open dialogue between clients and providers, inform provider case conceptualizations, and improve therapeutic and medical referrals and recommendations. We acknowledge that recording sexual orientation within the clinical record may raise important concerns about privacy and confidentiality of data, as is the case with any sensitive area. While these concerns are valid, we expect that substance abuse treatment programs and counselors are in an excellent position to lead the field in the integration of sexual orientation into EHRs, as substance abuse treatment counselors are already well versed in protecting sensitive information.

Limitations

It is important to note that data for our study were collected from San Francisco, thus the same trends may not occur in other locations. Given San Francisco's history of being a place

where LGB identities are accepted, and that stigmatizing social environments have been linked to poorer mental (Meyer, 2003) and physical (Hatzenbuehler et al., 2014) health outcomes among LGB people, rates of physical and mental health problems may be greater among LGB people in substance abuse treatment in more socially or politically conservative locations. The self-report nature of these data represents another potential limitation. This study was also done with data collected for other purposes, thus sexual orientation responses were limited to “heterosexual,” “lesbian,” “gay,” and “bisexual.” In health care settings, it would be better to include additional sexual orientation categories, such as “something else,” as suggested by the Fenway Institute (Bradford et al., 2012).

Conclusions

It is important to attend to sexual orientation in substance abuse treatment. Providers within treatment programs, as well as those who plan treatment systems, should consider the methods of assessment they can use; how to train staff and create an inclusive and affirming treatment environment; how to build links among treatments for substance use disorders, mental, and physical health problems; and how to integrate sexual orientation into EHRs.

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