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Several common bonds: Addressing the needs of gay and bisexual men in LGBT-specific recovery housing

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Abstract

Recovery housing is a promising way to augment the substance use continuum of care, but we know little about the experiences of members of the lesbian, gay, bisexual, transgender, and queer (LGBTQ) community who live in them or about residences specifically for them. Within the LGBTQ community, gay, bisexual, and other men who have sex with men (MSM) often experience co-occurring syndemic conditions (e.g., trauma, depression, and HIV) that present unique recovery challenges. Using qualitative data gathered from residents living in a recovery residence specifically for gay and bisexual men and from community key informants, we examine the experiences of men living in the home and factors that facilitate operating it. Findings highlight the need for residences that can address syndemic burden among gay and bisexual men in recovery and identify programmatic and community-level factors critical to operating residences for this population.

Keywords

sexual minority stress; syndemic; substance abuse; recovery; recovery residences; gay and bisexual men

Alcohol and drug use often play a prominent role in the social fabric of the LGBTQ community (Halkitis & Green, 2007; Halkitis, Green, & Mourgues, 2005; Halkitis et al., 2011; Trocki, Drabble, & Midanik, 2005) and may also represent a way to escape or avoid experiences of sexual minority stress such as family rejection, stigma, and discrimination (Cabaj, 2000; del Pino, Moore, McCuller, Zaldívar, & Moore, 2014; McDavitt et al., 2008;

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Milliger & Young, 1990). Within this community, gay, bisexual, and other men who have sex with men (MSM) have been found to be at increased risk for substance use disorders (Cochran, Ackerman, Mays, & Ross, 2004; McCabe, Hughes, Bostwick, West, & Boyd, 2009; McCabe, West, Hughes, & Boyd, 2013; Stall et al., 2001) and to present with unique substance use treatment needs. Adverse life experiences such as childhood sexual abuse and sexual minority stress fuels the development of co-occurring psychosocial health problems that increase risk for HIV infection and HIV disease progression among MSM (Friedman et al., 2011; Herrick et al., 2013; Mustanski, Andrews, Herrick, Stall, & Schnarrs, 2014; Parsons, Grov, & Golub, 2012; Singer, 2009; Stall et al., 2003). This syndemic that partially drives HIV/AIDS among MSM includes interconnected and mutually reinforcing conditions such as polysubstance use, childhood sexual abuse, intimate partner violence, depression, and sexual compulsivity.

Members of the LGBTQ community must contend with a host of personal, interpersonal, and societal barriers (Eliason & Schope, 2001; Jillson, 2002; Mathews, Booth, Turner, & Kessler, 1986; Smith & Mathews, 2007) as well as organizational and structural factors (Badgett & Ash, 2006; Heck, Sell, & Gorin, 2006; Ponce, Cochran, Pizer, & Mays, 2010) that may limit access to and compromise the quality of healthcare, including substance use treatment (Barbara, 2002; Cochran, Peavy, & Cauce, 2007; McCabe, Bostwick, Hughes, West, & Boyd, 2010). For those who do access treatment, it may not adequately address their needs. Although relatively few treatment centers offer specific programs for this population (Cochran, Peavy, & Robohm, 2007), there is some evidence to suggest that culturally-tailored substance use treatment leads to better outcomes for sexual minority men (Carrico et al., 2014; Senreich, 2010; Shoptaw et al., 2008).

With respect to substance use treatment more generally, there is growing recognition that substance use disorders are chronic health conditions (McLellan, Lewis, O'Brien, & Kleber, 2000) and that treatment for them needs to shift from an acute care approach to a model incorporating services geared toward fostering addiction *recovery* (Dennis, Foss, & Scott, 2007; Laudet & Humphreys, 2013), broadly defined as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" (Substance Abuse and Mental Health Services Administration, 2012, p. 3). One particularly promising recovery support service is recovery housing provided in recovery residences. Recovery residences go by a variety of different names (e.g., Oxford Houses, sober living houses, recovery homes, etc.) but generally refer to safe and supportive living environments that promote recovery from substance use and associated problems (Jason, Mericle, Polcin, & White, 2013). A growing body of research supports the effectiveness of recovery housing in sustaining abstinence and promoting gains in other domains as well (Jason, Davis, & Ferrari, 2007; Jason, Olson, Ferrari, & Lo Sasso, 2006; Jason, Olson, & Harvey, 2015; Polcin, Korcha, Bond, & Galloway, 2010a; Polcin, Korcha, Bond & Galloway, 2010b), but we know little about the experiences of residents who are members of the LGBTQ community and even less about recovery residences specifically designated for them.

This study was designed to begin addressing this gap in knowledge. Using data gathered from a focus group with residents living in a recovery residence specifically for sexual

minority (gay and bisexual) men and from qualitative interviews with community key informants, this study examines the experiences of men living in the home and factors that facilitate operating it. From the men participating in the focus group, we explore how they came to be at the recovery home, the issues that they were struggling with in their recovery, their expectations about living in a gay men's recovery home, and their experiences in the home. From the key informants, we examine perceived need for the home, elements that have contributed to the success and longevity of it, and factors that may present challenges more generally to opening and running homes for gay and bisexual men.

Method

Data for this study were collected between the fall of 2015 and spring of 2016. The study protocol and procedures were approved and monitored by the Public Health Institute Institutional Review Board.

Sites and Participants

The recovery home from which men in the study were recruited and about which key informants were interviewed was located in Austin, Texas. It was one recovery home that was part of a larger organization operating a group of recovery homes in the Austin area. These homes were similar to other types of recovery residences, however unlike Oxford Houses and California sober living houses, residents in these homes participated in routine urine drug screens, met regularly with professional recovery coaches, and had access to substance use treatment services via linkage to an intensive outpatient program (IOP) opened specifically to meet the needs of the recovery home residents (see Mericle, Polcin, Hemberg, & Miles, 2017 for additional information about these homes). The home for gay and bisexual men had a capacity of 12 residents, and a house manager lived onsite with the residents. The house was named in remembrance of a gay man who died from addiction, and it opened in 2009. At the time that the study was designed, it was the only recovery residence specifically designated for a segment of the LGBTQ community that was certified by an affiliate of the National Alliance for Recovery Residences.

All seven residents living in the house at the time participated in the study. One resident came to the focus group late, left early, and did not substantively participate in it. However, he did complete a self-administered questionnaire as part of the study. As Table 1 displays, the mean age of residents was 34; the majority were White (57%), had some college education (71%), were working full-time (71%), and had been in the house for a month or more (57%). The key informants (N=6) were recruited to participate in the study because of their knowledge of and affiliation with the home. They represented individuals who were instrumental in opening and operating the residence or affiliated with organizations providing services to the residents in the home; two (33%) were female, three (50% identified as sexual minorities, and all but one (83%) were treatment and/or other recovery support service providers.

Recruitment and Data Collection Procedures

A flyer was posted in the recovery home announcing the date and time of the focus group, which was held immediately before a regularly scheduled house meeting. Information about the project and the focus group was presented by the facilitators of the focus group (AAM & AWC), and residents were given an informed consent form to review and sign prior to beginning the focus group. Residents needed to be 18 years or older in order to participate. The focus group lasted approximately one hour and was audio recorded. At the end of the focus group, participants were asked to fill out a brief self-administered questionnaire to gather information about demographics, treatment, and recovery history. Refreshments were served during the focus group and participants received a $10 gift card for their participation.

To recruit key informants who might be able to speak to factors that would facilitate and/or present barriers to operating the recovery home and meeting the needs of residents in it, we implemented a chain referral sampling plan (aka, snowball sampling; Biernacki & Waldorf, 1981) starting with the CEO of the organization operating of the recovery home and ending once we had interviewed key informants who were knowledgeable about the history of the recovery home as well as treatment and recovery support services that could be accessed by the home's residents. Key informants needed to be at least 18 years or older to participate. The purpose of the study and nature of participation in the key informant interview was described to potential participants who were asked to provide informed consent. The interview with the CEO was conducted in person, but all other key informant interviews were conducted over the phone with study staff (AAM & JH). All interviews were audio recorded. The interviews lasted 30–60 minutes; the CEO was given in $25 in cash and all other key informants were mailed a $25 gift card.

Question Guides and Analytic Procedures

In the focus group, residents were asked how they learned about the recovery home, what they were looking for in a recovery home, and about their experiences in the home (see Appendix A). Key informants were asked about the nature of their involvement with the recovery home, their thoughts on how best to meet the needs of gay/bisexual men in recovery, and about the role of recovery residences for members of the LGBTQ community (see Appendix B). Audio recordings were transcribed verbatim using guidelines to ensure standardization of the transcription process (O'Connell & Kowal, 1999). Transcripts were independently reviewed for accuracy prior to analysis and analyzed using a mixed approach involving both thematic (Braun & Clarke, 2006) and qualitative content analysis (Morgan, 1993) to identify patterns and systematically classify them with descriptive codes.

Initial codes were developed from the topic areas addressed in the interview guides, and the coding scheme was refined through discussions with study team members about emerging themes (Crabtree & Miller, 1999). Transcripts were independently coded by two team members (AAM & JH), and any discrepancies were discussed until consensus was achieved. NVivo software (QSR International, 2015) was used to organize transcripts for coding, to tally how many times a particular theme was mentioned and by how many different speakers, and to facilitate retrieval of coded passages to illustrate common themes. Passages

were referenced by participant number to protect the identity of individual speakers, and other personal information that might identify the speaker was redacted. Care was taken to use passages that represented the most common themes discussed and the voices of as many participants as possible.

Results

Focus Group Findings

In this section, we present themes that emerged with respect to residents' pathways to the recovery home as well as their expectations about and experiences within the home.

Referral source.—Participants in the focus group were asked about how they came to be at the recovery home. Some residents (n=2) spoke of hearing about the home from a sponsor or peer in recovery. For example, one resident said that "I was pretty much open to whatever people that knew better how to get sober than I obviously did [recommended], and I took their direction. [Name of sponsor] told me to go into that house, and I did" (Resident 6). Other residents (N=3) talked about hearing about the home in a treatment program. For example, one resident explained that "…my counselor referred me, [by saying] 'Oh there's this gay and bisexual house in Austin.' And I'm like, 'Okay, I'll think about it for a little bit.' So I kind of let it sit for a week or two, and then I was like, 'Okay, I'll try it out'" (Resident 4). Indeed, all but two of the residents spoke of being in substance use treatment prior to coming to the recovery home, many mentioning multiple treatment episodes.

Service needs.—Although residents were not asked directly about their service needs per se, residents often talked about their struggles within the context of discussing how and why they came to be at the recovery home. Nearly all of the residents in the focus group (n=5) talked about wanting or needing to learn how relate to other gay men, particularly gay men who didn't use alcohol or drugs and were in recovery. As one resident explained, "I was looking to see how, you know, a sober, gay person could live and have a social life" (Resident 1). In addition to learning how to relate to gay men, residents also talked about just wanting to focus on their recovery and not having to worry about their sexual orientation while living among heterosexual men. For example, as one resident noted, "You don't need to sit around and wait, 'When am I going to tell them that I'm gay?'" (Resident 6). Another resident added, "...you don't have to worry about – you don't have to have anything else added into the mix of chaos. Like someone being prejudiced towards you..." (Resident 5).

Need for supportive and *affordable* aftercare and housing following treatment was mentioned by residents (n=3), and residents (n=4) also talked about negative emotions or the need to develop coping skills to deal with these emotions as internal triggers for using. As one resident explained, "You can use something because it is hard, and you don't want to deal with it, and you don't have a coping skill in order to do that, so you turn to another substance to mask that for the moment to suppress the feelings" (Resident 5). Residents detailed complex, overlapping, and stressful life events including sexual minority stress, HIV stigma, sexual trauma, and criminal justice involvement. Some residents experienced a multitude of these experiences. For example, one resident shared that "When I got HIV, I told my grandparents, and my grandma was like, 'I was waiting. All this sleeping around

you do and you being a gay male, I was waiting for you to come home and tell me this'" (Resident 3). This resident also related a history of prostitution, drug dealing, probation, and recently being sexually assaulted.

Expectations.—After hearing about the recovery home from peers or from treatment providers, residents reported having different thoughts on the merits of living in a gay men's residence. Some residents (n=3) talked about having negative expectations—mostly based on internalized homonegativity about gay men (one resident referred to this as "Queen Diva kind of stuff," (Resident 1)) or because of concerns about forming romantic attachments to men in the house. As this resident explained, "I actually told the coordinator in the office that I needed to be in a straight house because I was afraid I would end up making an unhealthy attachment to somebody else in the house or something" (Resident 1). Residents less frequently talked about other expectations or what they were specifically looking for in a recovery home, but some residents mentioned looking for affordable housing that wasn't too crowded (n=2), was structured and made residents accountable for following house rules (n=2), offered opportunities to advance recovery goals (n=2), and provided a safe environment (n=3) with respect to being drug-free, secure, and emotionally supportive.

Experiences.—Although residents primarily had negative expectations (when they had any) about the residents and what it might be like living with other gay men in the home, their experiences were both different from what they expected and overwhelmingly positive. For example, Resident 1, who was concerned about "Queen Diva" stuff, was quick to point out that "It definitely is not what I thought it would be" and added that "It's just a bunch of level-headed guys who are really serious about the program and want to get well" (Resident 1). Residents appreciated the home having rules (including rules banning sexual relationships among residents in the houses), and many (n=4) talked about how the rules helped them foster accountability. As one resident noted, "Coming here and having to follow by a set of rules is a way to create habits and create a better way of living, not just complete chaos" (Resident 7). Another resident commented that "...being here and seeing that you have that structure where we all have to respect the place we live and each other really is nice, because it's teaching me how to set boundaries like that more" (Resident 1).

Rules contributed to an overall sense of safety and security within the house, but with respect to the environment within the house, all residents talked about emotional support received from other residents. This environment was facilitated by living among fellow gay men who understood them because of shared life experiences. As one resident explained:

> ... once I got here, I became pretty close to the guys pretty quick. I have a home here today, and it's kind of nice. It's really nice to come home to this house. And I've been here a little over a month, or almost two months, and it's really nice to come home to people who understand your problems. You know what I mean? They may not be going through the same exact thing but we – we both have – we all have several common bonds, and it's just, it's been a nice experience (Resident 3).

Being able to relate on a "personal level as well as a recovery level" (Resident 5) and being at ease in their home was seen as integral to their recovery. According to one resident, "If

you're uncomfortable, and if you ever feel like you're hiding something, and you can't be rigorously honest, it holds back for that progress that you make in building and getting strong and secure" (Resident 7). Resident 1 summarized the importance of living among other gay men in recovery by saying, "...alone without peers to support me and to – to relate to, I would have been lost and in my head all the time, and I could have possibly relapsed." He added in reference to his decision to move into the home that "it's the best decision I ever made."

With respect to their experiences with the treatment and recovery support services received while living in the home, residents (n=5) described it as consisting of regular drug testing and weekly meetings with an Addiction Monitoring Program (AMP) coach. Residents who had attended the program's adjunctive intensive outpatient (IOP) treatment (only one was currently attending) reported that it addressed topics that would be relevant to gay/bi men such as HIV/AIDS education and trauma. However, residents noted that services like HIV testing and counseling, pre-exposure prophylaxis (PrEP), HIV care navigation, and "deep therapy or stuff like that" (Resident 5) had to be accessed elsewhere. Yet, even with just offering AMP coaching and drug testing, residents were grateful for the experience of living in the recovery home—connecting with a "whole group of gay people out there that don't drink and drug" (Resident 6), learning "how to support myself financially and everything that goes along with that" (Resident 4) and, as one resident noted, allowing "me to do a lot of long needed work" (Resident 3).

Residents (n=5) also discussed experiences pertaining to quality and affordability of the home. With respect to the physical structure of the home and the neighborhood, respondents generally had positive things to say about both. For example, one resident reflected that "I thought I was going to walk into like a cesspool or something really ugly (chuckles), but I was surprised when we first came in... I was like, 'It's actually a decent, clean facility'" (Resident 1). Other residents commented on how the home's physical proximity to an LGBTQ 12-step meeting house and having neighbors who were also members of the LGBTQ community and in recovery was an asset to the living in the home. The home's capacity and the affordability of it seemed to be a source of debate. The monthly fees charged ($725/month) were talked about as being higher than what it would cost to live on one's own (in a studio or one-bedroom apartment), however, other residents were quick to point out that a variety of other expenses were included in the monthly fees (furniture, electricity, cable and Wi-Fi, etc). With respect to the size of the home, residents thought that having the house at capacity (12 residents) would detract from their quality of life in the home. As one resident noted, "It's really nice how it works out right now [with 7 residents living in the house]. Very rarely are two people in the kitchen at the same time trying to cook a meal" (Resident 3). Another resident pointed out that "... having a roommate for me is different than having four roommates" (Resident 6).

Key Informant Findings

Key informants were recruited to participate in the study based on their knowledge of and affiliation with the recovery home or their expertise with respect to particular needs of the residents living in the home. In this section, we present common themes that emerged across

key informants regarding the unique needs of gay men in recovery and the need for a gay men's recovery home, potential barriers to operating a recovery home like the home in Austin, and factors that have facilitated and supported the operation and longevity of the house.

The need for a gay men's recovery home.—All key informants spoke directly to the need for the home as well as for LGBTQ-specific residences more generally. These sentiments often followed from discussing the unique service needs of gay men in recovery. With respect to these needs, key informants described many of the same problems and concerns that men in the focus group discussed (e.g., need for LGBTQ-specific services to address their identity as a gay man (n=6), affordable treatment and aftercare (n=5), services to address trauma and adverse life experiences (n=4), and health and medical services (n=3)), however key informants talked more specifically about the mental health of gay men (n=5) as well as about gay men in recovery also needing to develop basic life skills in addition to coping skills (n=5). Key Informant 2 spoke of mental health issues in terms of "dual-diagnosis," but others spoke about specific conditions such as "sex addiction" (Key Informant 6) as well as "depression, anxiety, bipolar disorder, [and] eating disorders" (Key Informant 3). As one key informant summarized, "There's a higher prevalence of mental health issues. There's a higher prevalence of process disorders, which I guess you can call them the other addictive disorders that are not involved in substance use, whether that be self-harm, eating disorder, body dysmorphia, gambling, social compulsivity." This key informant added that, with all the diverse needs of gay men, "It's not unheard of to see LGBT individuals in early recovery that have a quadruple diagnosis" (Key Informant 4). With respect to basic life and coping skills, one key informant explained, "These guys have been doing drugs and alcohol for most of their lives, and they may be 32, but they're still really 15 or 16 – teenager skills, if you will, because they haven't grown. While they were high, they ceased on maturing and growing" (Key Informant 1).

Key informants' ideas about why a gay men's home was integral to helping gay men in recovery address these needs mirrored many of the same themes that men in the focus group brought up with respect to their experiences in the home—themes around the home addressing safety, accountability, and providing residents with access to services and recovery support. Regarding the environment of the gay men's home and why such an environment was needed, key informants talked about the importance of the home being a place that was alcohol and drug-free (n=3), where gay men were physically safe (n=4), and where men could find acceptance and support (n=6) for who they were and what they were going through. As one key informant, who is also a gay man in recovery, explained:

> When I first started my own recovery, being able to identify as a gay man was really difficult. It invoked a lot of fear. The first hurdle for me was being able to be comfortable in my own skin, become my authentic self. In the roommate situation, being around other people that are comfortable with that part of their identity, or even people that are uncomfortable but working on that part of their identity gives us common ground and makes it easier to focus on recovery, if you will. I don't have to change my pronouns when I'm talking to people about who I love and who

> loves me. I can focus on just the troubles I'm having in those relationships without having to wonder about the gender issue (Key Informant 2).

Even if key informants did not talk specifically about different reasons why having a gay men's home was important, all talked about needing more homes in addition to the one in Austin—affordable homes that are also "decent" and "physically appealing" (Key Informant 1), homes for other segments of the LGBTQ community, "especially for women" (Key Informant 2), "transgender individuals" (Key Informant 5), and tiered homes where residents "live in a home and then after a period of time they graduate to an environment where there's less accountability but there still is the structure, but there's freedom and independence so that they're transitioning to when they'll be able to live on their own" (Key Informant 3).

Potential road blocks.—Key informants were asked their thoughts on why there weren't more homes like the Austin home. Nearly all key informants (n=5) talked about at least one of three different barriers: staffing and program infrastructure, finances, and stigma. Although the same number of key informants mentioned stigma, they more frequently discussed potential barriers that focused on the need to ensure that staff, programming for residents living in the home, and relationships with service providers were in place to address resident needs as well as the need to be able to financially sustain such a residence. Regarding having the staff and the overall programming to meet the needs of gay men in recovery, one key informant noted it takes more than just designating a residence as a home for gay men. As he put it, "I think it's a good start... However, even within the gay community, there can still be biases. For example, between the gays and transgenders or between men who are butch acting or flamboyant." This key informant also added that, "A lot of times staff members are in that job [as House Manager] because they are former members of the sober house and that somehow qualifies them. But I think [it takes] having more education and understanding about addiction and mental illness, co-occurring mental illness, such as depression, anxiety, bipolar disorder, eating disorders – which are also common among gay men and transgender" (Key Informant 3). In addition to training, key informants also talked about the value of staff being peers in both the recovery and the LGBTQ community. As one key informant noted, "I think professionals can be trained to be culturally competent," but that "In an ideal world, you would have all those stars align" (Key Informant 4). Another key informant talked about the importance of being flexible about one's idea or adherence to one type of recovery housing model. As he put it, "...you can't run it all through the same mill and expect to get results. You have to be able to tailor certain things" (Key Informant 6).

Comments about potential financial barriers came up in discussing how best to meet the needs of gay men and how to do so while keeping the costs of living in the house in reach for the men needing to live there. As one key informant remarked, "When individuals are in early recovery, they may have burned through a lot of their resources, so they often times can't pay for their support" (Key Informant 4). With respect to the issue of price-point, one key informant remarked that "being able to deal with folks that can't access $600 a month for living expenses..." (Key Informant 2) was critical. House census also came up in discussing potential financial barriers. This was talked about in terms of needing "patience"

(Key Informant 6) and conducting outreach with service providers to ensure a "steady flow of individuals" (Key Informant 4) to keep the beds filled. However, census was also talked about in terms of ensuring that the house accommodated enough residents to keep costs down but that it wasn't so large that it negatively affected residents' experiences. Talking specifically about the home in Austin, one key informant said that, "…I think houses like [name of recovery home] would be more successful with a smaller census that's six to eight residents. Because in working with clients who live at [name of recovery home], often when they're at full census, the conflicts and stress in the house seems to increase" (Key Informant 3). Finding the right neighborhood for a home was also mentioned in relation to financial barriers. Locating a home that felt comfortable in a neighborhood with community resources was noted to be important, but property values in neighborhoods that might have these homes and such resources affect operating costs. On the topic of financing a home for gay men, one key informant commented that "We need to have companies that maybe have a connection with the gay community or are gay themselves, maybe. When I say companies I mean people with money, investors." This key informant also talked about the importance of connecting a home to an organization with an existing infrastructure and summed up this barrier by adding that "I think in time we're going to see growth of it, but right now it boils down to money" (Key Informant 1).

It takes a village.—Given these obstacles and potential barriers, how was the home in Austin able to open and stay open? What would it take to open more homes for members of the LGBTQ community? Key informants talked about the importance of ensuring that operators of LGBTQ-specific houses have connections to treatment and service providers (n=6), that residents in these homes have access to a wider network of LGBTQ peers who are in recovery (n=4), and that operators have adequate financial and organizational resources (n=3). Indeed all of the key informants served in one or more of these functions for the Austin home. For example, five of the key informants were service providers in the community, three were peers (gay men in recovery), and three were responsible for providing financial and organization capital or other programmatic expertise to the home.

Regarding the centrality of connections with resources in the community, one key informant noted that "It's very important to get individuals connected to community resources. That's one of the best practices when running recovery residences is how to get people connected to a myriad of community-based resources, including gay AA." This key informant also added, with respect to the Austin home in particular, that he assists program staff in finding these resources:

> ...periodically, one of the counselors that works for [name of organization operating the home] has reached out to me asking me about LGBT-specific resources because they know that individuals have higher needs. It's just not about going to any counselor; it's about "How do you get them connected with individuals that understand where they're at?" (Key Informant 4).

One of the most important resources available to the residents living in the Austin home was seen to be its proximity to a 12-step meeting house specifically for the LGBTQ community. In addition to hosting a variety of different mutual aid groups, this facility is also used for

public education, community outreach, and two separate key informants also talked about this resource hosting service providers to conduct HIV and Hep C testing, thereby expanding even further the network of resources available to residents in the home. This rich network of resources was seen as a key ingredient to success. As one key informant reflected, “I think the advantage of Austin, Texas is that there are so many other resources in the community. If we were to try to replicate [name of home] somewhere else that didn’t have robust resources in the community, then the recovery residence would need to shoulder a lot more responsibility for meeting those needs” (Key Informant 4).

Other factors contributing to the success of the home included having a network of peers in recovery who are also gay men available to residents as well as having champions of the home who have made a number of financial and organizational commitments to it over the years. For example, neighbors of the recovery home periodically host dinners for residents to promote bonding among residents in the house and a greater sense of community. One of these neighbors reported that “we have an open door policy--anytime, don’t ring that doorbell, knock once and walk in. There’s always food in the kitchen, whatever. We like to leave the door open for the guys next door in an effort to help them.” He also added that “I’ve sponsored a couple of them next door. And I think, just us being there, living our lives, I think is a really good thing for being a role model for these guys” (Key Informant 1). Other key informants were also part of this peer network and served as sponsors or supported residents waiting for a spot or recently discharged from the house by opening their own homes to them. For instance, one key informant shared that “At Christmas, I think it was up to 11 or 12 [gay men in recovery living in his home]. It wasn’t intended to be a sober house though. I still don’t do UAs [urine analysis tests], and I don’t do chore wheels or none of that stuff. It’s just roommates and we’re all trying to get along and stay sober and help each other. It’s a great environment. I love it” (Key Informant 2).

Financial and organizational commitments to the home were facilitated by having the home designated as a recovery residence for gay and bisexual men by the owner of it, finding someone who was a peer in recovery to initially serve as the manager of it, and finally by finding an organization to absorb the home into a larger network of recovery homes and treatment services. Regarding the commitment of a larger organization, one of the key informants related that only the current organization was willing to keep it designated as a gay men’s home. As he explained, “Other providers were willing – it’s a really nice property, so they were interested in taking over the property, but they were wanting to make it, say, ‘gay friendly’ or having a mixture of both gay and straight men, but our original vision was to create that specifically for gay and bi men” (Key Informant 4). Regarding this commitment, another key informant remarked that, “Having a gay sober house is relatively new on this planet. And for a company to dive in there and provide for these folks--and this company was started by straight people who own it--so then to tap into the needs of the LGBT community [is], I think, pretty darn good. Is there room for improvement? There’s always room for improvement. What’s happening next door is pretty special...” (Key Informant 1).

Discussion

The first report to document higher rates of substance use among gay and bisexual men appeared approximately 40 years ago (Fifield, 1975). Since that time, a series of increasingly rigorous studies have confirmed and expanded our understanding of disparities in problematic patterns of alcohol and drug use among LGBTQ populations. There is now no question that gay and bisexual men, along with others who are members of the LGBTQ community, are populations for whom substance use disorders constitute a serious health disparity when compared to heterosexual individuals. Although academic research literature has primarily focused on the descriptive epidemiology of substance use and its myriad health consequences among gay men, many “home grown” treatment programs have been developed over the years to meet the compelling need for efficacious substance use treatment programs specifically designed for sexual minorities. These programs demonstrate that there is strong demand for services to address the issue of substance use disorders among LGBTQ populations, and there is a growing literature on behavioral interventions targeting substance use and HIV/AIDS among sexual minority men. Despite this progress, important questions remain regarding how to best deliver culturally tailored treatments for this population (Carrico, Zepf, Meanley, Batchelder, & Stall, 2016), and there is a clear need to articulate a model of recovery for this population that promotes sobriety following formal treatment *and* addresses co-occurring syndemic conditions.

Drawing upon the social model of recovery from addiction (Borkman, Kaskutas, Room, Bryan, & Barrows, 1998), recovery housing expands the substance use continuum of care by specifically addressing key structural and social barriers encountered by sexual minority men in recovery. Findings from this study highlight the role of recovery housing in addressing common structural barriers to recovery such as housing and finances. Results also underscore the prominent role of LGBTQ-specific residences to address sexual minority stress as an important factor that contributes to etiology and maintenance of substance use disorders in this population. Distinct facts of sexual minority stress such as anticipated stigma, discrimination, concealment of sexual orientation, and internalized homonegativity (Meyer, 2003) were experiences common to residents in the recovery home. However, men did not fear stigma and discrimination within the home. Indeed the home in this study was described as creating a safe environment where men did not feel compelled to conceal their sexual orientation, and for many, this provided an opportunity to openly address sex, romantic relationships, and friendships with other sexual minority men as relevant factors in their recovery. This recovery home also provided opportunities for its residents to challenge their own negative attitudes and beliefs about sexual minority men (i.e., internalized homonegativity), allowing them to begin to join a network of sexual minority men in recovery. Further research is needed to examine whether changes in sexual minority stress processes are associated with improved recovery outcomes among sexual minority men receiving culturally tailored treatments.

Findings from this study also highlight the importance of organizational infrastructure and community connections to support recovery residences and members of the LGBTQ community who live in them. The home in this study was part of a larger organization operating a group of recovery homes in the Austin area as well as a support network that

included connections with 12-step self-help groups, neighbors, and other champions within the recovery field and the larger LGBTQ community. The organization operating the home was able to commit to keeping it a home for gay and bisexual men, and this was likely facilitated by having other homes to defray costs when the home was not full and to provide options to gay and bisexual men when the home was full or to those who wanted to live in one of the other homes for men. Greater integration with a supportive LGBTQ community provided residents with new ways to understand how to relate to other sexual minority men outside of sexual encounters fueled by alcohol and other substances. These beneficial connections with the LGBTQ community were further augmented by linkages to community-based treatment providers to address issues relevant to co-occurring syndemic conditions including mental health disorders and HIV/AIDS.

Information about this recovery residence and the experiences of the men living there outline an innovative approach to supporting sexual minority men in recovery, but this study is not without notable limitations. One limitation is the generalizability of study findings. Findings from this study are from one home for gay and bisexual men in Austin, Texas; prior work has shown that the homes run by the organization operating this home have features distinguishing them from other types of recovery residences (e.g., Oxford Houses and sober living houses in California) because residents are provided recovery support services while living in the home (Mericle et al., 2017). Thus findings from this study may not generalize to other types of recovery residences, similar residences in other geographic regions, or residences specific to other segments of the LGBTQ community. Additionally, these findings represent one snapshot in time of residents currently living in the home. Attitudes, norms, and laws affecting members of the LGBTQ community have shifted dramatically in recent years (Jones, Cox, & Navarro-Rivera, 2014), and ongoing debates about rights and protections for members of the LGBTQ community will continue to shape public sentiment and service availability for those in this community. Further, given the importance of the house environment in shaping the residents' perception of their experience in the house, the composition of residents in the house and how well they got along with each other at the time likely had an effect on their perception of the value of their experience. Moreover, there were only seven residents living in the house at the time of the focus group, limiting more comprehensive analysis of important, yet understudied questions about how race/ethnicity, age, and socioeconomic status might affect entry into and experiences within the home. Finally, although all key informants talked about the need for this home and others like it, our findings cannot address the question of whether residents' experience in this home contributed to improved outcomes for them.

The prevalence and devastating effects of addiction coupled with barriers faced by members of the LGBTQ community underscore the importance of research on how to best support their long-term recovery. The current study has illustrated how a recovery residence for gay and bisexual men can be helpful to men living in it and described elements that have been instrumental in establishing and maintaining this home. Additional research is needed to further this work. Larger studies are needed to address important gaps in the literature about the recovery needs of aging sexual minority men and sexual minority men of color and how these needs may be addressed in recovery housing. Studies are also needed to understand the experiences of members of the LGBTQ community in other types of recovery residences

and in other parts of the country. Through work on this study, we have learned of other recovery residences across the United States that either designate themselves as a residence for segments of the LGBTQ community or that generally have a large portion of their residents identifying as part of this community which should facilitate this work. It is critical that future work in this area focus on surveying operators of these residences to identify aspects of the house environment, policies, and programming that may differentiate these residences from others not specifically designated as serving members of the LGBT community. Most importantly, studies focusing on the outcomes of residents identifying as members of the LGBTQ community living in these residences as well as from residences that are not specifically designated as such need to be conducted to begin identifying recovery housing best practices for members of the LGBTQ community.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Table 1.

Focus Group Participant Characteristics (N=7)

	n	%
Race/Ethnicity		
White/Caucasian	4	57.1
Hispanic	2	28.6
Other[1]	1	14.3
Age (M, SD)	34	10.7
Educational Attainment		
High school diploma	1	14.3
Some college	4	57.1
College degree	2	28.6
Current Employment Status		
Working full-time	5	71.4
Not working	2	28.6
Currently Receiving Financial Assistance[2]	4	57.1
House Tenure		
1-2 weeks	1	14.3
3-4 weeks	2	28.6
1-3 months	2	28.6
4-6 months	1	14.3
More than 6 months	1	14.3
Prior Living Arrangements		
Own home/apartment	1	14.3
Treatment setting	3	42.9
Jail	1	14.3
Shelter/on the streets	2	28.6
Alcohol Use 30 Days Prior to Move-in	0	0.0
Drug Use 30 Days Prior to Move-in	1	14.3
Length of Time in Recovery		
3-4 weeks	1	14.3
1-3 months	3	42.9
4-6 months	1	14.3
More than 6 months	2	28.6
Current Self-Help Attendance		
1-2 meetings/week	1	14.3
3-4 meetings/week	5	71.4
5-6 meetings/week	1	14.3
Current Substance Use Treatment Enrollment	1	14.3

[1] One respondent reported being Native American.

[2] Types of financial assistance received included food stamps/SNAP (n=3) and disability (n=1).