Trainer Guide

A Provider’s Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals

First Edition

Based on the publication:
(DHHS Publication No. (SMA) 01-3498)

Training Curriculum
Acknowledgements

A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals

This training curriculum was edited and prepared for publication by the Prairielands Addiction Technology Transfer Center.

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If you would like to know more about A Provider’s Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals, contact Prairielands ATTC, www.pattc.org, or the ATTC serving your region at http://www.nattc.org/regCenters.html. A downloadable version of the training curriculum is obtainable at: http://www.public-health.uiowa.edu/pattc/lgbtrainingcurriculum
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## Overview of the Training

<table>
<thead>
<tr>
<th><strong>Title</strong></th>
<th>A Provider’s Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals Training Curriculum</th>
</tr>
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<tbody>
<tr>
<td><strong>Author</strong></td>
<td>Content based on the US Department of Health &amp; Human Services, Center for Substance Abuse Treatment (CSAT) publication by the same title. Training activities designed by Barbara Warren, Psy D. Curriculum layout formatted and completed by Prairielands Addiction Technology Center (ATTC).</td>
</tr>
<tr>
<td><strong>Length</strong></td>
<td>Approximately 22 classroom hours, with breaks (5.5 hours for Overview, 9 hours for Clinician’s Guide &amp; 4.5 hours for Program Administrator’s Guide)</td>
</tr>
<tr>
<td><strong>Scope</strong></td>
<td>Closely follows the content of the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment DHHS Publication No. (SMA) 01-3498.</td>
</tr>
<tr>
<td><strong>Intended Audience</strong></td>
<td>This training curriculum was developed to be informative to a range of audiences including, the trainee who has no familiarity with LGBT populations, the trainee who has moderate knowledge and experience, and the trainee with considerable knowledge who can benefit from a refresher. The curriculum is targeted to clinical and administrative staff, but Modules 1-4 Overview may also be helpful to support staff, and Modules 14-17 Administrator’s Guide may be helpful to operating and financial staff.</td>
</tr>
<tr>
<td><strong>Method of Instruction</strong></td>
<td>Lecture, facilitated discussion, and group activities.</td>
</tr>
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Guide to Curriculum

Purpose of the Curriculum

This training curriculum is based on A Provider’s Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals (hereafter referred to as A Provider’s Introduction), published by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), in 2001. This publication serves as the textbook for this curriculum, and trainers are encouraged to be thoroughly familiar with its contents before offering this training. In addition, it is recommended that trainees have access to the textbook, as it will enhance their training experience.

A Provider’s Introduction was intended to provide both practitioners and administrators involved in substance abuse treatment with

- Increased familiarity with the issues and barriers faced by lesbian, gay, bisexual, and transgender (LGBT) persons in need of substance use disorder-related services
- Knowledge about the interaction between LGBT issues and substance use and abuse
- Enhanced ability to offer sensitive, affirmative, culturally relevant, and effective treatment to LGBT clients in substance use disorders treatment.

Trainers should be aware that, because there is a rapidly growing and evolving body of knowledge and data on these communities, some of the material in this curriculum may need to be updated periodically; however, all the core information and recommendations are valid over time.

This curriculum was created to “translate” A Provider’s Introduction into a training experience with visual aids and opportunities for discussion and practice. The curriculum itself is not intended to be a “stand-alone” product; it is strongly recommended that the text be available to trainees for reference and background because the curriculum does not offer the detail that the text does.

Audience

This training curriculum was developed to be informative to the trainee who has no familiarity with LGBT populations, the trainee who has moderate knowledge and experience, and the trainee with considerable knowledge who can benefit from a refresher. More experienced trainees can validate and share knowledge and practice with fellow trainees with less experience.
The curriculum is targeted to clinical and administrative staff, but Modules 1-4 of the Overview may also be helpful to support staff. Modules 14-17 form the Administrator’s Guide, which may be helpful to operating and financial staff.

It is recommended that all staff members take the Overview as a prelude to any other session of the training.

The reading and comprehension level of this training is at the high school graduate and college level, and it is available at this time only in an English-language version.

**Trainer Qualifications**

This curriculum was designed to be offered by experienced substance abuse treatment trainers. This training confronts what are often controversial issues in our society about sexual orientation and gender identity, and trainers need to have experience facilitating discussion and response, handling dissent, and mediating differing opinions and attitudes.

All trainers should be thoroughly acquainted with the curriculum and the textbook before offering this training.

The ideal setup is to have a team of at least two trainers where one is an openly identified LGBT professional who is comfortable presenting these issues without taking trainees’ opinions and lack of knowledge personally, and the other is a heterosexually identified colleague who is familiar with LGBT issues and adept at offering effective interventions to the LGBT population.

Trainers should be aware that in offering LGBT training in this and other areas of health and human services, they may encounter religious or moral objections to homosexuality. Although trainers need to respect trainees’ religious and moral views, it is important to remain committed to providing accurate information about LGBT persons and increasing provider sensitivity about and affirmation of LGBT persons’ identities, concerns, and right to respectful and supportive substance abuse treatment services. Trainees who are unable to tolerate this perspective may not be appropriate candidates for this training.
Curriculum Guide

This curriculum follows the order and chapters of A Provider’s Introduction, with a few exceptions that are noted. The order of presentation should follow the order of sessions and modules as written. If possible, the training should be presented in its entirety, over time.

- Module 1 is an overview.
- Module 2 focuses in on LGBT culture-specific issues and looks at cultural issues within different groups that make up the diverse LGBT community, for example, African-American LGBT persons and Latino/a LGBT persons.
- Module 3 addresses legal issues within the context of substance abuse treatment for clients and for staff working with LGBT clients.
- Module 4 presents approaches to treatment and offers a philosophy and a framework for making effective interventions.

- Modules 5-13 constitute the Clinician’s Guide and is suggested to be offered in the following order:

  o Module 5: The Coming Out Process
  o Module 7: Working With Lesbians
  o Module 8: Working With Gay Men
  o Module 9: Working With Bisexuals
  o Module 10: Working With Transgender Individuals
  o Module 11: Working With LGBT Youth
  o Module 6: Families of Origin and Families of Choice (LGBT Families)
  o Module 12: Related Health Issues.
  o Module 13: Case Examples (Practice)

This section does not follow the order of each chapter of the textbook; however, each module references the chapter or chapters that the module is based on. Chapter 13 in A Provider’s Introduction is integrated into other sections as well as into case examples.

- Modules 14-17 make up the Administrator’s Guide. (Although it is not imperative that administrators attend the Clinician’s Guide training, it may be helpful in providing a fuller context for them.)

  o Module 14: Policies and Procedures
  o Module 15: Training and Education
  o Module 16: Quality Improvement and LGBT Clients
  o Module 17: Using Alliances and Networks To Improve Treatment for LGBT Clients.
How to Use Curriculum

Trainer materials are laid out in the following format for each Module in the Microsoft Word documents:

**Title page:** Contains the module number and title for the session, as well as an indication of the overall time needed to cover the module content.

**Handouts:** Handouts to be used by participants (also included in participant packets) are included.

**Presentation Notes:** A slide-by-slide narrative is included for each module. Subsets of these notes are also provided in the participant’s presentation notes. The notes for each presentation contain the following in a slide-by-slide format:

- The slide number, which is also present on the bottom right hand corner of the corresponding PowerPoint slide.
- The text from the PowerPoint is included for ease in reviewing the material in printed format. Additional content information to complement the slide may also be included. Participant materials contain all of the same text.
- Below each slide is a section titled *Notes for Slide # - #* that contains special instructor notes for each slide. These notes are coded with icons and highlighting to assist the trainer as explained below.

[Special trainer notes are denoted by this icon and typically include additional content the trainer should include in their lecture or discussion.]

This icon indicates a group exercise. This is typically a formal group exercise where participants are divided into small groups and a handout is used. Following the small group discussion, the trainer then conducts a large group sharing and debrief session on the small group discussion to enhance understanding for the larger group.

This icon indicates an opportunity for the trainer to shift from a lecture-type delivery to a more interactive discussion. Prompts are indicated for probing questions to ask trainees to draw on their experience and knowledge.

Text is highlighted throughout the trainer notes. The content and key words that are highlighted are intended to serve as an aid for the trainer to easily refer to while delivering instruction.
Power Points: The PowerPoint Presentations are available in the PowerPoint folder. The PowerPoint slides were created as guides and as visual aids and do not contain the complete information that is provided in the curriculum Word documents. In some cases, trainees will want to write down what trainers are conveying about points shown in slides. The participant guides are designed to allocate extra space for that purpose.

Materials: At each training session, there should be an LCD projector, a computer with PowerPoint capacity, the requisite PowerPoint slides on disk or in the computer, several newsprint charts to write on, markers, and the necessary handouts as designated in the curriculum. Handouts and materials specific to each module are included in the participant guides for that module.

Other Session Logistics Recommendations

Sign in/out Record: Each participant’s name and signature can be recorded on the “sign in/out record” for each training. This type of documentation may be needed to ensure Continuing Education Unit (CEU) credit. Presenters should take roll-call at the beginning and end of the session to ensure compliance as requested by the certification boards.

Evaluations: Evaluation forms allow an opportunity to improve future training sessions. Prairielands ATTC will be happy to provide a sample evaluation form for your use. For assistance in obtaining these forms, please contact Prairielands ATTC at prairielands@uiowa.edu or 319-335-5368.

Certificate of Completion: It is recommended that certificates of completion be forwarded to participants upon completion of the session. A certificate reflects the importance of the training and serves as a receipt for continuing education efforts. A template for creating these certificates can also be provided by Prairielands ATTC. Please contact Prairielands ATTC at prairielands@uiowa.edu or 319-335-5368.

Additional References and Resources

A Provider’s Introduction contains some additional materials not covered in this training as well as resources and a bibliography of references. This is another reason that it is important to have copies on hand during the training. Trainers should inform trainees that A Provider’s Introduction can be requested from SAMHSA’s National Clearinghouse for Alcohol and Drug Information (NCADI) Web site at http://www.ncadi.samhsa.gov.
SAMHSA’s Substance Abuse Treatment Locator
www.findtreatment.samhsa.gov

SAMHSA National Helpline (for locating drug and alcohol abuse treatment programs)
(800) 662-HELP (4357) (English and Espanol)
(900) 487-4889 (TDD)

National Runaway Switchboard (Youth)
It’s anonymous, confidential and free. 1-800-RUNAWAY.

AIDS Info
800-874-2572
9:00 a.m.-7:00 p.m.
Spanish-speaking operators available.
www.aidsinfo.nih.gov

CDC National STD/AIDS Hotline
800-227-8922 English (STD)
800-342-2437 English (AIDS)
800-344-7432 (Spanish)
800-243-7889 (TDD)
English: 24 hours/7 days a week; Spanish: 8 a.m.-2 a.m., 7 days a week (eastern time);
TTY: 10:00 a.m.-10:00 p.m., Monday-Friday (eastern time)
www.ashastd.org/nah/index.html

Project Inform National HIV/AIDS Treatment Hotline
800-822-7422
9:00 a.m.-5:00 p.m., Monday-Friday (Pacific time)
10:00 a.m.-4:00 p.m., Saturday (Pacific time)
Spanish-speaking operators available.
www.projinf.org

Gay and Lesbian Medical Association: http://glma.org/ - click here under "Resources for Patients" to access the LGBT-friendly physician database, list of important things to discuss with your health care provider, and information on hepatitis and depression.

In addition, the Resources slide/Trainer's Notes should encourage trainers to convey local information about the closest LGBT Community Center, LGBT-friendly Health Center (e.g., Whitman Walker, Howard Brown, etc.), LGBT-friendly crisis hotlines, and local LGBT-friendly web or phone resources for runaway/homeless youth, people in crisis, domestic violence services, etc.
**Adult Learning Theory 101**

<table>
<thead>
<tr>
<th>You can assume about adult learners...</th>
<th>Adult learners have the expectations...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Varied backgrounds</td>
<td>Class time will be well spent</td>
</tr>
<tr>
<td>- They may have limited college</td>
<td>- They hope they can apply content</td>
</tr>
<tr>
<td>experience to advanced degrees</td>
<td>directly to real situations in their</td>
</tr>
<tr>
<td>- Self-efficacy may range from</td>
<td>lives</td>
</tr>
<tr>
<td>intimidated by learning to bored</td>
<td>- Will evaluate the relevancy of the</td>
</tr>
<tr>
<td>because they considered themselves</td>
<td>learning - what are examples of this</td>
</tr>
<tr>
<td>experts on the subject</td>
<td>being used effectively in the field</td>
</tr>
<tr>
<td>Carrying reservoirs of personal</td>
<td>- Most believe the content will be</td>
</tr>
<tr>
<td>experiences, which can be tapped as</td>
<td>helpful, some are there as an ‘escape’</td>
</tr>
<tr>
<td>learning resources</td>
<td>from work or to merely fulfill a ‘requirement’</td>
</tr>
<tr>
<td>Training assignments take a back seat</td>
<td>- Expect the training to be ‘engaging’,</td>
</tr>
<tr>
<td>to work and family responsibilities</td>
<td>although they might be bashful about</td>
</tr>
<tr>
<td>They have a short attention span...</td>
<td>group exercises</td>
</tr>
<tr>
<td>after about 10 minutes of continuous</td>
<td>- They will make their own conclusions</td>
</tr>
<tr>
<td>input, people cease to absorb much</td>
<td>on how to change their beliefs based</td>
</tr>
<tr>
<td>new information</td>
<td>on the evidence presented to them</td>
</tr>
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**The Trainer can influence...**

<table>
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<tr>
<th>The Atmosphere</th>
<th>Techniques to enhance learning</th>
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<tr>
<td>Friendly, informal, and humorous usually works best</td>
<td>Provide evidence-based research and tangible examples to guide participants to their own conclusions</td>
</tr>
<tr>
<td>Physically comfort is important - room temperature, restroom and food breaks</td>
<td>Repetition and reinforcement are important: Keep coming back to key topics or concepts</td>
</tr>
<tr>
<td>Seating that encourages an intimate environment, soft music when participants arrive or during breaks</td>
<td>Have clear, crisp presentation materials and handouts for everyone</td>
</tr>
<tr>
<td>Taking the time at the beginning to get to know each other, and learn participants hopes and expectations</td>
<td>Pause between sections to probe for questions and encourage learner participation (ex. “What are you doing in regard to XYZ where you work?”) - rather than barreling through content</td>
</tr>
<tr>
<td>Set guidelines for the session. Examples: raise your hand at anytime if you have a question, encouraged to share on-the-job examples/questions (in a concise way)</td>
<td>Use a variety of aids to stimulate learning styles - activities, video-clips, visual representations</td>
</tr>
</tbody>
</table>

| Provide adequate structure for group discussions and activities to keep them productive and on track. |
MODULE 1: An Overview for Providers Treating LGBT Clients

Total Timeframe: 2 hours

Overview of Treatment Approaches, Modalities, and Issues of Accessibility

A Provider’s Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals

Based on the publication: (DHHS Publication No. (SMA) 01-3498)

Training Curriculum
Module 1: Handout 1-A

**Terminology Quiz**

Match the twelve descriptive on the right to the most appropriate general category on the left hand side of the page. Please note that a few of the descriptor words may fit under more than one category. (5 minutes)

<table>
<thead>
<tr>
<th>Categories</th>
<th>Descriptors</th>
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<tbody>
<tr>
<td>Sex</td>
<td>Lesbian</td>
</tr>
<tr>
<td></td>
<td>Gay</td>
</tr>
<tr>
<td>Gender/Gender Role</td>
<td>Bisexual</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>Transgender</td>
</tr>
<tr>
<td>Gender Identity</td>
<td>Transsexual</td>
</tr>
<tr>
<td></td>
<td>Heterosexual</td>
</tr>
<tr>
<td></td>
<td>Queer</td>
</tr>
<tr>
<td></td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td>Female</td>
</tr>
<tr>
<td></td>
<td>Masculine</td>
</tr>
<tr>
<td></td>
<td>Feminine</td>
</tr>
</tbody>
</table>

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A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals
Module 1: Handout 1-B

LG BT Terminology

- **Sex** in this context refers to anatomy, for our purposes specifically genital and reproductive anatomy. If you have a penis, scrotum, testicles, and a prostate, your sex is generally referred to as male. If you have a vagina, labia, clitoris, uterus, and ovaries, your sex is generally referred to as female.

- **Gender** refers to the concept of femaleness or femininity and maleness or masculinity; gender role refers to behaviors and desires to act in certain ways that are viewed as masculine or feminine by a particular culture or society and within a given time period. For example, in white, middle-class America in 1940, a woman who wore trousers was considered to be behaving out of her gender role. Today it is normal for women to wear trousers. So gender role behaviors that are associated with masculinity or femininity can change depending on the times, the culture, and who is in power.

- **Sexual orientation**—lesbian, gay, bisexual, heterosexual—describes one’s attraction to, sexual desire for, lust for, or romantic attachments to others. We use the word orientation as more inclusive and appropriate than preference because the use of the word preference indicates a choice that can imply moral decision making. Although some LGBT people may say their sexual orientation was a choice, many feel it is not a choice—that it is as inborn as some other characteristics we have, like eye or hair color. For civil rights purposes, it is easier and clearer to seek equal protection under the law for inborn characteristics than for something that is perceived to be a choice, that is, a moral decision. Therefore, many in the LGBT community have advocated the concept of orientation over preference.

- **Gender identity** is one’s inner sense of oneself, a person’s self-concept, in terms of gender. Most of us think in terms of only two genders, male and female, but we are beginning to understand that gender is complex and not just polarized. Today some individuals identify as bigender. Gender identity is not always derived from genital anatomy.

- **Queer** is a term that is coming more and more into use by the LGBT communities to describe everyone who identifies anywhere along the spectrum of identities of lesbian, gay, bisexual, transgender, questioning, and, even more recently, intersex. Although at one time, it was a pejorative, in the 1980s LGBT rights activists reclaimed the word as an empowerment word. It can even include heterosexually identified allies who are advocates for LGBT human rights. Transgender activists have used the term gender queer to describe gender identities that do not fit into the more traditional polarity of male to female.
Module 1

Title Slide - An Overview for Providers Treating Lesbian, Gay, Bisexual & Transgender Clients

Module 1 - A Provider's Introduction to Substance Abuse for Lesbian, Gay, Bisexual, and Transgender Individuals

Learning Objectives

(Text: Chapter 1 in A Provider's Introduction)

At the end of this session, trainees will

1. Understand the epidemiology of substance abuse among the LGBT population
2. Be able to identify types of substances abused
3. Be able to define key terms
4. Be able to describe characteristics of LGBT individuals
5. Understand differences in LGBT life experiences and connect LGBT experiences to substance abuse issues

Notes for Slide 1-1

- **Trainer Notes:**
  - **Learning Needs:** Trainers will lead participants in a discussion identifying their training needs in regard to substance abuse issues and the LGBT community.
  - **Epidemiology, Data, and Studies:** Trainers will review historical and recent epidemiological data about substance abuse in the LGBT communities, as well as data about the estimates of LGBT persons in the general population.
  - **Identity and Terminology:** Participants will explore terms and definitions related to understanding LGTB cultures and communities.
  - **Heterosexism and Homophobia and Their Effect on Substance Abuse in LGBT Populations:** Participants will explore the definitions of homophobia and heterosexism, as well as how these dynamics affect substance abuse concerns in LGBT communities.


**Introduction Activity: Introducing Ourselves & Our Concerns**

*(Before Slide 1-2)*

**Timeframe:** 20 minutes

- Trainers start by introducing themselves, explaining their backgrounds, and sharing why they are involved in doing this training.
- Trainees identify themselves, what they do, where they work (if from different agencies, or if in the same agency, which department or unit), and one thing they would like to learn in the training today. Trainers record the learning goals.
- Trainers point out similarities across training goals expressed by different trainees and post them on wall.

**Trainer Notes:**

- To more fully engage trainees, it is important to first establish trainee individual learning needs and as a further support to demonstrate the similarities of learning needs between trainees across different settings or professional experiences.
- This exercise and discussion enable trainees to establish an LGBT client needs assessment based on trainees' experience of LGBT numbers and issues within their own settings and on current data and studies.

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**How many LGBT clients are in your treatment facility?**

- How many clients does your facility/agency/organization see/treat on a monthly or annual basis?
- Of those, how many are "out" to you as lesbian, gay, bisexual, or transgender?
- How many are out as LGBT to everyone in the treatment setting?
**Notes for Slide 1-2**

**Timeframe: 10 minutes**

**Discussion**
- Trainers ask a sample of trainees to answer questions from the slide whom are either from different settings or, if all are from the same setting, in different professional roles questions on the slide.
- Trainers record these responses on the chart to refer back to.

Trainers conduct a large group discussion on:
- Whether the numbers of out clients realistically reflect how many LGBT persons are actually being served within their settings?
- Why or why not?
- The potential to serve more LGBT clients within the setting.
- Why it is important for LGBT clients to address identity in the context of treatment?
- The importance of providing culturally competent treatment to LGBT clients.

**Trainer Notes:**
- Trainers should be aware that the numbers given may not be accurate depending on program location, reputation as LGBT sensitive, the trainees' experience with LGBT populations, and other factors.
- When trainees admit to large numbers of LGBT clients, it underscores the need for LGBT-relevant services. When trainees admit that more LGBT clients are probably in the system then staff recognizes, it also points to the necessity for LGBT-sensitive services. And when trainees question how many clients they serve who need LGBT services, trainers can segue into the next section on substance abuse epidemiological data and the potential to serve more LGBT clients in need of LGBT-specific services.
- Examples of issues that may come up at this point are lack of intake questions regarding sexual orientation and gender identity, clients' fear of coming out in a mainstream setting, and clients' confusion or lack of clarity about their sexual orientation or gender identity.
- Trainers should encourage trainees to attend all training sessions to learn how to better address these issues and concerns within their settings and practice.
Limitations

EPIDEMIOLOGY, DATA, AND STUDIES

- Lack of reliable data on how many lesbians, gay men, bisexuals, and transgender people in the general population
- Reluctance to disclose sexual orientation, gender identity, and drug use
- Use of convenience samples which may bias results:
  - collecting data in gay bars
  - from LGBT events like Pride Parades
  - at HIV services organizations

Notes for Slide 1-3

Timeframe: 10 minutes

What Do We Know About Substance Use, Abuse, and Dependence in Lesbian, Gay, Bisexual, and Transgender Populations?

Trainer Notes:

Explain the limitations of the existing data and studies:

- There is a lack of reliable data on how many lesbians, gay men, bisexuals, and transgender people are in the general population because Federal Government population surveys on health issues do not routinely ask sexual orientation or gender identity questions. Update and more information on LGBT populations and data collection at: www.gaydata.org.
- Many LGBT people may not self-disclose identity for fear of discrimination or stigmatization based on sexual orientation, gender identity, or drug use.
- Therefore, researchers rely on use of convenience samples that may bias results, for example, data collected in gay bars where there will be more drinkers from LGBT events like Pride Parades that often attract people who are already out or at HIV organizations that may have clients with a history of higher risk behaviors.

For updates:
- www.gaydata.org
Historical Perspectives on Homosexuality & Bisexuality

- **1940s and 1950s** - Same-sex sexual attraction and behavior was a mental disorder.
- **1957** - Dr. Evelyn Hooker’s landmark study finds gays and lesbians “normal.”
- **1973** - The American Psychiatric Association removes homosexuality as psychopathology from the DSM.

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Notes for Slide 1-4

**Timeframe: 10 minutes**

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**Trainer Notes:**

Historical perspectives on homosexuality and bisexuality included a pervasive belief that same-sex sexual attraction and behavior were mental disorders that in many cases were the result of inadequate early childhood development and family upbringing, for example, that gay men had uninvolved fathers and overinvolved mothers.

In 1957 psychologist Evelyn Hooker did a landmark study that showed no discernable differences between the psychological profiles of gay men and straight men, debunking the myth that homosexuality was a mental illness.

In 1973 the American Psychiatric Association removed homosexuality as psychopathology from its diagnostic and statistical manual.

More recent studies have been examining genetics and biology for the source of homosexuality, but to date no conclusive evidence exists to support a genetic basis.

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**Discussion:**

Trainers can ask trainees whether they know what the estimates are of how many people would identify as lesbian, gay, bisexual, or transgender in the general population.

The estimate on the prevalence of gay and lesbian sexual orientation in the general population is usually cited at 10 percent figure that comes from the Alfred Kinsey Institute studies of sexual behaviors in Americans, 1948–1953. There have been more recent studies that have challenged the 10 percent figure with estimates as low as 3 percent.
The Kinsey Scale

0  Exclusively heterosexual
1  Predominantly heterosexual, incidentally homosexual
2  Predominantly heterosexual but more than incidentally homosexual
3  Equal heterosexual and homosexual
4  Predominantly homosexual, but more than incidentally heterosexual
5  Predominantly homosexual, incidentally heterosexual
6  Exclusively homosexual

Notes for Slide 1-5

Timeframe: 10 minutes

Trainer Notes:

The Kinsey studies were structured interviews that measured the degree of sexual responsiveness (fantasies, dreams, thoughts, feelings, and actual behaviors) on the above seven-point continuum. Because the Kinsey studies were conducted with a small, white, mostly male, and affluent population in the 1940s and 1950s, it is hard to generalize to everyone today.

The Kinsey studies found that 6 percent of the adult male population measured 6; 10 percent ranked between 4 and 6, between which is where the “10 percent of the population is gay” statistic comes from; 18 percent ranked between 3 and 6; and 60 percent had experienced sex with another man at some point in their lifetimes.

Ten percent of the people surveyed by Kinsey were willing to be out about their “same-sex” desires and experiences. Today, it might be easier to get a more representative sample of people willing to reveal sexual orientation. Updated research on the range of human sexual practices is needed for many purposes, including HIV prevention.

The importance of Kinsey was to demonstrate that same-sex sexual experience was within the normal range of human sexual experience. It took another 20 years, however, for the American Psychiatric Association to remove homosexuality as a diagnosis of psychopathology from the Diagnostic and Statistical Manual (DSM) in 1973.
What is important to emphasize, however, is that to date, there still are no studies that accurately depict the number of people who would identify as lesbian, gay, or bisexual. This may be the result of the lack of funding or interest in academic and government settings for this type of research and the reluctance of many people to disclose this information for fear of discrimination and prejudice. Most people, however, who have worked extensively with gay, lesbian, and bisexual persons support the 10 percent estimate.

Trainers should also point out here that because of the scarcity of accurate research, very little is known about the true prevalence of transsexual and transgender identity in the general population. Some studies have indicated rates of 1 in 300,000, but those studies have addressed only a small sample of male-to-female transsexuals who self-disclosed in inpatient psychiatric settings, an unrepresentative statistic for all the trans-identified people who recently are beginning to come out.

Recent Surveys

- **CDC Study (1989):** statistics on bisexuality from HIV prevalence data indicate self-identification of bisexuality in men who have sex with men at 54% in African Americans, 44% in Hispanics and 11% in white men.
- **Michael's study (1996):** meta-analysis of sexual orientation data produced very variable results with some indicating 10% of men and 5% of women identifying as engaging in same-gender sexual behaviors and other studies with rates as low as 3% of men and 1.4% of women.
- **CDC Study (2002):** 4% of females had a sexual experience with another female in the past 12 months. 11% of women had a same-sex sexual experience in their lifetime. 2.8% of women identify selves as bisexual.
- **Seil (1996):** Transgender Study in 1996 had a figure of 15% in general population but culled only from mental health data.
- **Bockting (2003):** More recent data from studies on HIV risk indicate 6% identification on the transgender spectrum.
Notes for Slide 1-6

Timeframe: 5 minutes

Trainer Notes:

Other more recent surveys have indicated a wide range of reported identification. Again, it is important to note that differences in methodologies, (e.g., how the questions on orientation and identity are asked; subjects’ reluctance to self-identify for fear of stigmatization) can skew these results.

Substance Abuse Studies

- Early studies, such as Fifield’s in Los Angeles (1975) and others in the 1970s, found that gay men and lesbians reported alcohol abuse problems at 30 to 33 percent, almost three times the percentage for alcoholism in the general population.
- Later studies conducted by McKim and Peterson in 1989 at the University of Illinois Chicago found alcohol, cocaine, and marijuana consumption rates among lesbians and gay men at 23 percent, still almost twice the rates found in the general population.
- Similar studies in the 1990s (Cochran and Mays 2000; Hughes and Wilnack 1997; Skinner and Otis 1994; Woody et al. 1999) also found that gay men and lesbians were heavier substance and alcohol users than the general or heterosexual population.
- In addition, Woody’s study of men who have sex with men (MSM) indicated that the MSM population studied was 21 times more likely to use nitrite inhalants and 4 to 7 times more likely to use hallucinogens, stimulants, and sedatives.
- Stall et al. (2001) found that of MSM 52% used recreational drugs and 85% use alcohol. Levels of multiple drug use (18%), three or more alcohol-related problems (12%), frequent drug use (19%) and heavy-frequent alcohol use (8%) were not uncommon.
Notes for Slide 1-7

Timeframe: 5 minutes

Trainer Notes:
In The Provider's Introduction, Cabaj and colleagues compiled 16 studies on substance use, abuse, and dependence among lesbian, gay, bisexual, and transgender populations over the past 30 years.

Refer trainees to appendix D in The Provider's Introduction, page 189 for more studies.

Goals and Objectives

Some research on LGBT populations and drug use and abuse has focused on the use of party drugs, also called designer drugs, club drugs, or recreational drugs that include:

- Methamphetamine, also known as crystal, Tina, meth, speed, crank
- Methyleneoxymethamphetamine (MDMA), more commonly known as ecstasy or X
- Ketamine, known as Special K or just K
- Gamma Hydroxybutyrate also known as GHB.

Notes for Slide 1-8

Timeframe: 5 minutes

Trainer Notes:
Research indicates a strong correlation between the use of these drugs and increased sexual risk taking, with evidence supporting a link between party drug use and increases in HIV infection and hepatitis C infection.

For updates on recent research on methamphetamine use among MSM, visit http://www.nyhealth.gov/diseases/aids/harm_reduction/crystalmeth/docs/meth_literature_index.pdf
MSM/Party Drug Data Summary

- Earlier methamphetamine prevalence assessments during the early 1990s determined that its use was largely a regional phenomenon confined to the western portion of the United States.

- These earlier studies documented methamphetamine prevalence rates that ranged between 5 and 25 percent of the gay and bisexual men surveyed. (Anderson et al. 1994; Eggen et al. 1996; Gorman et al. 1995, 1996; Harris et al. 1993; Heischober and Miller 1991; Reback 1997).

- More recent investigations have found that methamphetamine now appears to be reaching epidemic levels of abuse in the major metropolitan cities of the western United States and their gay communities (Reback 1997).

- In New York City, the Hunter College/New York University Center for HIV/AIDS Education, Studies and Training (CHEST) investigative team has begun to document methamphetamine’s potential and emerging problem (Halkitis and Parsons 2002).

- Data from several of their other studies, including the Seropositive Urban Men’s Study (SUMS), a study of HIV-positive MSM funded by the Centers for Disease Control and Prevention, identified an overall methamphetamine prevalence rate of 11 percent, with respective prevalence rates of 17 and 7 percent in San Francisco and New York City (Purcell et al. 2001).

- In 2001 CHEST’s National Institute on Drug Abuse (NIDA) investigation of club or party drug use among gay and bisexual men in New York City named Project BUMPS, preliminary data on 324 self-identified gay or bisexual males who used club drugs indicates 62 percent of the participants indicated at least one incident of use in the 4 months before assessment.
  - A substantial proportion of the men reported polydrug use and the combining of methamphetamine with alcohol (45%), MDMA (39%), ketamine (32%), Viagra (29%), inhalant nitrates (28%), and cocaine (25%).
  - Use of methamphetamine spans sociodemographic lines of race or ethnicity, age, income, and HIV status. For example, 44.9 percent of the sample were men of color; 57.1 percent reported being HIV positive; 42.9 percent reported being HIV seronegative.
Notes for Slide 1-9

Timeframe: 10 minutes

Trainer Notes:

- Trainers should emphasize that research is still inadequate and more needs to be done.
- The existing data focus more on patterns of use and abuse and have not adequately examined the etiology (why a disease or condition develops and how it progresses within a given individual or group) of substance abuse and dependence in LGBT populations.
- There have been a few studies that support the concept that the increased stress resulting from prejudice, discrimination, and stigma that LGBT populations experience in the general society may be a contributing factor to increased substance use and abuse as a coping mechanism. This subject will be covered later on in this session.
- Further support for this conclusion is in the research on LGBT youth and risk factors for increased substance use that is correlated to antigay violence, harassment, and stigma and will be covered more thoroughly in Session 11 on LGBT Youth.
Notes for Slide 1-10

Timeframe: 10 minutes

Refer participants to Handout 1-A Matching Quiz

Matching Quiz

Trainers should instruct trainees that this is a matching quiz, similar to what they may remember from elementary school! There are four general categories on the left hand side of the page. On the right hand side are 12 descriptive words. Trainees are to match the words or terms on the right with their most appropriate category on the left. A few of the descriptor words on the right can be matched to fit under more than one of the categories on the left. Allow trainees a few minutes and then discuss their answers.

Trainers should go down the list of categories on the left and ask trainees how to best define each category.

Trainer Notes:

- In this part of the training session, trainers will dispel misconceptions about LGBT persons through establishing a common understanding of terms and definitions regarding sexual orientation and gender identity, differentiating between the two concepts, and enabling providers to help clients, and themselves, begin to assess sexual orientation and gender identity and treatment issues at intake.
- Trainers can explain the need for a common language or a consensus of meaning on definitions and language to understand and more accurately describe who is discussed in this training series. It is still common for many people who are not familiar with LGBT identities, cultures, and lifestyles to be confused about the differences and similarities among these groups. Misunderstandings about language and terms of identity also may be the basis for inappropriate assessment or bias.
TERMS - Categories and Descriptors

- **SEX**
  - Male
  - Female

- **GENDER/GENDER ROLE**
  - Male
  - Female
  - Masculine
  - Feminine

- **SEXUAL ORIENTATION**
  - Lesbian
  - Gay
  - Bisexual
  - Queer

- **GENDER IDENTITY**
  - Transgender
  - Transsexual
  - Male
  - Female
  - Queer
  - Intersex

See Module 1: Handout 1A

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**Notes for Slide 1-11**

**Timeframe: 10 minutes**

**Discussion Follow-up:**

After reviewing the matching answers, **Pass out Handout 1-B** Definition of LGBT Terms as a reference for participants.

**Trainer Note:** In the discussion here, trainers should point out that

- Because of the **need for lesbian visibility** and a desire to not always be subsumed under a male designation, many women **prefer the term lesbian** to gay women.
- **Male and female** are not polarized identities; they are more fluid.
- Identities are to some extent socially constructed; what is considered feminine or masculine changes as indicated in our definition of sex role and is on a **spectrum**.
- **Transsexual** usually refers to a person whose anatomy is in conflict in some way with his or her gender identity, and some people, but not all, choose to close this gap through living in their self-identified gender or by having corrective surgeries.
- **Transgender** also relates to this category because it is now the umbrella term for a variety of gender expressions including drag, cross-dressing, transsexuality, and bigender experience. It is **not a sexual orientation**.
- **Sexual orientation** is best described as a function of gender identity; if a person gender identifies as female and is sexually oriented to females, she will probably describe herself as lesbian. If a person gender identifies as a man and is sexually oriented to men, he might best describe himself as gay.
- Transgender people who transition from male to female can vary their gender roles. Some are more “femme” and some more “butch”, just as nontransgender men and women vary, and because some are sexually attracted to women regardless of their anatomy, they self-identify as lesbian. This is a complicated definition, so if trainees get confused, trainers should emphasize the differences between sexual orientation and gender identity and refer trainees to resources for more information and training.
Hello Exercise

“Hello, my name is ________________” (identify yourself); and then say “and I am (if male identified) a gay man”  
• (if female identified) a lesbian”

Notes for Slide 1-12
CONTENT: HETEROSEXISM AND HOMOPHOBIA AND THEIR EFFECT ON SUBSTANCE ABUSE IN LGBT POPULATIONS

Exercise: Hello
Timeframe: 15 minutes

This exercise gives people a direct experience of being identified as LGBT in a group. Trainers ask trainees to participate in an exercise as follows: “We will go around the room and each person is to say...

“Hello, my name is ________________” (identify yourself); and then say “and I am (if male identified) a gay man, (if female identified) a lesbian.”

Trainees can also have two people add to the statement that they are transgender, that is, “I am a gay man of transsexual experience.”

Make sure that each trainee participates and follows directions exactly. If a person protests that he or she is not gay, ask the individual to say it anyway. The group will process it afterwards.

Some people absolutely refuse; they should not be pressured.

Trainer Notes:

• At the conclusion of this exercise, the group should process what it felt like to say “I am lesbian or gay, (and in some cases) transgender” aloud. The trainers will get a variety of responses. Some people will say “piece of cake; I had no problem.” Others will say it felt weird or uncomfortable, some will giggle, and others will get angry.
• Some of the people in the training who are LGBT identified may come out in the training at this point and share that it felt empowering to say who they were, or hear others say it, or that it felt unsafe.

Several points to make:

• It is still uncomfortable for people to share lesbian, gay, bisexual, or transgender identity in a mixed group of strangers.

• If it is not that easy for those who are not LGBT to say aloud that they are LGBT in a classroom exercise, then when we ask our clients to self-disclose in real life, imagine how they must feel about taking a real-life risk.

• Safety is a legitimate issue for gay, lesbian, bisexual, and transgender people. It is not paranoia for many LGBT people but a fact that when they self-disclose they are vulnerable to physical and psychological attack.

• It can be empowering, especially when LGBT identity is the norm and not the exception. Sometimes, it will be easier for the people at the end of the group exercise to say “I am gay or lesbian” because the norm of being gay has already been established in the room. It is always harder to be the only one.

• Homophobia and heterosexism will be defined and covered in more depth in the next session on Cultural Issues. However, it is important to note here that there is a correlation between internalizing a social stigma and abusing substances.
MODULE 2:
Cultural Issues for Lesbian, Gay, Bisexual, and Transgender Clients

Total Timeframe: 1 hour, 40 minutes

Overview of Treatment Approaches, Modalities, and Issues of Accessibility

A Provider’s Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals

Based on the publication:
(DHHS Publication No. (SMA) 01-3498)

Training Curriculum
Unifying science, education and service to transform lives

Title Slide - Module 2: Cultural Issues for LGBT Clients

From:
A Provider's Introduction to Substance Abuse for Lesbian, Gay, Bisexual, and Transgender Individuals

Learning Objectives
(Text: Chapter 2 in A Provider's Introduction)

At the end of this session, trainees will

1. Be able to define and understand sexual orientation, gender identity, and other aspects of diversity and identity
2. Be able to connect diversity, stigma, and the addiction recovery process
3. Understand the effect of homophobia and heterosexism on LGBT persons

Notes for Slide 2-1

Timeframe: 3 minutes

Trainer Notes:

- **Defining and Understanding Sexual Orientation, Gender Identity, and Other Aspects of Diversity and Identity:** In this session, the trainers present the diversity of identities within the lesbian, gay, bisexual, and transgender communities, for example, ethnocultural identitii, religions, class backgrounds, and age.

- **Diversity, Stigma and the Addiction Recovery Process:** Trainees will see how prejudice and discrimination against LGBT persons and against other groups are linked. Trainers will define and describe homophobia and heterosexism, and trainees will examine the effect of stigma on the addiction recovery process.

These are sensitive and dynamic issues, and trainers should be aware that they may raise as many concerns as they address. Reemphasize that developing increased sensitivity and consciousness-raising around these issues is ongoing for all of us.
Core Aspects of Identity

Core aspects of identity refer to the ways in which we identify ourselves and the ways in which others perceive us. Because we are social beings who for the most part live in relationship with others, there are the ways in which we see ourselves as a part of or similar to a given group, family, or social structure and how we see ourselves as different from others.

- Family of Origin
- Race
- Ethnicity
- Age
- Class
- Sexual Orientation
- Gender Identity
- Abilities
- Appearance
- Religion
- Other

Notes for Slide 2-2

Timeframe: 10 minutes

Content: DEFINING AND UNDERSTANDING SEXUAL ORIENTATION, GENDER IDENTITY, AND OTHER ASPECTS OF DIVERSITY AND IDENTITY

Trainer Notes:

Trainers can go through the list and ask trainees to try to define each term and give a few examples for each identity.

Family of origin refers to identity as it is derived through family or given name—I am a product of my parents, grandparents, and so forth.

Race and ethnicity are different although as people often confuse the two. Race refers to the three Western-scientific classifications that were once called Caucasian, Negro, and Mongoloid and today are often referred to as white, black (or African descent), and Asian. Sometimes a fourth group, referred to as indigenous or aboriginal, is cited.

Important note: Controversy exists about the scientific basis for “race” classification. Current knowledge of genetics and new information on the human genome do not support significant distinctions between races, only differences in skin color.

Ethnicity is culturally and geographically derived from a nation, a country, or cultural traditions.

Age can be specific or general (“young” and “old”).

Class often refers to socioeconomic background and in our society often is determined by education as well as money. Sometimes occupation is part of class identity.
Sexual orientation (e.g., lesbian, gay, bisexual, heterosexual [as defined in Session 1]) describes one’s attraction to, sexual desire for, lust for, or romantic attachment to others.

Gender identity (as defined in Session 1) is a person’s inner sense of self, a person’s self-concept, in terms of gender.

Abilities includes more than whether one is physically challenged. It also refers to talents and abilities for which people are identified like athlete, movie star, or genius or occupations like doctor, firefighter, priest, or other.

Appearance is also a major aspect of identity. What is considered to be fat, thin, large, small, or attractive is also socially and culturally influenced.

Religion can refer to either a specific organized religion or a set of spiritual practices and beliefs.

Other. Trainers ask trainees for other aspects of their identities that have been important for them. These may include mother, father, daughter, community member, activist, among others.

After completing definitions, trainers should point out that

- Lesbian, gay, bisexual, and transgender persons are included within every other category or aspect on the list and therefore constitute the most diverse subgroup of all groupings.
- By including gender identity and sexual orientation with other core aspects of identity, we acknowledge that these are as valid as any other way to identify ourselves, thereby establishing a context for and normalizing LGBT identity.

DIVERSITY, STIGMA, AND THE ADDICTION RECOVERY PROCESS

Group Discussion

Content: Defining Stereotypes, Myths, Prejudices and Stigma as Types of Messages That We Get

Trainers conduct a large group discussion on the concept that the core aspects of identity are being a source of both the positive and negative messages that influence the development of our self-images, self-concept, and self-esteem.

- Trainers ask trainees to give examples of where these messages come from—parents, family members, teachers, peers, educational system, religious institutions, neighborhood, media, government. Trainers point out that the family, although powerful, is not the only influence on the messages we get about ourselves.

- Trainers then ask trainees to give an example of a message they got about one of their aspects of identity that was positive and one that was negative and briefly describe the influence of both on them.

- Trainers give a few generic examples, for example, being tall can be viewed as positive in that you can play basketball or you are too big to be intimidated; being tall can be negatively viewed as being a freak or only being able to play basketball.
Definitions

- **Stereotyping** is attributing a characteristic of one or a few members of a group to all members of that group. Stereotypes can be positively or negatively imbued.

- **Prejudice** is a set of beliefs, in actuality assumptions, about a whole group of people based on hearsay or emotions, where one’s own group is the point of reference.

- **Myths** are stories and beliefs about something or someone that at one time may have been rooted in an actual occurrence but have been changed so as to be more legend or metaphoric than reality.

- **Stigma** is a reproach, slur, stain or blot and that which vilifies, defames, casts a slur on, imputes shame to, puts down, snubs, or reproaches.

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**Notes for Slide 2-3**

**Timeframe: 5 minutes**

**Trainer Notes:**

This discussion and the next exercise will raise strong feelings among trainees. Trainers should advise trainees of this in advance and ask trainees to be aware of what feelings arise in them as they go through the list. Trainers should emphasize that it is important to hear how all groups experience myths, prejudices, and stereotypes. This may help one group to connect to another group’s experience. Diversity trainer and poet Dana Rose has expressed this as “The words to our blues may be different but the rhythm is just the same.”
Group Exercises to Follow Slide 2-3

Timeframe: 30 minutes

- Across the top of a sheet of flipchart paper, write the following categories:
  
  **ALCOHOLICS/ADDICTS**
  
  **WOMEN**
  
  **POOR PEOPLE**
  
  **AFRICAN-AMERICANS**
  
  **LGBT PERSONS**

- Generate a list from trainees of positive and negative stereotypes, prejudices, and myths under each category. When the list has been completed across all categories, process the feelings of trainees in the large group. Point out common stereotypes that are linked across categories.

- Ask trainees what the effects of these messages are on others, themselves, their clients, people in each of these groups. Examples include psychological effects such as depression; feelings of rage, frustration, grief; effects on self-concept such as low self-esteem or self-hatred; social effects such as increased discrimination and violence.

- Ask trainees to imagine, after seeing this list of stereotypes and prejudices that may affect them personally, how an LGBT client might be affected as that client tries to work through issues of coming out and staying substance free in a society that holds negative views of LGBT persons.

- On the newsprint, label each category in terms of the “ism” each represents, as shown below.

<table>
<thead>
<tr>
<th>People With Alcoholism or Addictions</th>
<th>Addictophobia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women</td>
<td>Sexism</td>
</tr>
<tr>
<td>Poor People</td>
<td>Classism</td>
</tr>
<tr>
<td>African-Americans</td>
<td>Racism</td>
</tr>
<tr>
<td>LGBT Persons</td>
<td>Homophobia and Heterosexism, Biphobia, Transphobia</td>
</tr>
</tbody>
</table>
HOMOPHOBIA and HETEROSEXISM

- **Homophobia** is an irrational fear of gay and lesbian people or fear of same-sex relationships. In its most extreme form, homophobia is a hatred for or violence against LGBT persons.

- **Heterosexism** is an assumption of heterosexuality and the heterosexual perspective as the predominant or meaningful viewpoint.

- **Biphobia** is fear of and hatred for bisexuality.

- **Transphobia** is fear of and hatred for transgender persons.

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**Notes for Slide 2-4**

**Timeframe: 10 minutes**

**Trainer Notes:**
Ask the trainees for their understanding of the definitions.

**Review definitions as follows:**

- **Homophobia** was a word coined in the 1970s and used extensively by two gay psychologists, Rob Eichberg and David Goodstein, who ran gay and lesbian empowerment workshops in San Francisco. This word means an irrational fear of gay and lesbian people or fear of same-sex relationships. In its most extreme form, homophobia is a hatred for or violence against LGBT persons.

- **Heterosexism** is a more recent term that refers to an assumption of heterosexuality and the heterosexual perspective as the predominant or meaningful viewpoint, the assumption that all persons in any given group are heterosexual or should be heterosexual.

- **Biphobia and transphobia** have been used to describe fears of and hatred for bisexual and transgender persons.
Cultural Pain, Addiction, and Recovery

Cultural Pain is feeling “insecure, embarrassed, angry, confused, torn, apologetic, uncertain or inadequate because of conflicting expectations of and pressure from being a minority and an African American.”

Bell, P. (1981)

Examples include:
- Resentment when another African-American seems to be denying his or her blackness
- Discomfort when another African-American uses black English in the presence of white people
- Discomfort when a white person is patronizing on black issues
- Anxiety when a white person seems to expect African-Americans to defend or explain questionable behavior by other black people.

Notes for Slide 2-5

Timeframe: 20 minutes

Trainer Notes:
- Introduce Peter Bell’s (1981) concept of cultural pain. Note that he is an African-American substance abuse expert who has worked extensively with cross-cultural issues in addiction prevention and treatment. Formerly with the Johnson Institute in Minnesota, he was head of the Institute for Black Chemical Dependency now known as the African American Family Institute.
- Bell defines cultural pain as feeling “insecure, embarrassed, angry, confused, torn, apologetic, uncertain or inadequate because of conflicting expectations of and pressure from being a minority and an African American.”
- He gives several personal examples, including
  - Resentment when another African-American seems to be denying his or her blackness
  - Discomfort when another African-American uses black English in the presence of white people
  - Discomfort when a white person is patronizing on black issues
  - Anxiety when a white person seems to expect African-Americans to defend or explain questionable behavior by other black people.

Trainers can ask for a volunteer to read through the list above and substitute gay, lesbian, bisexual, and transgender for African-American and heterosexual or straight for white.
Examples of Cultural Pain

African-Americans
- Resentment when another African-American seems to be denying his or her blackness
- Discomfort when another African-American uses black English in the presence of white people
- Discomfort when a white person is patronizing on black issues
- Anxiety when a white person seems to expect African-Americans to defend or explain questionable behavior by other black people.

What’s the equivalent for LGBT Persons?

Notes for Slide 2-6

Timeframe: 10 minutes

Discussion

Trainers can ask for a volunteer to read through the list on the left and substitute gay, lesbian, bisexual, and transgender for African-American and heterosexual or straight for white.

<table>
<thead>
<tr>
<th>African-Americans</th>
<th>LGBT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resentment when another African-American seems to be denying his or her blackness</td>
<td>Resentment when another gay man or lesbian seems to be denying his or her sexual orientation</td>
</tr>
<tr>
<td>Discomfort when another African-American uses black English in the presence of white people</td>
<td>Discomfort when a gay man acts “too gay” in the presence of straight people</td>
</tr>
<tr>
<td>Discomfort when a white person is patronizing on black issues</td>
<td>Discomfort when a straight person is patronizing on LGBT issues</td>
</tr>
<tr>
<td>Anxiety when a white person seems to expect African-Americans to defend or explain questionable behavior by other black people.</td>
<td>Anxiety when a straight person seems to expect lesbians and gays to defend or explain questionable behavior by other lesbians and gays</td>
</tr>
</tbody>
</table>
Trainer Notes:

- Bell (1981) says that the feeling identified above represents only a few examples of cultural pain, but African-Americans (and LGBT people) must learn to deal with the constant challenge of cultural pain to stay sober. Staying sober is achieved through recognition of the pain, courage to openly talk about feelings, and an ability to choose how to respond to cultural and emotional pain.

- Bell (1981) outlines four interpersonal styles exhibited by clients that should be assessed during substance abuse treatment. These styles are fluid, meaning individuals can move among them depending on the context or stage of their development or both.

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**Notes for Slide 2-7 to 2-10**

**Timeframe: 5 minutes**

Trainer Notes:

- **Assimilation** is adaptation to a new culture by taking on a new identity and abandoning the old cultural identity. Assimilated individuals consciously or subconsciously reject their culture of origin in favor of their adopted culture.

- **Acculturation** refers to accommodation to the rules and expectations of the majority culture without entirely giving up cultural identity. Bicultural, or multicultural, individuals are proud of their cultures and can function in, fulfill their needs through, and be proud of the dominant culture.

- **Culturally immersed** individuals have rejected mainstream culture, and their emotional and spiritual needs are met exclusively in their ethnic community or in the gay community.
Traditional individuals are defined as carriers of the community ethos. They neither overtly accept nor reject their ethnic identity. Most of their needs are met through their ethnic community, and they have limited contact with the dominant culture or any outside communities.

Discussion

After the introduction of the four terms, ask trainees to discuss how these different styles might impact client responses to substance abuse treatment:

- For example, assimilated clients might resist placement in an LGBT-identified group or might prefer a straight-identified clinician.
- Multicultural clients are more likely to be comfortable in any clinical setting, though they may experience what Bell calls “cultural schizophrenia,” the feeling of not belonging to any community.
- Because they have rejected mainstream culture, the effectiveness of treatment with culturally immersed clients may depend on the ability of the provider to be supportive as clients work through issues related to being a person from a minority group.
- For traditional clients, entering a mainstream treatment program is often a frighteningly foreign experience that calls for sensitive treatment.

Acculturation

refers to accommodation to the rules and expectations of the majority culture without entirely giving up cultural identity.

Culturally immersed

- individuals have rejected mainstream culture, and their emotional and spiritual needs are met exclusively in their ethnic community or in the gay community.
Traditional individuals are defined as carriers of the community ethos. They neither overtly accept nor reject their ethnic identity. Most of their needs are met through their ethnic community, and they have limited contact with the dominant culture or any outside communities.

Core Aspects of Identity
- Family of Origin
- Race
- Ethnicity
- Age
- Class
- Sexual Orientation
- Gender Identity
- Abilities
- Appearance
- Religion
- Other

Notes for Slide 2-11

**Timeframe:** 10 minutes

**Trainer Note:** Moving through cultural pain and learning to acculturate leads to the development of cultural pride.

**Discussion**
- Refer back to the core aspects of identity and ask trainees for examples of cultural pride from their own cultural backgrounds, for example, Kwaanza, Cinco de Mayo, “black is beautiful,” Star of David.
- Treatment providers should recognize gay, lesbian, bisexual, and transgender identities as more than just orientation or gender but as a cultural identity, that is, there are sets of traditions, beliefs, values, and practices as diverse as these communities are that have become a part of being LGBT, identified beyond who one’s partner or lover may be or whether one is transgender in gender identity. Ask trainees for examples they may know of LGBT cultural activities and cultural pride.
Examples might include an annual celebration of LGBT pride; drag and the house balls; “camp”; butch-femme; disco dance music and house music; Halloween as the “gay” holiday; womyn’s music festivals; the annual National Adodi Retreat for gay and bisexual men of African descent; Castro Street, Provincetown, Key West, Greenwich Village, and Fort Greene/Clinton Hills in Brooklyn where a large black gay and lesbian community is emerging.

Connecting the dots ............... 

- LGBT people are a significant and important part of society.
- LGBT people have developed their own rich and unique cultural traditions and practices.
- LGBT persons are found within all other groups.
- Recovery demands coming to terms with the effect of shame, of oppression, of hurts suffered not only within family relationships but within social experiences and society as well and accepting that homophobia and heterosexism can therefore influence addiction and recovery.

Notes for Slide 2-12

Timeframe: 5 minutes

Trainer Notes:

Tie together the information and concepts presented in this portion of the training. Review the main points of each section that have been discussed.
MODULE 3:
Legal Issues for Programs Treating LGBT Clients

Total Timeframe: 1 hour, 50 minutes

Overview of Treatment Approaches, Modalities, and Issues of Accessibility

A Provider’s Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals

Based on the publication:
(DHHS Publication No. (SMA) 01-3498)
Module 3: Handout 3-A

Case Study Examples

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

What should you or your agency encourage her to do?

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

What can your program suggest to help Harry?
Case Study Exercise

Case History #1

Bill is a 41-year-old African-American man who has applied for admission to an inpatient alcohol treatment facility. Bill’s history of substance abuse goes back 20 years but includes several years of sobriety and active participation in Alcoholics Anonymous. He is in a committed relationship with Harold (36), his partner of 5 years. Bill’s wife died of a drug overdose 3 years ago, and he has custody of his two young children, Melissa (6) and Philip (4). The children live with Bill and Harold in their rented townhouse. Bill’s late wife’s parents have never accepted him and have always blamed Bill for their daughter’s drug problems. Bill has been teaching seventh-grade English for the past 10 years. Only a few colleagues in the school system know about his sexual orientation and his relationship with Harold. Bill was referred to the treatment facility by the school district’s employee assistance program (EAP); and his employer-provided health maintenance organization (HMO) will cover his treatment. He must satisfactorily complete treatment to retain his job. Bill has signed a form consenting to disclosures about his progress in treatment to the district’s EAP.

For Discussion:

What legal and policy issues does this case present?
Case Study Exercise

Case History #2

Denise is a 16-year-old white female who entered an inpatient treatment program after being hospitalized twice: once for alcohol poisoning and once after a suicide attempt. Denise’s parents are working professionals with a comfortable income and large home in the suburbs. Denise has been living at home but does not get along with her two older sisters or her younger brother. She has been habitually truant. Denise has confided in her counselor that for some time she has been having a hard time with her attraction to and feelings about other girls. Denise characterizes her parents as homophobic and is terrified about what might happen if they find out. Once, when her father found her watching an episode of the TV program “Ellen,” he screamed at her: “Why would you want to watch that disgusting smut? I will not have that stuff in my house!” Denise has signed a consent form permitting her counselor to speak with her parents about her substance abuse treatment. After Denise has been in the program for a month, a staff member discovers her acting out sexually with another girl.

For Discussion:

What legal and policy issues does this case present?
Module 3: Handout 3-B

Case Study Exercise

Case History #3

Frankie is a 66-year-old retired postal worker who has been in and out of 12-Step programs and outpatient treatment for 10 years. This will be his first inpatient treatment episode. Frankie came to the intake session with Janice, his female partner of 16 years. The couple lives together in a home they purchased 12 years ago. They are not legally married, but their friends and family consider them husband and wife. They have two grown children (one each from previous marriages) and five grandchildren. Frankie expects that Medicare will pay for his treatment. Janice works for the city and is covered by the city’s HMO plan. After intake, Frankie is settled in a room with another male patient. On Frankie’s first night at the facility, a nurse observes that Frankie has female genitals. Frankie’s roommate demands that he be moved out of the room. The nurse has told her supervisor that she’s not going to work “with that ‘weirdo’ in Room 112.”

For Discussion:

What legal and policy issues does this case present?
Module 3
Unifying science, education and service to transform lives

Title Slide - Module 3: Legal Issues for Programs Treating LGBT Clients
From:
A Provider’s Introduction to Substance Abuse for Lesbian, Gay, Bisexual, and Transgender Individuals

Learning Objectives
(Text: Chapter 3 in A Provider's Introduction)

At the end of this session, trainees will
1. Understand how programs can protect the confidentiality of LGBT clients
2. Be able to define the legal barriers facing LGBT individuals
3. Understand the legal issues raised by HIV/AIDS
4. Know what policies treatment programs should adopt to ensure that clients and staff are fairly treated

Notes for Slide 3-1
Timeframe: 3 minutes

Trainer Notes:
- Confidentiality: In this session, trainers will review confidentiality requirements, identifying the elements of a valid consent, as well as the use of consent and guidelines for disclosure without consent.
- Discrimination and Protection: Trainers will review the reality of discrimination against LGBT persons and explore how treatment facilities can protect their LGBT clients.
- Case Studies: Trainees will review several case examples, identifying relevant disclosure guidelines and other legal concerns.
Confidentiality


- No disclosure without consent about anyone who has applied for or received any substance abuse-related assessment, treatment, or referral services
- Applies from the time an individual makes an appointment
- Applies to former clients
- Prohibits disclosure of information that would identify the individual either directly or by implication as a substance abuser.

Notes for Slide 3-2

Timeframe: 15 minutes
Content: A Review of Confidentiality Requirements

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

The Federal law and regulations severely restrict communications about identifiable clients by programs specializing, in whole or in part, in providing treatment, counseling, assessment, or referral services for substance abuse problems.

This law and the regulations prohibit substance abuse treatment program staff from disclosing information about anyone who has applied for or received any substance abuse-related assessment, treatment, or referral services. This prohibition

- Applies from the time an individual makes an appointment
- Applies to former clients
- Prohibits disclosure of information that would identify the individual either directly or by implication as a substance abuser
- Allows disclosure of specific information if the program has obtained a written consent to disclose treatment information.
Group Exercise: Consent Forms

- In a large group, trainers ask trainees for elements of a consent form by recalling their agency’s consent to release information forms.
- Trainers create a form from trainee responses on a flip chart.

To be valid, a consent form must be in writing and must contain each of the items specified in 42 CFR, Part 2:

- Program Name
- Client Name
- Purpose of Disclosure
- Nature of Disclosure
- Revocation Statement
- Expiration Clause
- Client Signature
- Date of Consent

Notes for Slide 3-3

Timeframe: 10 minutes

Trainer Notes:

Trainers refer trainees to “Consent for Release of Confidential Information,” p.32, in A Provider’s Introduction.

To be valid, a consent form must be in writing and must contain each of the items specified in 42 CFR, Part 2:

- The name or general description of the programs making the disclosure
- The name or title of the individual or organization that will receive the disclosure
- The name of the client who is the subject of the disclosure
- The purpose or need for the disclosure
- How much and what kind of information will be disclosed
- A statement that the client may revoke (take back) the consent at any time, except to the extent that the program has already acted on it
- The date, event, or condition on which the consent will expire if not previously revoked
• The **signature** of the client (and in some States, his or her parent if the client is younger than 18 years)
• The **date** on which the consent is signed.

Trainers then compare this model of valid consent with what trainees created and see what was covered and what was missing.

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**Use of Consent and Disclosure Without Consent**

**CONSENT MUST BE USED:**
- To seek information from collateral sources
- To make periodic reports or coordinate care
- To make referrals

**DISCLOSURE WITHOUT CONSENT:**
- Medical emergency
- Child abuse mandated reporting
- Communications between program staff

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**Notes for Slide 3-4**

**Timeframe:** 10 minutes

**Content:** Use of Consent and Disclosure Without Consent

**Trainer Notes:**

Disclosure without consent may be made only in certain circumstances, including those listed on the slide.

**HIV and confidentiality:**
- Almost all States now have laws protecting the confidentiality of a client’s HIV status.
- In some States, there needs to be a separate written consent for release of HIV-related information.
- Program administrators need to make sure all program staff members are kept informed of their State’s HIV confidentiality regulations.

*Disclose information with caution, consequences of disclosure may be detrimental to the client.*
TRUE or FALSE?

Although two Federal and several State statutes protect recovering substance abusers from many forms of discrimination, in most areas of the United States discrimination against individuals because of their sexual orientation or gender identity is legal.

Notes for Slide 3-5

Timeframe: 10 minutes, Content: Discrimination

Trainer Notes:
Trainers ask trainees whether the statement on the slide is true or false.

True in some cases. In most areas of the United States, LGBT people can legally:
- Be denied employment or be fired from a job simply for being LGBT
- Be barred from housing if found to be LGBT
- Be excluded from health and social services because of sexual orientation or gender identity
- Be prohibited from marrying a same-sex partner, which means possible difficulty in bequeathing assets to each other; not be entitled to health insurance for partners; and be barred from visiting partners in hospitals
- Be discharged from the U.S. military if they are open about their sexual orientation
- Lose child custody simply for being LGBT
- Be denied the right to adopt children solely on the basis of gender identity or sexual orientation.

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

- The Federal Rehabilitation Act and the Americans with Disabilities Act (ADA) prohibit discrimination against individuals with "disabilities," including individuals who are alcoholics or have a history of drug abuse.
- The Rehabilitation Act and ADA also classify individuals with HIV/AIDS as individuals with disabilities and prohibit employers, government agencies, and places of public accommodation from discriminating against them on the basis of their being HIV positive. Because gay men, other men who have sex with men, and people who inject drug constitute the largest portion of persons diagnosed with AIDS in the United States, this protection is important.
- For a detailed discussion of the scope of protection offered and how these statutes have been applied in cases of individuals with HIV/AIDS, see Treatment Improvement Protocol 37, Substance Abuse Treatment for Persons With HIV/AIDS (CSAT 2000), available from Substance Abuse and Mental Health Services Administration’s National Clearinghouse for Alcohol and Drug Information at 800–729–6686.
Many States also have laws protecting people with HIV/AIDS from discrimination. Local HIV/AIDS and gay and lesbian advocacy groups and resource centers are often able to provide information and advice about both Federal and State laws in this area. These laws can be helpful to LGBT clients and the programs treating them.

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

### What Treatment Programs Can Do To Help LGBT Clients

- **Confidentiality**
- **Caution on Self-Disclosure**
- **Educate Staff and Clients**
- **Legal Inventory**
- **Respect for LGBT Clients**
- **Program Safety for LGBT Individuals**
- **Affirmative Action/Cultural Competence**

### Notes for Slide 3-6

**Timeframe: 5 minutes**

**Trainer Notes:**

- **Confidentiality:** Programs should establish written policies that ensure information about sexual orientation is confidential, prohibiting disclosure unless the client consents.

- **Caution on Self-Disclosure:** Just as it is suggested that substance abuse clients use caution in revealing their substance abuse histories (e.g., to potential employers), LGBT persons should be urged to think carefully before disclosing their sexual orientation to others. Because LGBT individuals have no legal protection against discrimination, disclosures should be made only to those they are confident will respect them and their privacy.

- **Educating Staff and Clients:** Programs should educate staff and clients about local laws and regulations regarding LGBT persons.
Staff members and clients can go to www.lambda.org, the Web site of the Lambda Legal Defense and Education Fund, to find out about national and local legal protections for LGBT persons.

**Example 1: Barbara**

See Handout 3-A

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**Notes for Slide 3-7**

**Timeframe: 8 minutes**

**Trainer Notes:**

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

**Direct trainees to Handout 3-A to review the case study.**

Trainees should ask trainees what the program should encourage Barbara to do. In general:

- Barbara should share information about her sexual orientation and substance abuse treatment with her attorney

- With family support, seek a negotiated custody agreement

**Further notes:**

- Depending on Barbara’s relationships with her spouse and the children’s grandparents, her attorney may advise her to consider seeking a negotiated custody agreement.

- Information about her sexual orientation (and substance abuse history) is less likely to be used against Barbara in this context than during a heated court battle.
Example 2: Harry

See Handout 3-A

Notes for Slide 3-8

Timeframe: 8 minutes

Trainer Notes:

Direct trainees to Handout 3-A to review the case study.
Trainers should ask trainees what recommendations can be made to help Harry.

In general, the agency can recommend to:

- Sign advance directives about his health care
- Sign a legal document appointing Stephen his healthcare proxy

Explore the options available to him, which may include (depending on State law) signing advance directives about his health care or signing a legal document appointing Stephen his proxy, enabling him to make healthcare decisions should Harry become incapacitated. This legal document is often called a “health care proxy” or a “medical power of attorney.”

Respect for LGBT Clients

- Screen staff members to ensure they are willing to work with LGBT individuals.
- Require all clients to exhibit respect for one another without regard to race, gender, religion, national origin, or sexual orientation. Establish grievance procedures for violations of the rules.
- Treat the partners of LGBT clients in the same way as members of traditional families

Program Safety for LGBT Individuals

- All clients should be informed at admission that the program will not tolerate sexual harassment or sexual overtures between persons of the same or different gender.
- Written personnel policies should include prohibition of harassment in the workplace, including harassment of LGBT staff members by other staff members and sexual harassment between persons of the same or different gender.
Affirmative Action and Cultural Competence

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

Case Studies

Please see Handout 3-B for details.

Notes for Slide 3-9

Timeframe: 45 minutes

Group Exercise

Direct trainees to Handout 3-B for the case studies.

- Divide participants into small groups and assign one of the three case studies to each group.
- Let the groups know they will have 20 minutes discussion. Give them a warning when they have 5 minutes left. Suggest they appoint a spokesperson for each group to report back their discussion.
- Regroup and have each group report back on how it answered the case study questions.
- Go through the notes for each case study to ensure that all the important points are covered.

Discussion for Case Study 1

What legal issues does this case present?

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

Disclosures of treatment information to the district’s HMO:

- The HMO will require information about Bill’s need for treatment to make a decision about covering that treatment. It will also demand that the facility update the information periodically.

- Bill must sign a consent form to permit the program to disclose information to the HMO. Disclosures to the HMO should be as limited as possible, but this may prove difficult. Many managed care organizations require programs to submit detailed information periodically before they will authorize continued treatment (or benefits).

- Bill has reason to be concerned that his admission to treatment may trigger a flow of information that might, through school reviews of personnel or HMO records, result in his losing his job. The Federal rules prohibit HMOs from redisclosing information to the district, but there is no assurance that the HMO will refrain from doing so.

- Therefore, and although this can be difficult, there should be no disclosure of any information to the HMO about Bill’s sexual orientation or his living arrangements. Bill should sign a consent form that gives him the option of permitting or prohibiting disclosure of this information.

Disclosure of information about Bill’s sexual orientation to his in-laws:

- Disclosure could spark an attempt to challenge Bill’s custody of his children. In many States, the combination of Bill’s sexual orientation and his history of alcohol abuse could be used by relatives to try to wrest custody from him.

- If Bill’s in-laws do file a court case seeking custody and their attorney issues a subpoena for Bill’s treatment records, the program can, working with Bill’s attorney, ask the court to issue an order restricting the scope of the information the program will be required to provide.

- For detailed information on dealing with subpoenas and court orders, see Treatment Improvement Protocol 24, A Guide to Substance Abuse Treatment for Primary Care Clinicians (CSAT 1997a), available from Substance Abuse and Mental Health Services Administration’s National Clearinghouse for Alcohol and Drug Information at 800–729–6686.

What policy issue does this case present?

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

- Facilities may set their own policy about how they treat life partners. At the least, programs should allow clients to sign a consent form specifying whom the program can call in emergencies.
Discussion for Case Study 2

What legal issues does this case present?

- **Does the facility have to tell Denise’s parents about her sexual attraction to other girls?**
  - **No.** Denise has consented to communications with her parents about her substance abuse treatment. Denise’s fears about her parents’ reaction may be entirely realistic. Disclosure of this information to Denise’s parents at this time would certainly destroy any therapeutic relationship developing between Denise and her counselor. Such disclosure may also be a violation of professional ethics.
  - **Now that Denise’s counselor knows Denise’s concern, she could ask her to sign a new consent form that specifically requires the program to withhold information about her sexual orientation from her parents.**

- **Can Denise’s counselor discuss her discovery with other facility staff?**
  - **Yes, the counselor can discuss her discovery with other program staff.** The Federal confidentiality regulations contain an exception permitting communication of information between or among program staff members who have a need for the information in connection with their treatment responsibilities.

- **Should Denise’s counselor discuss her discovery with other staff?**
  - **Yes, the counselor should tell other staff, including the program director, about her discovery.** The sexual acting out may have affected either Denise or the other girl, and failure to disclose it might create a legal risk for the program.
  - **If one girl makes an unwanted advance to another girl, the program has a responsibility to help the victimized child.** The information is important to the other girl’s treatment counselor. He or she should be working with the girl to help her cope with this experience.
  - **The information is also important to the program director.** If the other girl was an unwilling target or participant, her parents might sue the program for failing to protect their child. Moreover, if such an incident is swept under the rug, the aggressor may act out again, in which case the program could be put in real jeopardy.

What policy issues does this case present?

- **Program rules regarding client behavior.**
  - If the program does not have rules about sex between clients, it should adopt rules now.
  - If the program does have rules, the treatment staff members and the program director should discuss whether the acting out violated any program rules and, if so, what the program should do.

- **Preventive measures:**
  - The program director should consider whether the program can take additional steps to ensure such incidents do not occur in the future.
Discussion for Case Study 3

What legal issues does this case present?

- **Who is responsible for the cost of Frankie’s care?**
  - Because Frankie and Janice are not legally married, and cannot be, Janice is not responsible for the cost of Frankie’s treatment. Janice may want to support part of the costs of treatment, but there is no legal requirement that she do so, and unless her employer provides health benefits to domestic partners, her HMO will not contribute.

- **Will Medicare cover Frankie’s treatment if his declared gender is not in accord with his biological sex?**
  - Ask Frankie whether Medicare identifies him as male or female. If he gives a different gender from what appears on the original Medicare application, there may be problems with payment.

- **Who is considered “next of kin”—Janice or Frankie’s child?**
  - Because Frankie’s and Janice’s relationship is not State sanctioned, Frankie’s child is considered his next of kin. However, if Frankie prefers to name Janice as his next of kin for visiting and emergency-notification purposes, the program should respect his wishes.

- **Can the program fire staff who refuse to work with Frankie because he is transgendered?**
  - Yes. Unless the staff person is protected by a union contract with a provision covering this situation, he or she can be fired at any time, unless the action is taken because he or she is female, a member of a minority group, or disabled.
  - In the United States, most employment is “at will,” which means that either the employer or employee can end the relationship at any time and for any reason, unless that reason violates one of the civil rights statutes discussed above.

What policy issues does this case present?

- **What policies should the program have in place to ensure that LGBT individuals are treated fairly?**
  - Programs should have written policies in place that require staff members to be willing to treat all clients without regard to race, gender, disability, or sexual orientation.
  - Job descriptions should make treatment of clients (regardless of their status) an integral part of the responsibilities of each position.
  - Staff members should be screened before hiring to ensure they are willing to abide by the program’s treatment rules and should be required to attend educational and sensitivity training about LGBT individuals.

- **Should the program move Frankie away from his objecting roommate?**
  - Yes. No one should have to endure a hostile roommate. Moving Frankie avoids a difficult situation and helps with his treatment.
  - With Frankie’s consent, the program should conduct a sensitivity session to educate clients about transgendered individuals as well as those who are lesbian, gay, or bisexual.
MODULE 4: An Overview of Treatment Approaches, Modalities, and Issues in Accessibility in the Continuum of Care

Total Timeframe: 1 hour, 40 minutes

Overview of Treatment Approaches, Modalities, and Issues of Accessibility

A Provider’s Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals

Based on the publication: (DHHS Publication No. (SMA) 01-3498)

Training Curriculum
Module 4, Handout 4-A

**LGBT-Sensitive and LGBT-Affirmative Treatment Program**
**Principles and Practices**

Participants will be divided into four groups and each group will be responsible for one of the following four topics:

- **Group 1 - Staff sensitivity:** What knowledge, skills, and attitudes do treatment staff members need to have to offer LGBT clients effective treatment?

- **Group 2 - Assessment practices and issues:** When an LGBT client enters a treatment program, what are effective assessment practices?

- **Group 3 - Facilities and modalities:** Are there special needs that LGBT clients may have in terms of the way a facility operates, for example, room assignments and shared bathrooms? What about treatment modalities such as individual, group, and family interventions?

- **Group 4 - Discharge and aftercare:** What are effective discharge planning practices and referrals for aftercare and recovery support?

✓ Brainstorm a list for each issue of the do’s for LGBT-sensitive and LGBT-affirmative treatment and the don’ts that are harmful, insensitive, or ineffective.

✓ Be prepared to present your groups do’s and don’ts to the larger group.
Case Study

Ruth is a 47-year-old African-American lesbian living in a large Midwestern city. She is currently in an inpatient substance abuse treatment program that is gay sensitive. She has talked openly about being lesbian, and her partner of the past 25 years has been part of the treatment program. Ruth was admitted for help with her crack cocaine use. She grew up in a poor part of the city but had developed supports and strengths at her local Baptist church. Ruth and her mother went to regular services and many social functions, and she developed many friendships. She did well in school and liked sports. She was surprised one day in the ninth grade when she read a story about a lesbian teacher and felt a sudden awareness of sexual feelings for other women. She went home to talk about it with her mother, who said she should talk to the minister. When Ruth told him about her feelings, he became very upset and said she was an abomination before God. Although some clergy are LGBT supportive, this minister asked Ruth’s mother to keep Ruth away from the church until she “recovered her senses.”

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

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

1. What key recovery issues is Ruth facing?

2. What issues is Ruth facing that are particular to her identity as a lesbian?

3. What kind of interventions would you suggest if you were her counselor?
Learning Objectives
(Text: Chapter 4 in A Provider's Introduction)

At the end of this session, trainees will

1. Understand special issues in working with LGBT clients
2. Understand levels of care and modalities
3. Know guidelines for insuring accessibility and LGBT-affirmative treatment

Notes for Slide 4-1

Timeframe: 3 minutes

Trainer Notes:

- This session provides an overview of LGBT-sensitive and -affirmative substance abuse treatment principles and practices.
- Some of what is reviewed in this session is presented in more detail in previous and subsequent parts of this curriculum and is noted as such in this session.
- Trainers should emphasize that
  - Substance abuse treatment for LGBT individuals is the same as that for other individuals in its primary focus on stopping the substance abuse that interferes with the well-being of the client.
  - However, LGBT clients will need to address their feelings about their sexual orientation and gender identity as part of their recovery process.
  - Even if the LGBT individual is open about his or her identity, it is virtually impossible to deny the effects of society’s negative attitudes, which can result in feelings of doubt, confusion, fear, and sorrow.
### Approaches, Levels and Continuum of Care, and Access to Treatment

- **Treatment-readiness approaches**
  - Sexual orientation and gender identity issues
  - Coming out
  - Social stigma and discrimination
  - Health concerns, such as HIV/AIDS
  - Homophobia and heterosexism

- **Level of care**
  - Residential vs outpatient
  - LGBT community based support services

- **Continuum of care**
  - LGBT specific versus mainstream

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**Notes for Slide 4-2**

**Timeframe:** 10 minutes

**Content:** Approaches, Levels and Continuum of Care, and Access to Treatment

**Discussion**

Trainers conduct a large group discussion on the following points:

**Question:** Why would a treatment-readiness approach be helpful for an LGBT client?

**Answer:** Treatment-readiness approaches emphasize working first on the level of readiness the client exhibits related to changing alcohol and drug use behaviors without demanding total abstinence as a condition of treatment. For LGBT persons, the necessity of dealing with sexual orientation and gender identity issues, coming out, social stigma and discrimination, HIV/AIDS, and other problems related to homophobia and heterosexism may need to precede or coincide with ability to access and successfully maintain abstinence-based treatment.

**Question:** What level of care is needed and what may be different in determining the level of care for LGBT clients than for other clients?

**Answer:** LGBT clients may not do well in residential programs that lack LGBT-sensitive and LGBT-specific treatment, where staff members are not adept in dealing with the possible homophobia of other clients or staff members in an inpatient facility. The ideal is that all levels of care would be LGBT affirmative but in some cases, outpatient treatment that is more LGBT sensitive or LGBT community-based support services would be preferable for LGBT clients.
Question: *In the continuum of care, what additional services may be needed to support the LGBT client’s recovery process?*

Answer: *Again, LGBT clients often will need referrals to LGBT-sensitive or specific ongoing aftercare and support services, such as LGBT community-based programs, LGBT therapists, and LGBT 12-Step meetings. Some LGBT clients are not able to be out in the workplace, and that may affect the need for additional support to return to the workplace and be able to cope, such as locating an LGBT-sensitive EAP counselor or service.*

### Notes for Slide 4-3

**Timeframe:** 45 minutes  
**Content:** Program Accessibility for LGBT Clients—Examining LGBT-Sensitive and LGBT-Affirmative Treatment Program Principles and Practices

#### Group Exercise:

Refer participants to Handout 4-A.

- Break participants into four groups and assign each group one of the following topic:
  - **Group 1 - Staff sensitivity:** What knowledge, skills, and attitudes do treatment staff members need to have to offer LGBT clients effective treatment?
  - **Group 2 - Assessment practices and issues:** When an LGBT client enters a treatment program, what are effective assessment practices?
  - **Group 3 - Facilities and modalities:** Are there special needs that LGBT clients may have in terms of the way a facility operates, for example, room assignments and shared bathrooms? What about treatment modalities such as individual, group, and family interventions?
  - **Group 4 - Discharge and aftercare:** What are effective discharge planning practices and referrals for aftercare and recovery support?
Ask each group to brainstorm a list for each issue of the do’s for LGBT-sensitive and LGBT-affirmative treatment and the don’ts that are harmful, insensitive, or ineffective.

Have each group present its do’s and don’ts to the large group. Compare with the points on the LGBT Sensitivity Model (see Provider’s Introduction, p. 53).

Defining LGBT Affirmative Care

- **LGBT-tolerant**
  - Aware that LGBT people exist and use their services

- **LGBT-sensitive**
  - Aware of, knowledgeable about, and accepting of LGBT people

- **LGBT-affirmative**
  - Actively promote self-acceptance of an LGBT identity as a key part of recovery

Notes for Slide 4-4

**Timeframe: 10 minutes**

**Trainer Notes:**

**LGBT-tolerant:** aware that LGBT people exist and use their services. Such awareness is usually the result of the facility’s having an LGBT staff member. Even so, helping clients accept their sexual orientation and dealing with homophobia most likely will not be addressed.

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

**LGBT-affirmative:** actively promote self-acceptance of an LGBT identity as a key part of recovery. These programs affirm LGBT individuals’ sexual orientation, gender identity, and choices; validate their values and beliefs; and acknowledge that sexual orientation develops at an early age.
Research data: The Pride Institute, an LGBT-affirmative program, released data showing that programs that consider acknowledging one’s sexual orientation a key factor in recovery have a successful treatment rates (Ratner et al. 1991). At 14-month follow-up:

<table>
<thead>
<tr>
<th>Program</th>
<th>Abstinence Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>LGBT-affirmative program</td>
<td>67%</td>
</tr>
<tr>
<td>Non-LGBT-sensitive program</td>
<td>55%</td>
</tr>
</tbody>
</table>

Content: Examples of DO’S and DON’TS may include

- **Staff Issues:**
  - Heterosexual staff may be uninformed about LGBT issues and culture.
  - Some professionals may falsely believe that an LGBT person’s sexual orientation or gender identity caused his or her alcohol and drug use.
  - If LGBT clients object to working with non-LGBT staff, explore their fears and concerns in a therapeutic context.
  - Acknowledge that negative feelings or attitudes are often based on real experiences.
  - Don’t assume that LGBT clients are more likely to flirt or act out sexually than their heterosexual counterparts.
  - Actively promote self-acceptance of a sober LGBT identity as a key part of recovery.

- **Assessment:** Many issues are the same for all substance abusers. However, some additional factors may need to be assessed when working with LGBT clients.

Special Assessment Questions

- Level of comfort being LGBT person?
- Stage of coming out?
- Family/support/social network?
- Health factors?
- Milieu of use?
- Drug use and sexual identity or sexual behavior connections?
- Partner/lover use?
- Legal problems related to sexual behavior?
- Gay bashing?
- Same-gender domestic violence?
- Out as LGBT in past treatment experiences?
- Correlates of sober periods?
Notes for Slide 4-5

Timeframe: 10 minutes

Trainer Notes:

- Determine the individual’s comfort with being an LGBT person. Evaluate the person’s comfort level with his or her sexuality and expression of sexual feelings.
- If appropriate, determine the individual’s stage in the coming-out process.
- Determine the extent of the individual’s family, support, and social network.
- Determine whether there are any health factors of concern, including the individual’s HIV status.
- Look at the most recent alcohol and drug use: Was it with family, friends, a significant other, a lover, or a date? With work colleagues? Where was it? At a circuit party? Alone? At a sex club or bathhouse? At a lesbian, gay, bisexual, transgender, or straight bar?
- Are drugs used to enhance sexual intensity? To alleviate guilt or remorse about sexual orientation?
- If the client has a significant other, does that person believe there is a problem? Does he or she have his or her own substance abuse problems?
- Has the client ever had legal problems or police harassment related to sexual behavior?
- Has the client ever been attacked or assaulted (gay bashed) because he or she was thought to be an LGBT person?
- Has there been domestic violence by a same-sex lover?
- If client had treatment in the past for substance abuse, was his or her sexual orientation or sexuality discussed?
- What is the longest time the client did without alcohol and drug use, and what allowed that to happen?

Modalities

- **Group counseling**: Groups may be difficult for LGBT individuals if heterosexism/homophobia is demonstrated by staff/other group members. Staff needs to ensure that LGBT clients are treated in a therapeutic manner and should provide a strong oral directive that homophobia and hostility will not be tolerated.
- **Family counseling**: Can be difficult due to issues relating to the client’s sexual identity/orientation, substance abuse, and in some cases, HIV/AIDS diagnosis, which have caused distance and alienation. LGBT clients are more likely to seek support for their partners and their relationships if they view the program as LGBT sensitive.
- **Individual counseling**: Providing one-on-one services may decrease the difficulty of mixing heterosexual and LGBT clients in treatment groups. Thus, LGBT individuals will be...
more able to discuss issues revolving around their sexual orientation/identity without fearing that non-LGBT individuals will be hostile, insensitive, or minimize LGBT issues.

- PROP (Positive Reinforcement Opportunity Project) – this project demonstrated the feasibility of delivering a low-intensity contingency management intervention in both outpatient and community settings and demonstrated preliminary efficacy at reducing methamphetamine use (Shoptaw et al, 2006).

- Shoptaw et al (2005) demonstrated the ability of several interventions to reduce both methamphetamine use and sexual risk behaviors in methamphetamine-dependent gay & bisexual men. The intervention that demonstrated the greatest ability to reduce drug use was one that combined a 16-week 3x/week CBT group with contingency management (provision of vouchers for methamphetamine metabolite-free UA samples). The intervention demonstrating the greatest efficacy for reducing sexual risk behaviors during the course of the study was the GCBT (Gay-specific CBT) group. This intervention was based on standard CBT treatment and adapted to present the same concepts in language and contextual references specific to urban gay/bisexual men. It also integrated material on the roles that sexual orientation, internalized homophobia, and the sexual risk behaviors that frequently accompany methamphetamine use in this population into standard CBT material targeting drug use.

- Since this intensive, 48-session, 3x/week for 16 weeks intervention may be cost-prohibitive for some community treatment programs, the authors have developed a modified version that is delivered in 24-sessions, twice/weekly for 12 weeks. This abbreviated version is currently under evaluation in a clinical research/community treatment provider collaborative program in Hollywood, CA (personal communication, C.J. Reback, 1-9-07).

- These interventions also significantly reduced depressive symptoms in this sample of methamphetamine-dependent gay and bisexual men in a fashion that highlighted the methamphetamine use-withdrawal-depression-meth use cycle (Peck et al., 2005).

**Notes for Slide 4-6**

Timeframe: 5 minutes

Trainer Notes: See highlighted notations above.

- **Discharge Planning and Aftercare or Recovery:** The following concerns require attention when planning aftercare for LGBT clients:
  - Who are the client’s social supports, including family of origin and family of choice (partner, friends, or others)?
What is their living arrangement or environment? Is it conducive to ongoing abstinence and recovery?
What will be the client's employment status or type of employment? Will it support ongoing recovery?
What ongoing issues related to sexual orientation or identity need to be addressed? What supports are available for doing so, such as LGBT-sensitive counselors or programs, LGBT-specific 12-Step groups, or LGBT health, mental health, or community centers?

Case Example: RUTH

(a) What key recovery issues is Ruth facing?
(b) What issues is Ruth facing that are particular to her identity as a lesbian?
(c) What kind of interventions would you suggest if you were her counselor?

Notes for Slide 4-7

Timeframe: 30 minutes

Trainer Notes: Have participants divide into small groups. Direct trainees to Handout 3-B to review the case study. Let them know they will have 15 minutes to discuss the Case Study.

Small groups should reassemble and share their responses, which should be reviewed and compared with recommended responses as follows:

Suggested Interventions:

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

- Relapse is possible at any time. LGBT people in long-term recovery may be embarrassed about relapsing and use that as an excuse to avoid 12-step or other interventions. LGBT substance abuse counselors may feel that they have even fewer treatment options, especially if they wish to preserve a sense of personal confidentiality. In Ruth's case, the out-of-town location may not have been
necessary from a clinical point of view (that is, the treatment at a local site may have been just as good as the site chosen), but the client accepted the intervention and referral. Because getting back on the path of recovery is so important, this concession made perfect sense.

- **Relapse can be triggered by many things.** Although neither a death nor a reaction to prejudice causes the substance abuse, the emotional reaction to such events may be the trigger that brings on a relapse. Ruth will have to face several emotional challenges in her early recovery, and her substance abuse counselor will need to help her pace the rate at which she confronts the issues to help her remain clean and sober. The death of her mother, the homophobia of her church, her concern about the effect of her behavior on her lover, her return to work, and revisiting her own internalized homophobia all will be part of her long-term recovery.

- **Religion and spirituality may play an important part in recovery from substance abuse for many LGBT people.** If the client’s church is an issue, the counselor may need to help the client find an LGBT-accepting church or a different church branch. Some organized religious groups and churches have congregations for LGBT people. Most religious groups will have some LGBT-sensitive, if not even openly LGBT, clergy who may be helpful. Counselors will need to know the difference between religion (commitment to a religious faith) and spirituality (of or related to the spirit) and help the LGBT client understand that difference. Such a client may find spiritual comfort even if he or she cannot find religious comfort.

- **Psychotherapy usually does not work for substance abusers who are actively using.** In Ruth and her lover’s case, couples therapy would probably not have been helpful. The therapist was aware of this fact and used the couple’s meetings to help the lover shape an intervention, which led to Ruth’s beginning treatment. After Ruth is clean and sober for several months, the couple could start therapy if it is still needed. Meanwhile, the lover can continue to seek the help she needs to manage her own depression.
Ruth herself will also need to see how her life has been affected by racism and homophobia. If she has not explored this in past counseling, she will need to look at it now to help shore up her recovery. In the same way that not acknowledging the effects of homophobia may make relapse more likely, so, too, will not addressing the impacts of racism.

Since the lover is so involved in Ruth’s life and recovery, she should play a role in the early recovery process. Ruth’s inpatient treatment counselor will need to include her just as she would the significant other of a non-LGBT person.
MODULE 5:
The Coming Out Process for Lesbians and Gay Men

Total Timeframe: 1 hour and 10 minutes (without film)

Clinician’s Guide
A Provider’s Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals

Based on the publication:
(DHHS Publication No. (SMA) 01-3498)

Training Curriculum
Module 5

Overview, Goals and Objectives

**Total Timeframe: 9 hours**

- **The Coming Out Process**: In this session, trainers will present information on different models for the coming out process, helping participants understand how LGBT clients navigate this ongoing life challenge.
- **Clinical Issues**: Through case studies and didactic material, trainees will gain knowledge about clinical issues unique to specific groups within the LGBT communities.
- **Health Issues**: Trainees will gain understanding of various health concerns that affect the LGBT communities.
Module 5

Unifying science, education and service to transform lives

Title Slide - Module 5, 7-10: A Clinician’s Guide (Part 1 of 2)

From:
A Provider’s Introduction to Substance Abuse for Lesbian, Gay, Bisexual, and Transgender Individuals

Learning Objectives - Clinician’s Guide
to Working With Lesbian, Gay, Bisexual, and Transgender Clients in Substance Abuse Treatment

(Text: Section 2 in A Provider's Introduction)

At the end of this session, trainees will

4. Understand the "coming out" process and its impact
5. Understand clinical issues and effective interventions with lesbians, gay men, bisexuals, transgender individuals, and LGBT youth
6. Have skills for working with LGBT families
7. Be able to identify and assess related health and mental health issues
8. Demonstrate skills for evaluating and improving counselor competence in treating LGBT clients
Notes for Slide 5-1

**Timeframe: 3 minutes**

**Trainer Notes:**

- To enhance the flow of the material, the following training modules are in a different order from the way the chapters are organized in *A Provider’s Introduction*.
- In this section, there will be references to what chapter the training material is from to enable participants and trainers to use the textbook as needed.

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**Module #5 - The Coming Out Process**

(From Chapter 5 in *A Provider’s Introduction*)

**Learning Objectives**

- Understand the coming out process
- Understand the connection between recovery and coming out
- Learn effective counselor interventions

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**The Labeling Exercise**

- You are at an important career-related networking function.
- You want to meet and greet every other person in the room at least once.
- Read the label on each person’s forehead and treat him or her according to what that label says.
Notes for Slide 5-3

**Timeframe: 30 minutes**

**Group Exercise: Labeling Exercise**

This exercise requires a standard sheet of white labels that can be peeled off and stuck on each trainee's forehead. Trainers should have these made up in advance.

The labels should be simple and easily readable. They should not contain ethnic, racial, or physical characteristics. Behavioral instructions are more effective. Trainers will mostly use “positive” labels but will also need some “negative” labels.

Examples of positive labels can include:

<table>
<thead>
<tr>
<th>Glad To Meet Me</th>
<th>Endorse Me</th>
<th>Be Nice To Me</th>
</tr>
</thead>
<tbody>
<tr>
<td>Offer Me A Job</td>
<td>Happy To See Me</td>
<td>Compliment Me</td>
</tr>
<tr>
<td>Congratulate Me</td>
<td>Shake My Hand</td>
<td>Greet Me Warmly</td>
</tr>
<tr>
<td>Praise Me</td>
<td>Tell Me I'm Swell</td>
<td>Give Me Support</td>
</tr>
</tbody>
</table>

Examples of negative labels can include:

<table>
<thead>
<tr>
<th>Be Rude To Me</th>
<th>Avoid Me</th>
<th>Criticize Me</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scowl At Me</td>
<td>Be Cold and Abrupt</td>
<td>Ignore Me</td>
</tr>
</tbody>
</table>

Use about 5 negative labels for every 15 positive ones. For a small group (fewer than 10), 2 or 3 negatives is sufficient. Only trainees already identified as strong, engaged participants should have negatives. A negative label should not be put on a hostile or troublesome trainee to teach him or her a lesson. It may backfire and further alienate that trainee.

- Let trainees know that they will have to move their hair away from their foreheads.
- Encourage full participation in this exercise—don’t let anyone sit it out!
- Ask each trainee to affix a label to his or her forehead. The trainers tell them that they are all at an important career-related networking function and that they need to stand and to mingle. They must meet and greet every other person in the room at least once. They need to read the label on each person's forehead and treat person according to what the label says.
- After mingling about 5 minutes, trainees should return to their seats to process the exercise.
**Follow-up Discussion:** Trainers process the exercise in the large group as follows:

- Trainers first ask each person who had a negative label to speak about his or her experience. Most will say that even though they knew it was a game, it felt bad/sad/uncomfortable to be ignored, diminished, or marginalized. Some may say that it brings back memories of being left out, teased, or marginalized as a child: not picked for the team, not invited to the party or to the dance.

- Ask some of the positive labels to share. Some will say it felt contrived. Some will say they enjoyed the attention. Most will agree that it always feels better to be in the “in” crowd than to be left out.

- The point of this exercise is the experience of being other, left out, not included, different, and sometimes not being sure why—being labeled but for unknown or ambiguous reasons, for example, Is it because they know I am gay, or is it because my hair looks funny, or is it just me feeling too sensitive?

- Let trainees discuss implications of being marginalized: both their personal feelings and reactions and the implications for their clients. One example is the gay person in a treatment setting who aggressively asserts his identity as a reaction to feeling marginalized or invisible.

Segue from this discussion into the process of coming out as being able to accept and then share an identity, in this case being LGBT, as a positive and empowering experience, not as a label.

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**Slide 5-4**

*Coming Out*

The term “coming out” refers to the experiences of lesbians and gay men as they work through and accept a stigmatized identity, transforming a negative self-identity into a positive one.

**Coming Out**

The term "coming out" refers to the experiences of lesbians and gay men as they work through and accept a stigmatized identity, transforming a negative self-identity into a positive one.
Notes for Slide 5-4

Timeframe: 3 minutes

**Trainer Notes:**

For many lesbians and gay men, the process of coming out occurs over time and is related to a variety of circumstances and issues:

- How safe it is for persons to reveal their identity in a particular group or situation
- What resources they have for support, both professionally and in terms of community
- Whether there are other “out” role models and friends they can relate to and be with
- What the other consequences for them may be in terms of family relationships, child and parenting issues, work, and so forth.

Most clinicians agree that helping a client to accept and then feel empowered around his or her LGBT identity is an important part of recovery from addiction, that keeping secrets and feeling internalized shame about any aspect of one’s identity and experience can be harmful to a full recovery process.

The CASS Model

**Stage I: Identity Confusion**

Occurs when a person begins to realize that he/she may relate to or identify as being gay or lesbian, a process of personalizing the identity.

- **Tasks:** Exploration and increasing awareness
- **Feelings:** Anxiety, confusion
- **Defenses:** Denial
- **Recovery:** Having a confidential support person

**Stage Models** provide a framework to understand and facilitate the process of coming out for gay men and lesbians.

Although there are similarities in this process for transgender and bisexual persons, there are also important differences that will be discussed later in more detail.
The Cass Model is a widely used model developed by an Australian psychologist, Vivienne Cass, in 1979, out of her research and extensive work with her community on coming out issues. It was derived in part from the work of African-American psychologist William Cross in the early 1970s. Cross developed a staged model to describe and explain the process through which people of color, in particular African-Americans, recovered from the effects of discrimination and racism to transform a stigmatized identity into a positive one.

Emily McNally (1989) used this model to further describe how lesbians transform their identities from active alcoholics to sober ones. The model here was developed by Barbara Warren and Dana Rose in 1996 to integrate the stages and tasks of addiction recovery, based on John Bradshaw's work in the mid-1980s and Cass’s model of identity transformation as tools and guides for the New York State LGBT training curriculum.

Notes for Slide 5-5 to 5-10

**Timeframe: 10 minutes**

**Trainer Notes:**
Using Cass’s Model of Gay and Lesbian Identity Development (see below),

describe and discuss with trainees

- The tasks at each stage
- The feelings that may emerge
- Defense mechanisms that may be evident
- The skills needed to resolve each stage
- The relationship to addiction and recovery.

Research indicates that the Cass model may not apply to minority groups


- Individuals in minority groups do not go through the self-identity process as outlined by the Cass Model
- Identity occurs in two phases
- Sexual minority self-identification is fully integrated into the individual
- Sexual self-identity is unintegrated into the individual’s sense of self.
**Stage II: Identity Comparison**

*Occurs when a person accepts the possibility he/she might be gay or lesbian.*

- **Tasks:** Exploration of implications, encountering others like oneself
- **Feelings:** Anxiety, excitement
- **Defenses:** Bargaining and rationalizing
- **Recovery:** Meeting gays/ lesbians/bisexuals/transgender persons in recovery

**Stage III: Identity Tolerance**

*Occurs when a person comes to accept the probability that he/she is an LGBT person.*

- **Tasks:** Recognizing social and emotional needs as a gay man or lesbian
- **Feelings:** Anger, excitement
- **Defenses:** Reactivity
- **Recovery:** How to be gay, lesbian, bisexual, or transgender and stay sober

**Stage IV: Identity Acceptance**

*Occurs when a person fully accepts rather than tolerates himself or herself as an LGBT person.*

- **Tasks:** Development of community and acculturation
- **Feelings:** Rage and sadness
- **Defenses:** Hostility towards straight culture
- **Recovery:** Lesbian/gay/bisexual/transgender recovering community building
Stage V: Identity Pride

Occurs when the person immerses himself or herself in the LGBT community and culture to live out identity totally

- **Tasks:** Full experience of being an LGBT person, confronting internalized homophobia
- **Feelings:** Excitement and focused anger
- **Defenses:** Arrogant pride and rejection of straight culture as the norm
- **Recovery:** Integrating sexuality, identity, and recovery

Stage VII: Identity Synthesis

Occurs when a person develops a fully internalized and integrated LGBT identity and experiences himself or herself as whole when interacting with everyone across all environments.

- **Tasks:** Coming out as fully as possible, intimate gay and lesbian relationship; self-actualization as a gay man, lesbian, bisexual, or transgender person
- **Feelings:** Excitement and happiness
- **Defenses:** Minimal
- **Recovery:** Maintenance (end stage)

Neisen's 3-Phase Model for Recovery From Shame – Phase I

Breaking the Silence parallels the process of coming out. It is important for LGBT individuals to tell their stories and to address the pain of being different in a heterosexist society.

**Counselor Tasks:**
1. Facilitate client discussion of hiding LGBT feelings from others
2. Explore emotional costs of hiding/denying one's sexuality
3. Discuss how the client has tried to fit in and at what cost
4. Examine negative feelings of self-blame, feeling bad or sick, and the effect of shaming messages on client
5. Foster client's ability to be out
Notes for Slide 5-11 – 5-13

Timeframe: 10 minutes

Trainer Notes:
This section is based on Chapter 13 of A Provider’s Introduction, Counselor Competence in Treating LGBT Clients. However, it makes sense, in the context of clinical guidelines, to reference it here.

This three-phase model, developed by Joseph Neisen (1993) from his extensive work with LGBT clients and addiction recovery, discusses the process of recovering from shame associated with heterosexism and parallels the coming out process.

DISCUSSION: Using Neisen’s three-phase model (see below), describe and discuss with trainees

- The counselor’s tasks at each stage
- The client’s feelings that may emerge
- The client’s defense mechanisms that may be evident
- The skills and insights the client needs to resolve each stage
- The relationship of each stage to the addiction-recovery process.

Phase Two: Establishing Perpetrator Responsibility

Allows clients to understand their struggle in the context of societal discrimination and prejudice.

Counselor Tasks:
1. Facilitate focusing end, managing anger constructively, not destructively
2. Help client understand and accept negative self-image as socio-cultural, not personal
3. Counteract client’s experience of heterosexism and homophobia by role-modeling and by providing a treatment environment that is empowering for LGBT persons, not stigmatizing.
Phase Three: Reclaiming Personal Power

Involves improving self-concept, self-esteem, and self-confidence

Counselor Tasks:
1. Facilitate client's self-concept and self-efficacy
2. Identify and change negative messages to affirmations
3. Recognize and release residual shame
4. Develop a positive affirming spirituality
5. Integrate public and private identities
6. Build a support network, connect to community
MODULE 6:
Families of Origin and Families of Choice

Total Timeframe: 1 hour, 15 minutes

Clinician’s Guide

A Provider’s Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals

Based on the publication:
(DHHS Publication No. (SMA) 01-3498)

Training Curriculum
Module 6: Handout 6-A

Taking a Family History

All Clients:

- What were the rules of the family system?
- Was there a history of physical, emotional, spiritual, or sexual trauma?
- Were all family members expected to behave or evolve in a certain way?
- What were the family’s expectations in regard to careers, relationships, appearance, status, or environment?

LGBT Clients:

- Was anyone else in the family acknowledged to be or suspected of being a lesbian, gay, bisexual, or transgender individual?
- How did the family respond to other individuals coming out or being identified as LGBT individuals?
- Is the client out to his or her family?
- If the client is out, what type of response did he or she receive?

- The family of origin’s response to a client’s self-disclosure can have a significant and long-lasting effect. Responses can range from abusive, rejecting, or avoiding to tolerant, supportive, or inclusive.
- LGBT individuals experience prejudice and, most frequently, a disconnection from their families of origin because of who they are.
Module #6: Families of Origin and Families of Choice

(Text: Chapter 6 in A Provider's Introduction)

At the end of this session, trainees will

1. Understand families of origin versus families of choice
2. Understand family-related relapse triggers
3. Be able to develop interventions for families of choice in treatment

Notes for Slide 6-1
Timeframe: 3 minutes

Family Influences

1. What are the important values and major influences, positive and negative, that you received from your families while growing up?
2. How do these family influences affect our lives?
3. How might all of these family values and influences affect a client’s relapse patterns and/or recovery?
Notes for Slide 6-2

Timeframe: 20 minutes

Group Exercise:
- Divide participants into groups of three or four.
- Provide each group with a sheet of flip chart paper and a marker.
- Give the groups 10 minutes to brainstorm the important values and major influences, positive and negative, that they received from their families while growing up.
- When finished, have groups post their sheets around the room.
- Return to large group, and have group discuss the following questions:
  - How do these family influences affect our lives?
  - How might all of these family values and influences affect a client’s relapse patterns or recovery?

Definition of Family of Origin

The birth or biological family or any family system instrumental or significant in a client’s early development.
Notes for Slide 6-3

Timeframe: 3 minutes

**Trainer Notes:**

All clients in recovery have unresolved issues with their families of origin. LGBT clients are no exception and often have particular issues regarding sexual orientation or gender identity. Addressing these issues is critical because they may pose a risk of relapse for clients.

Notes for Slide 6-4

Timeframe: 7 minutes

**Trainer Notes:**

- The family of origin’s response to a client’s self-disclosure can have a significant and long-lasting effect. Responses can range from abusive, rejecting, or avoiding to tolerant, supportive, or inclusive.
- LGBT individuals experience prejudice and, most frequently, a disconnection from their families of origin because of who they are.
**Definition: Families of Choice**

LGBT people create "replacement" family networks that are made up of individuals who are significant to them, including:

- friends
- partners
- families of partners
- ex-lovers
- blood relatives
- individuals who have died or are no longer an immediate part of the client's life because of addiction, HIV/AIDS, a relationship break-up, or other life events.

---

**Notes for Slide 6-5**

**Timeframe:** 5 minutes

**Trainer Notes:**

Trainers ask trainees what qualities make up a family and introduce the concept of family of choice in the LGBT community.

Families of choice does not necessarily exclude blood relatives.
Guidelines for Working With LGBT Families

- Demonstrate respect, understanding, and support for the life partners and significant others of LGBT clients. These individuals must receive services similar to those offered spouses and family members of heterosexual clients.

- Be sensitive to the diversity and variety of relationships in the LGBT community. Although many individuals seek out a life partner, others are single or may find themselves in nontraditional arrangements.

- Be sensitive to the individual’s self-identification; not all individuals in relationships with people of the same sex, or engaging in same-sex behavior, consider themselves lesbian or gay.

- Remember that there is no universal terminology regarding significant others in the LGBT community. Allow clients to define which terms (lover, partner, significant other) they wish to use and what the terms mean for them.

- Be careful of biases when working with clients whose sexual and relational behaviors are different from your own.

- Remember that lesbian, gay, and transgender individuals may have a history of opposite-sex relationships. Some choose to maintain contact with these partners, whereas others consider such relationships to be a part of a previous “life” before coming out.

- Different levels of comfort with one’s sexual orientation may be a significant relationship stressor, for example, if one person is out while the other remains closeted.
Notes for Slide 6-6
Timeframe: 10 minutes

Trainer Notes:

Review the detailed notes above.

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Myths and Facts About LGBT Parents

Myth: Lesbians and gay men do not have children.

Fact: The American Bar Association estimates that at least 6 to 10 million daughters and sons of lesbian, gay, and bisexual parents in the United States.

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Notes for Slide 6-7
Timeframe: 5 minutes

Trainer Notes:

Facts: The American Bar Association estimates that there are at least 6 to 10 million daughters and sons of lesbian, gay, and bisexual parents in the United States. (American Bar Association 1987). Until recently, many of these children originated from heterosexual relationships. Today, open lesbians are having record-breaking numbers of children. Various options are open to prospective parents, including artificial and donor insemination, domestic and international adoption, foster care, and surrogacy.
**Myths and Facts About LGBT Parents**

**Myth:** Children raised by LGBT parents are likely to turn out to be LGBT themselves.

**Fact:** Published studies have established that children raised by gay or lesbian parents are no more likely to grow up gay or lesbian than other children (Patterson 1992).

**Notes for Slide 6-8**

**Timeframe:** 5 minutes

**Trainer Notes:**
Most LGBT individuals were raised in heterosexual families, so a parent’s sexual orientation does not determine how children will identify when grown up.

---

**Myths and Facts About LGBT Parents**

**Myth:** Children who are in contact with gay men or lesbians face increased risk of being sexually abused.

**Fact:** Statistics indicate that 90% of all children sexual abuse cases involve a heterosexual male perpetrator.

**Myth:** Gay men and lesbians have unstable relationships that make them inadequate parents.

**Fact:** A large number of gay men and lesbians can and do enjoy long stable and satisfying relationships.

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Notes for Slide 6-9

Timeframe: 5 minutes

Trainer Notes:

- **Myth:** Children who are in contact with gay men or lesbians face increased risk of being sexually abused.

  **Facts:** Statistics indicate that 90 percent of all childhood sexual abuse cases involve a heterosexual male perpetrator. Sexual orientation, whether heterosexual or homosexual, is an adult sexual attraction to other adults. Pedophilia, on the other hand, is an adult sexual attraction to children. Pedophilia and sexual orientation are not the same thing.

- **Myth:** Gay men and lesbians have unstable relationships that make them inadequate parents.

  **Facts:** Gay men and lesbians are just as interested in finding committed, loving relationships as are heterosexual individuals. A large number of gay men and lesbians can and do enjoy long stable and satisfying relationships. In fact, if the unions of same-sex couples were officially recognized by their States, their relationships would be even further protected through legal marriage.

---

**Myths and Facts About LGBT Parents**

**Myth:** The only acceptable home for a child contains a mother and father who are married to each other.

**Fact:** The reality of today is that the traditional definition of the married, heterosexual couple with 1.5 children is only one of many types of families that children grow and thrive in.

**Myth:** Children raised by a gay or lesbian couple will not have proper male and female role models.

**Fact:** Research suggests that children of LGBT parents are exposed to more people of the opposite sex than many children of straight parents and even when children are not, there is no evidence to suggest that they are harmed (Kirkpatrick 1987).
Notes for Slide 6-10

Timeframe: 5 minutes

Trainer Notes:

Myth: The only acceptable home for a child contains a mother and father who are married to each other.

Facts: The reality of today is that the traditional definition of the married, heterosexual couple with 1.5 children is only one of the many families that children grow and thrive in. Children are raised in families large and small. There are one-parent, two-parent, and grandparent-headed families. There are stepfamilies, blended families, foster families, families of birth, and families of intention. There are families with 1 child, families with 10 children, families with no relatives, and families bursting with extended family activity. Families are interracial, multiracial, intergenerational, gay, and straight.

Myth: Children raised by a gay or lesbian couple will not have proper male and female role models.

Facts: Children find role models in every environment with which they are involved. Most LGBT parents make sure that their children have consistent, positive contact with teachers, grandparents, mentors, ministers, coaches, aunts and uncles, friends, and neighbors. Positive role models come in many forms. Research suggests that children of LGBT parents are exposed to more people of the opposite sex than many children of straight parents and even when they are not, there is no evidence to suggest that they are harmed (Kirkpatrick 1987).
MODULE 7:  
Clinical Issues with Lesbians

Total Timeframe: 50 minutes

Clinician’s Guide

A Provider’s Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals

Based on the publication: (DHHS Publication No. (SMA) 01-3498)

Training Curriculum
Module # 7: Clinical Issues With Lesbians

(Text: Chapter 7 in A Provider's Introduction)

At the end of this session, trainees will

1. Learn myths, stereotypes, and facts
2. Understand clinical issues for lesbians in treatment
3. Learn effective counselor interventions

Notes for Slide 7-1

Timeframe: 3 minutes

Myths and Facts About Lesbians

Myth: You can tell a lesbian by how she looks.

Fact: Lesbian appearances are diverse. Some women may look or act masculine; other women may look or act feminine. Not all lesbians are "butch".

Notes for Slide 7-2

Timeframe: 5 minutes

Trainer Notes:

Trainers should go through the following myths and ask trainees how believing each myth might negatively influence or impact how a counselor would treat a lesbian client.

Examples of Effect for this slide:

- Assume a client could not really be a lesbian because she appears too femme and subsequently inhibit or ignore her need to explore her same-gender sexuality.
- Assume that a more masculine appearing or dressing woman must be lesbian and insist that she address her "denial and resistance."
Myths and Facts About Lesbians

**Myth:** Lesbians hate men, are afraid of men, or want to be men.

**Fact:** Most lesbians do not hate, fear, or want to be men. Most lesbians have relationships with men in a variety of roles: family, friends, colleagues, coparents, etc.

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### Notes for Slide 7-3

**Timeframe:** 5 minutes

**Trainer Notes:**

**Examples of Effect for this slide:**

- Fail to effectively explore important or significant relationships with men.
- Assume and try to treat a nonexistent pathology towards men, for example, assume a client is “acting out” with women as a reaction to men.
- Neglect family or coparenting issues and concerns.

---

**Myths and Facts About Lesbians**

**Myth:** Lesbians do not form stable relationships.

**Fact:** Like their straight counterparts, some lesbians engage in serial dating and are not monogamous; some are in long-term partnerships.
Notes for Slide 7-4

Timeframe: 5 minutes

Trainer Notes:

Examples of Effect:
- Neglect to take lover relationships seriously.
- Fail to explore relationship, dating, and partnering issues as salient to treatment.

Myths and Facts About Lesbians

Myth: A lesbian identity is about sex.

Fact: Although being lesbian certainly is about being sexually attracted to other women, many lesbians also talk about the power and importance of their emotional and affectional feelings and attractions for other women. In addition, there is a lesbian cultural identity.

Notes for Slide 7-5

Timeframe: 5 minutes

Trainer Notes:

Examples of Effect:
- Fail to explore or encourage development of lesbian social relationships and recovery and other support networks.
Myths and Facts About Lesbians

**Myth:** Sexual abuse by men or bad relationships with men causes lesbianism.

**Fact:** There is no research that suggests sexual, physical, or emotional abuse by men causes lesbianism.

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**Notes for Slide 7-6**

**Timeframe:** 5 minutes

**Trainer Notes:**

**Examples of Effect:**
- Denigrate lesbian identity as pathological or sick.
- Fail to explore or encourage development of a positive lesbian identity.
- Emphasize repairing or restoring heterosexual relationships as the focus of treatment.

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**Myths and Facts About Lesbians**

**Myth:** Lesbianism is caused by a hormonal imbalance and could be changed by taking the right hormones.

**Fact:** There is no evidence to support a relationship between sexual orientation and hormonal levels.

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**Myths and Facts About Lesbians**

**Myth:** Lesbianism is caused by a hormonal imbalance and could be changed by taking the right hormones.

**Fact:** There is no evidence to support a relationship between sexual orientation and hormonal levels.
Notes for Slide 7-7

Timeframe: 5 minutes

Examples of Effect:
- Mislead client about health issues.
- Undermine development of positive lesbian identity.

Special Issues for Lesbians

1. Multiple stigmas and stressors related to sexism, lesbian identity, and substance use
2. Relationships as a major treatment focus for all lesbians
3. Relapse to protect themselves from painful feelings surrounding their sexuality

Notes for Slide 7-8

Timeframe: 15 minutes

Trainer Notes:

1. Multiple stigmas and stressors related to sexism, lesbian identity, and substance use

- Clinicians need to be aware of the intersection of gender and sexual orientation issues for women who are lesbians.
- Some lesbians will have experienced multiple traumas resulting from experiences such as sexual abuse, antigay discrimination or abuse, and substance abuse.

Lesbians, as women, must recover from the physical effects of alcoholism and the social diseases of sexism and homophobia... an individual lesbian alcoholic must surrender to her powerlessness over alcohol and other mood-altering drugs while at the same time reclaiming her power as a woman and a lesbian.—Brenda Underhill (1991)
2. Relationships as a major treatment focus for all lesbians

- Providers need to assess clients’ relationships with both men and women in their lives, sexual fears and guilt, patterns of sexual behavior, and relationship choices.
- If the client currently in a relationship, it is important to address the following:
  - Are there differences between how out the client is and how out her partner is?
  - What is her partner’s drug and alcohol use?
  - What is her partner’s level of knowledge about addiction?
  - What kind of support does her partner have for her own recovery process?

- Sometimes lesbians experience stress about
  - Negotiating social expectations of relationships between women versus the demands of a romantic and sexual relationship
  - Social expectations, inhibitions or guilt or shame about women’s sexuality and the intersection with lesbian sexuality.

3. Relapse to protect themselves from painful feelings surrounding their sexuality

- Many women who have not dealt with their sexuality in prior treatment report that they returned to drinking or drugs to protect themselves from painful feelings surrounding their sexuality in areas such as prostitution, sexual orientation, incest, abortion, fear of sex sober, having indiscriminate sex or compulsive sex, or sexual assault.
MODULE 8:
Clinical Issues with Gay Male Clients

Total Timeframe: 1 hour and 5 minutes

Clinician’s Guide
A Provider’s Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals

Based on the publication:
(DHHS Publication No. (SMA) 01-3498)
Module #8: Clinical Issues With Gay Male Clients

At the end of this session, trainees will

1. Understand myths and facts
2. Understand social, cultural, psychological, and developmental issues
3. Understand implications for treatment

Myth: Gay men appear and act more feminine.

Fact: Gay male appearances and behaviors are diverse. Some men may look or act hypermasculine; other men may look or act in a manner more associated with being feminine.

Notes for Slide 8-2

Timeframe: 5 minutes

Discussion

Trainers should go through the following myths and ask trainees how believing each myth might negatively influence or impact how a counselor would treat a gay male client.

Examples of Effect for this slide:

- Assume a client must not really be a gay because he appears or acts too masculine and subsequently inhibit or ignore his need to explore his same-gender sexuality.
- Assume a more effeminate man must be gay and insist on his addressing his "denial and resistance" to being out.
Myths and Facts About Gay Men

**Myth:** Same-sex sexual behaviors can often be blamed on using alcohol and drugs; once the client achieves sobriety, he will no longer desire or seek same-sex sexual relations.

**Fact:** Many gay men report using alcohol and drugs to cope with their guilt and shame about same-sex sexual desire and behaviors.

Men who have sex with men also report initially using drugs—especially the class of drugs commonly referred to as club or party drugs—to enhance sexual activity and then find themselves abusing or addicted to those drugs.

---

**Notes for Slide 8-3**

**Timeframe:** 5 minutes

**Trainer Notes:**

**Examples of Effect for this slide:**

- Assume or counsel that homosexual desire will stop with sobriety.
- As a result, avoid exploring same-sex sexuality, shame, and drug use.

---

Myths and Facts About Gay Men

**Myth:** Gay men are not interested in or are unable to engage in committed relationships, only in sexual encounters.

**Fact:** More gay men these days report seeking or being in long-term committed relationships with partners, and many gay male couples are parenting children.

It is also important to note that some gay men will have a history of relationships with women, may have been married and have children and need to address their issues as fathers.
Notes for Slide 8-4

**Timeframe:** 5 minutes

**Trainer Notes:**

**Examples of Effect:**

- Neglect to take same-sex lover relationships seriously.
- Fail to explore intimacy in relationship, dating, and partnering issues as salient to treatment.
- Neglect to work on resolving coparenting issues or family issues.
- Focus on restoring a former heterosexual relationship as “curative.”

---

Myths and Facts About Gay Men

**Myth:** Most gay men are overly enmeshed with their mothers and have cold or indifferent fathers.

**Fact:** Many gay men had "normal" family relationships; some had excellent relationships with both parents, and some had terrible relationships with both parents.

It is important for clinicians to assess, not to assume, the reality of the client's family of origin experience and then the effect of coming out or of being gay on the client's perception of relationships past and present.

---

Notes for Slide 8-5

**Timeframe:** 5 minutes

**Trainer Notes:**

**Examples of Effect:**

- Incorrect assumptions about family and psychodynamic issues and concerns.
- Neglecting to address early childhood issues appropriately.
Special Issues for Gay Men

1. Linking of substance abuse and sexual expression
   - Brought up in a society that says they should not act on their sexual feelings, gay men are likely to internalize this homophobia.
   - Often their first same-sex sexual experience was while drinking or being high to overcome fear, denial, anxiety, or even revulsion about gay sex.
   - This linking of substance use and sexual expression may persist and become part of the personal and social identity development processes.

2. Internalized homophobia
   - Many gay men may feel ashamed or uncomfortable about having sex with another man. This manifestation of internalized homophobia can lead to sexual activity in inappropriate places, such as parks or public bathrooms, and can strengthen the link between substance use and sexual activity.
   - Many gay men describe an awareness of “being different” early in life. They recognize that their loving and sexual needs and longings make them different from others around them. The psychology of being different, and of learning to live in a society that does not accept difference readily, shapes a young gay man’s sexual identity development.

3. The role of sexual abuse and violence
   - Some men as youth were especially vulnerable to sexual abuse and violence because they were gay and sometimes were introduced to sex via hustling or prostitution.
   - They may also have a history of being otherwise “used” or exploited sexually by others.

Notes for Slide 8-6

Timeframe: 15 minutes

Trainer Notes:

1. **Linking of substance abuse and sexual expression**
   - Brought up in a society that says they should not act on their sexual feelings, gay men are likely to internalize this homophobia.
   - Often their first same-sex sexual experience was while drinking or being high to overcome fear, denial, anxiety, or even revulsion about gay sex.
   - This linking of substance use and sexual expression may persist and become part of the personal and social identity development processes.

2. **Internalized homophobia**
   - Many gay men may feel ashamed or uncomfortable about having sex with another man. This manifestation of internalized homophobia can lead to sexual activity in inappropriate places, such as parks or public bathrooms, and can strengthen the link between substance use and sexual activity.
   - Many gay men describe an awareness of “being different” early in life. They recognize that their loving and sexual needs and longings make them different from others around them. The psychology of being different, and of learning to live in a society that does not accept difference readily, shapes a young gay man’s sexual identity development.

3. **The role of sexual abuse and violence**
   - Some men as youth were especially vulnerable to sexual abuse and violence because they were gay and sometimes were introduced to sex via hustling or prostitution.
   - They may also have a history of being otherwise “used” or exploited sexually by others.
4. Limited social outlets

- Legal prohibitions against same-sex behavior, overt discrimination, and the failure of society to accept or even acknowledge gay people have limited the types of social outlets available to gay men to bars, private homes, or clubs where alcohol and drugs often played a prominent role.
- Circuit parties have become popular among a large group of gay men. These weekend-long, primarily gay male, gatherings, held around the country, focus on dancing, sexual activity, and alcohol and drug use. Party drugs—ecstasy, GHB, Special-K, and others—are encouraged to enhance the dancing and sexual activity.

Special Issues for Gay Men

5. Geographic and cultural differences have an important impact on the lives of gay men

6. Limited role models and deeply ingrained stereotypes

7. Substance use and HIV/AIDS.

- HIV-seronegative MSM were found to be more likely to engage in SDUA (serodiscordant unprotected anal intercourse) during periods of any use of methamphetamine, cocaine, or poppers, suggesting that HIV prevention efforts should target individuals who report even “recreational” use of these drugs (Colfax et al, 2005).
- Methamphetamine was used by 15% and Viagra was used by 6% of a recent sample of MSM in San Francisco during their most recent sexual encounter (Mansergh et al, 2006)
- While many HIV+ MSM assume that having unprotected sex with another HIV+ person is not dangerous, if they each have different viral strains, they may reinfect each other with the other strain, leading to “superinfection” (Blackard et al, 2002)
- HIV and chronic methamphetamine use each have neurotoxic effects; it has recently been demonstrated that the combination of the two has an additive effect, causing more brain damage than both of them individually would cause (Chang et al, 2005; Carey et al, 2006).
Notes for Slide 8-7

Timeframe: 15 minutes

5. Geographic and cultural differences have an important impact on the lives of gay men
   - Life for a gay man in a small Midwestern town may bear little resemblance to that of a gay man living in Los Angeles or rural Texas.
   - The experiences of a Latino gay man may be quite different from those of a Caucasian gay man or an African-American gay man, even if they live in the same city.

6. Limited role models and deeply ingrained stereotypes
   - The popular media portrays gay men in various stereotypes. Young gay men just coming out, with limited role models or none at all, may believe these are the ways to act if one is a gay man. If they do not comply with the stereotypes they perceive, they may feel they do not fit in.
   - Older gay men may feel more inadequate as they age when gay culture puts an emphasis on youthful looks.
   - Older gay men lack traditional social and service supports as they age. For example, gay widowers are not acknowledged and being out as gay in senior centers and senior housing is often not acceptable.

7. Substance use and HIV/AIDS
   - HIV/AIDS is still a major health problem in the gay community and a health risk for men who have sex with men. Using drugs and alcohol can inhibit safer sexual practices as well as negatively impact immune system function in HIV-positive gay men.
   - Stressors for HIV-positive gay men include dealing with being positive and being sexual, living longer, medication decisions, maintaining safer sexual practices, and risk of secondary HIV infection.
   - Stressors for HIV-negative gay men are staying negative and maintaining safer sex practices.
   - Many gay men lost many friends and lovers to the AIDS epidemic in the 1980s and early 1990s before the new medications were available and have not yet dealt fully with loss and bereavement issues.
MODULE 9: Clinical Issues with Bisexuals

Total Timeframe: 50 minutes

Clinician’s Guide
A Provider’s Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals

Based on the publication:
(DHHS Publication No. (SMA) 01-3498)

Training Curriculum
Klein Sexual Orientation Grid

Developed by psychologist Fritz Klein in 1978, it was designed to examine the nuances of sexual orientation identity by looking at more than just sexual behavior. A range of sexual, emotional, and social variables contribute to our self-identification.

- Because Klein developed this nearly 30 years ago, he used the word sex to refer to how one gender identifies, as male or female.
- Each variable or dimension should be answered in terms of one’s main or predominant experience or preference.
- Emotional preference means whom we seek out for emotional interaction, nurturance, or support.
- Social preference refers to whom one tends to socialize with more, males, females, or both.
- Self-identification may be personal or public.
- Lifestyle is how affiliated one is with either the LGBT community or the heterosexual mainstream community.

The Klein Grid can also be a useful tool for clients who are coming out to explore where they may presently be on each variable or dimension and where they may want to develop.
### Klein Sexual Orientation Grid

**KLEIN SEXUAL ORIENTATION GRID**

Directions: Use the following scale to rate each of the following variables in each period.

1 = Other sex only  
2 = Other sex mostly  
3 = Other sex somewhat more  
4 = Both sexes equally  
5 = Same sex somewhat more  
6 = Same sex mostly  
7 = Same sex only

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<td>C. Sexual Fantasies about</td>
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Module #9: Clinical Issues With Bisexuals

(Text: Chapter 9 in A Provider's Introduction)

At the end of this session, trainees will
1. Understand myths and facts
2. Learn psychosocial issues
3. Understand implications for treatment

Notes for Slide 9-1
Timeframe: 3 minutes

Definition of Bisexuality
The contemporary understanding is that bisexuality, affectional, romantic and sexual attraction toward same gender and other gender individuals, is a sexual orientation in and of itself and distinct from heterosexuality and homosexuality.

Notes for Slide 9-2
Timeframe: 3 minutes
Myths About Bisexuals

- Bisexuals are confused about their sexual orientation.
- Bisexuals are afraid to be lesbian or gay because of social stigma and oppression from the majority.
- Bisexuals have gotten “stuck” in the coming out process.
- Bisexuals have knuckled under to the social pressure to “pass” as straight.
- Bisexuals are in denial about their sexual orientation.
- Bisexuals are “not fully formed” lesbians or gay men.

Facts About Bisexuality

A variety of sexual behaviors may be engaged in by bisexual women, men, and transgender individuals at any time because behavior and identity can be separate issues.

- **Continuous Bisexuality**: Bisexual identity is formed early in one’s life and remains intact across the lifespan.
- **Sequential Bisexuality**: Desire is experienced by bisexuals as sexual attractions to same-sex or opposite-sex partners at different times during their lives.
- **Concurrent Bisexuality**: Bisexuals express sexual desire toward men and women at the same time.
A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals

Notes for Slide 9-4
Timeframe: 5 minutes

Facts About Bisexuality

- Women and men (including transgender women and men) who identify themselves as heterosexual may have had, or may continue to have, sexual relations with partners of the same gender.

- Women and men (including transgender women and men) who identify themselves as gay or lesbian may have had, or may continue to have, sexual relations with partners of the other gender.

- People of transgender experience, including male-to-female and female-to-male individuals, may identify themselves as bisexual. This is because bisexuality (and sexual orientation identity generally) is a separate phenomenon from gender identity.

Notes for Slide 9-5
Timeframe: 5 minutes

Psychosocial Variables
Cultural norms and standards, political views, and environmental factors many influence bisexual identity and behaviors and keep them separate.
- Same-sex relationships in prison
- Gay-identified men who have a female sex partner
Notes for Slide 9-6

**Timeframe: 5 minutes**

**Trainer Notes:**

Cultural norms and standards, political views, and environmental factors may influence bisexual identity and behaviors and keep them separate:

- Individuals in same-sex settings who engage in same-sex behavior while they are in the institutional environment
- Financial considerations such as the need to engage in prostitution as a function of substance abuse
- Legal and child custody concerns
- Political views, for example, identity as gay, but practice bisexuality.

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**Klien Sexual Orientation Grid**

See Handout 9-A

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Notes for Slide 9-7

**Timeframe: 15 minutes**

**Trainer Notes:**

Refer trainees to Handout 9-A.

Encourage trainees to take the Klein Grid for themselves after the training. If one of the trainers is heterosexual, this would be a good point to model how answers to the Klein Grid do not fall into polarized identity categories but how people find varying degrees of same-sex social and affectional needs in interactions with others throughout the course of their lives.

The Klein Grid can also be a useful tool for clients who are coming out to explore where they may presently be on each variable or dimension and where they may want to develop.
For more information:

www.biresource.org

www.binetusa.org
MODULE 10: Clinical Issues with Transgender Individuals

Total Timeframe: 50 minutes

Clinician’s Guide

A Provider’s Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals

Based on the publication:
(DHHS Publication No. (SMA) 01-3498)

Training Curriculum
Module #10: Clinical Issues With Transgender Individuals

(Text: Chapter 10 in A Provider's Introduction)

At the end of this session, trainees will

1. Understand “transgender”
2. Be familiar with research & data
3. Be aware of clinical issues
4. Understand treatment implications

Review of Terms

- **Gender**: femaleness or femininity and maleness or masculinity
- **Gender Role**: masculine or feminine behaviors
- **Gender Identity**: inner sense of oneself, a person’s self-concept, in terms of gender
- **Sexual Orientation**: distinct from gender identity, describes one’s attraction to, sexual desire for, lust for, romantic attachments to others; lesbian, gay, bisexual, heterosexual.

Notes for Slide 10-2

Timeframe: 3 minutes

Trainer Notes:

- **Gender** refers to the concept of femaleness or femininity and maleness or masculinity.

- **Gender role** refers to behaviors and desires to act in certain ways that are viewed as masculine or feminine by a particular culture or society and within a given period.

- **Gender identity** is one’s inner sense of oneself, one’s self-concept, in terms of
Most of us think in terms of only two genders, male and female, but the more we learn about gender and identity, the more we understand that gender is complex and not just polarized. In fact, today there are individuals who identify as bigender. Gender identity is not always derived from genital anatomy.

- **Sexual orientation**, distinct from gender identity, describes one’s attraction to, sexual desire for, lust for, romantic attachments to others: lesbian, gay, bisexual, heterosexual.

**Definition of Transgender**

An *umbrella* term that came from the transgender communities in the 1990s and includes the spectrum and continuum of gender identities, expressions, and roles that challenge or expand the current dominant cultural values of what it means to be male or female.

**Notes for Slide 10-3**

*Timeframe: 3 minutes*

**Facts About Transgender**

- **Transsexuals** - Usually refers to a person whose anatomy is in conflict in some way with his or her gender identity.

- **Cross-dressers** - This is the preferred term of self-identification for men who enjoy expressing their feminine aspect through female presentation and attire.

- **Drag Queens and Drag Kings** - Drag is a cultural tradition in the gay community as is female impersonation as a performance art.

- **Bigender, Androgyny, Nongendered, Gender-Queer** - Refers to a small group of people under the transgender umbrella who identify with both genders, who do not identify as a gender, or who simply identify as differently gendered or gender-queer.
Timeframe: 18 minutes

Trainer Notes:

Transsexuals

Who:

- Usually refers to a person whose anatomy is in conflict in some way with his or her gender identity.
- Male-to-female describes individuals who gender identify as female and have predominant primary and secondary male sexual characteristics. About 50 percent of male-to-female transsexuals are attracted to men and therefore, in their female identity, see their sexual orientation as heterosexual.
- About 50 percent report being attracted to women and identify as lesbian or as bisexual.
- Female-to-male describes those who identify as male and have predominant primary and secondary female sexual characteristics.
- Most female-to-male transsexuals report themselves as heterosexual men, that is, they are attracted to women; however, a growing number are coming out as gay men, attracted to men, and as bisexual.

Note: Primary sexual characteristics include reproductive organs and glands; secondary characteristics include facial structure, breast formation and size, body shape and contour, and bone structures.

Why?

- There is no conclusive evidence to date that supports any theory about the cause or etiology of transsexualism.
- Older psychiatric models proposed transsexualism as psychopathology derived from childhood, that is, overidentification with the opposite-sex parent or insufficient identification with the same-sex parent or derived from child abuse or early sexual abuse. In fact, many transsexuals report normal childhood family relationships, and most people with traumatic early childhood experiences do not become transsexual as adults.
- More recent research has focused on prenatal hormonal influences and brain structure differences.

Important Points:

- Regardless of the “cause,” transsexuals are not maladjusted mentally ill people or deluded about their gender. Most need respect and support to affirm their gender identity and assistance in making informed decisions about physical and social transition into living fully in their self-identified gender.
Some people, but not all, choose to close this gap through living in their self-identified gender and having corrective surgeries. Some decide to transition to living as men or women but do not have surgeries.

Some elect to have medical procedures which today includes, for male to females, complete genital reconstruction, feminization of facial structure, hormone therapy for feminizing effects, breast implantation, tracheal shave, hairline adjustment, and body contouring.

For females to males, medical procedures include complete genital reconstruction, hysterectomy, mastectomy and chest contouring, and hormones for becoming more masculine.

Cross-Dressers

Who:

- This is the preferred term of self-identification for men who enjoy expressing their feminine aspect through female presentation and attire.
- Most cross-dressers do not identify as transsexual, nor do they choose to transition to living full time in their female identity. Many identify as heterosexual men, and some as bisexual.

Why?

- Previously the clinical term transvestite was used to describe cross-dressers who were thought to have an inability to become sexually aroused without wearing women’s clothing.
- Although many cross-dressers do have an erotic aspect to cross-dressing, many say it is for stress release, socialization, and expression and not for sex.

Important Points:

- Some cross-dressers will elect to have feminizing facial surgeries or body contouring to enhance their femininity when they cross-dress but do not identify as transsexual or intend to transition to living full time as women.
- Today many cross-dressers acknowledge that they are part of the transgender community and identity as transgendered. In many places, it is still illegal to cross-dress so many cross-dressers must be careful to protect themselves from arrest.
- There are many cross-dresser organizations in the United States and worldwide. Cross-dressers have become more actively involved in the LGBT community in terms of LGBT rights issues and to educate people about cross-dressing as expression instead of an “illness.”
Drag Queens and Drag Kings

Who:
- Drag is a cultural tradition in the gay community as is female impersonation as a performance art.
- Some gay-male drag queens today see themselves as part of the transgender spectrum and will identify that way.
- There is a tradition of drag as fashion and as performance in the African-American community called the “ball” culture that dates back to the 1920s.
- Drag kings are a more recent phenomenon and often a way for females to cross-dress as men and express masculinity. Many identify as lesbian or bisexual; a few are heterosexual.

Why?
- Many drag queens and drag kings participate for fun, as an art form, or as a form of social protest against traditional stereotypical gender roles and appearances.

Bigender, Androgyny, Nongendered, or Gender-Queer

Who:
- Refers to a small group of people under the transgender umbrella who identify with both genders, who do not identify as a gender, or who simply identify as differently gendered or gender-queer.

Why?
- Gender identity has become more fluid in recent years as society becomes more open to accepting a variety of gender-related expression and behavior.
- Some women and men are transcending or defying traditional stereotypes and behaviors.
- Society is learning more about the diversity of both biological and social gender identity and expression.

Important Points:
- These identities may be developmental, that is, part of an exploration process of gender identity; however, identifying as bigender, nongendered, or gender-queer may be the identity that someone feels most comfortable keeping.
Research and Data

In a recent (1999, 2000) San Francisco study by Dr. Kristin Clements at the San Francisco Department of Public Health AIDS Office:

- **HIV prevalence** among MTF persons was 35% and 65% among African-American MTFs.
- **Injection drug use** was 34% among MTF transgender individuals and 18% among FTM transgender individuals.
- 55% of MTF individuals reported they had been in alcohol or drug treatment sometime during their lifetimes.

Notes for Slide 10-5

**Timeframe: 5 minutes**

Research

A study from Hollywood, California, (Reback and Lombardi1999) reported that the drugs most commonly used by MTF transgender individuals were alcohol, cocaine/crack, and methamphetamine.

Other recent studies of transgender health risks in urban areas around the country, including Boston, New York City, Washington D.C., Chicago, Los Angeles and Houston, show similar results with higher rates of substance abuse in general and higher rates of substance abuse with HIV prevalence, particularly among transgender sex workers.
Clinical Issues and Implications for Treatment

1. Issues about appearance, “passing” and body image
2. History of hiding or suppressing gender identity
3. Lack of family and social support
4. Isolation and lack of connection to positive, proactive transgender community resources
5. Hormone therapy and use or injection history
6. Stigma and discrimination
7. Employment problems
8. Relationship/child custody issues

Notes for Slide 10-7

Timeframe: 10 minutes

DISCUSSION: Trainers should review each issue and then ask trainees to discuss

• The implications for counselors treating transgender clients in substance abuse treatment settings

• Resources treatment providers need for transgender persons

Trainer Notes:

• Issues about appearance, “passing,” and body image
  o For transgender persons who are transitioning, there are often anxiety, shame, and anger about being ridiculed, harassed, or assaulted for looking different or for not passing in their self-identified gender; and anxiety and sometimes hopelessness about being able to achieve “authenticity” of appearance and of identity.

• History of hiding or suppressing gender identity
  o For many transgender persons with histories of transgender feelings or behaviors in childhood, there are trauma, abuse, and shame that must be addressed and healed.
  o For some, the origin of drinking and using drugs is connected to this “hiding.”

• Lack of family and social support: Many transgender people face rejection if they reveal their transgender status or have been rejected by family, friends, employers, and others.

• Isolation and lack of connection to positive, proactive transgender community resources
Although today many transgender persons do have access to information and resources via the Internet and publications, there are many who have never met another transgender person and have no role models for successful resolution of transgender issues.

Many transgender persons have no access to understanding, knowledgeable, and supportive health professionals.

- **Hormone therapy and use or injection history**
  - Transgender persons may have a history of using illegal street hormones as injectables, sharing needles to inject hormones, and putting themselves at risk for HIV.
  - Some transgender people enter hormone therapy treatment and need to continue it in treatment.

- **Stigma and discrimination:** The rate of violence against transgender persons in the United States is high.
  - Data from the first major study on violence and discrimination against transgender persons in the United States (Lombardi et al. 2002) found that more than 60 percent had experienced some form of harassment or assault.

- **Employment problems:** In the same study, 37 percent of respondents had lost jobs or been denied employment because they are transgender.

- **Relationship and child custody issues:** Many transgender people have been in committed relationships or married, and they may have children. Many have issues with spouses as well as custody or visitation denied because they are transgender or in transition.
### Treatment Do's and Don'ts

**DO'S**
- Use the proper pronouns based on client’s self-identity when talking to/about transgender individuals.
- Get clinical supervision if they have issues or feelings about working with transgender individuals.
- Allow transgender clients to continue the use of hormones when they are prescribed. Advocate that the transgender client using “street” hormones get immediate medical care and legally prescribed hormones.
- Take required training on transgender issues.

**DON'TS**
- Find out the sexual orientation of all clients.
- Allow transgender clients to use bathrooms and showers based on their gender identities and gender roles.
- Require all clients and staff members to create and maintain a safe environment for all transgender clients. Post a nondiscrimination policy in the waiting room that explicitly includes sexual orientation and gender identity.
Treatment Don’ts

- Don’t call someone who identifies as a female “he or him” or call someone who identifies as male “she or her”.
- Don’t project transphobia onto the transgender client or share transphobic comments with other staff members or clients.
- Never make the transgender client choose between hormones and treatment and recovery.
- Don’t make the transgender client educate the staff.
- Don’t assume transgender women or men are gay.
- Don’t make transgender individuals living as females use male facilities or transgender individuals living as males use female facilities.
- Never allow staff members or clients to make transphobic comments or put transgender clients at risk for physical or sexual abuse or harassment.

Notes for Slide 10-10

Timeframe: 5 minutes

Trainer Notes: Review each bullet one at a time.

For updated information and resources on the transgender communities, the following organizations websites are very useful.

World Professional Association for Transgender Health at [www.wpath.org](http://www.wpath.org)

National Center for Transgender Equality at [www.ncequality.org](http://www.ncequality.org)

F to M International at [www.ftmi.org](http://www.ftmi.org)

International Federation for Gender Education at [www.ifge.org](http://www.ifge.org)
MODULE 11: Clinical Issues with Youth

Total Timeframe: 1 hour

Clinician’s Guide

A Provider’s Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals

Based on the publication:
(DHHS Publication No. (SMA) 01-3498)

Training Curriculum
Module #11: Clinical Issues With Youth

(Text: Chapter 11 in A Provider’s Introduction)

At the end of this session, trainees will

1. Know risk factors for substance abuse and HIV/AIDS
2. Understand approaches to assessment and treatment

Notes for Slide 11-1

Timeframe: 3 minutes

Trainer Notes: For the following slides, with the large group trainers go through the PowerPoint slides and ask trainees to respond “true” or “false.”

True or False

HIV infection rates have dropped among young gay white men and new infections are lower among all gay men than among their heterosexual counterparts

- **False**

- 7% infection rates among 3,000 15- to 22-year-old young gay men sampled in a rigorous new CDC study (Valleroy 2000).
- Fully one half of all new infections occur among people younger than 25.
- Young gay white men form the largest group in this age bracket, followed closely by young gay black men.
Timeframe: 5 minutes

Trainer Notes:

- In June 2002 Centers for Disease Control and Prevention (CDC) researcher Linda Valleroy and her colleagues released alarming statistics that showed 7 percent infection rates among 3,000 15- to 22-year-old young gay men sampled in a rigorous new CDC study.
- A full 41 percent, moreover, reported having recently engaged in unprotected anal intercourse.
- According to the best estimates of researchers, fully one half of all new infections occur among people younger than 25.
- Young gay white men form the largest group in this age bracket, followed closely by young gay black men and black females.

True or False

There is overwhelming evidence that verbal and physical violence against LGBT youth of all backgrounds can lead to high-risk behaviors that increase their risk for substance abuse and HIV/AIDS

Youth who were victims of bias-related harassment and/or violence are:

- Twice as likely to report bingeing on alcohol (5-plus drinks at one time) at least once in the past month
- Twice as likely to report using marijuana in the past month
- Three to ten times as likely to report having tried cocaine
- Two to three times as likely to report having ever tried hallucinogens, depressants or stimulants

Notes for Slide 11-3

Timeframe: 5 minutes

Trainer Notes:

- The Fourth Annual Safe Schools Report of the Anti-Violence Documentation Project from the Safe Schools Coalition of Washington (1997) found that LGBT youth who are victims of violence often begin defining themselves in accordance with negative peer and societal viewpoints toward their sexual identities.

- Too often, these young people initiate self-destructive behaviors as a way to cope with their low self-esteem and ostracism from their peer group.

True or False

Reports of higher rates of suicidal behaviors and suicide among LGBT youth have not been supported in the research on adolescent suicide.

The Youth Risk Behaviors Survey in the States of Vermont and Massachusetts (2000) found that LGBT youth are

- Twice as likely to report having seriously considered suicide in the past year.
- Twice as likely to say they made a suicide plan in the past year.
- Three to four times as likely to report having attempted suicide in the past year.
- More than four times as likely to say they made a serious enough suicide attempt in the past year to have been treated by a health care professional.

Notes for Slide 11-4

Timeframe: 18 minutes

Trainer Notes: Details contained within slide
**True or False**

LGBT adolescents are twice as likely as straight students to feel unsafe or afraid at school, some, most, or all of the time.

- 97% of students in public high schools report regularly hearing homophobic remarks from their peers.
- LGBT youth are two to four times more likely than their heterosexual peers to have been threatened or injured with a weapon at school.
- 34% of lesbian, gay, and bisexual students surveyed had been the target of verbal assaults at school or en route to or from classes.

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**Notes for Slide 11-5**

**Timeframe: 5 minutes**

**Trainer Notes:**

Additional Notes:

- The 45 percent of the gay men and 20 percent of the lesbians surveyed were victims of verbal and physical assaults in secondary schools.
- Twice as many gay students reported having been in physical fights.
- Between two and three times as many LGBT youth said they had been forced or pressured into having sexual intercourse as their heterosexual peers.
True or False

School officials and guidance counselors are more aware today of the need to protect LGBT youth from antigay harassment.

- Of 289 high school counselors surveyed in the Seattle Safe Schools Survey, one in six thought there were no lesbian, gay, bisexual or transgender youth in their schools.
- 20% believed they were not competent at counseling LGBT students.

Notes for Slide 11-6

Timeframe: 5 minutes

Notes for Slide 11-7

Timeframe: 10 minutes

Risk and Protective Factors for LGBTQ Youth (CSAP 1993)

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Protective Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Higher school dropout rates related to discrimination</td>
<td>Social support and prosocial bonding with peers</td>
</tr>
<tr>
<td>Inadequate social services that are not culturally relevant</td>
<td>Increases in knowledge through peer education</td>
</tr>
<tr>
<td>Violence and fear of disclosure among peers in the community</td>
<td>Situational self-efficacy; teaching youth coping skills for dealing with school victimization</td>
</tr>
<tr>
<td>Pro-use norms in the adult LGBT communities; lack of adult LGBT role models</td>
<td>Community support; positive LGBT adult role models</td>
</tr>
<tr>
<td>Pro-use norms in the adult LGBT communities; lack of adult LGBT role models</td>
<td>Family support</td>
</tr>
</tbody>
</table>

Trainer Notes:
Ask participants for examples of each risk & protection factor
### Slide 11-8

#### Sexual Identity: Age of Onset

<table>
<thead>
<tr>
<th>Event Occurs</th>
<th>Earlier Studies*</th>
<th>More Recent Studies**</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Males</td>
<td>Females</td>
</tr>
<tr>
<td>First awareness of same-sex attraction</td>
<td>13</td>
<td>14-16</td>
</tr>
<tr>
<td>First same-sex experience</td>
<td>15</td>
<td>20</td>
</tr>
<tr>
<td>First self-identified as lesbian or gay</td>
<td>19-21</td>
<td>21-23</td>
</tr>
</tbody>
</table>

*Studies of adults who remembered their experiences as children and adolescents
**Studies of adolescents who described their experiences as they were happening or right after they happened

---

**Notes for Slide 11-8**

**Timeframe: 8 minutes**

**Trainer Notes:**

Sexual orientation evolves over time. However, studies have documented a decreasing age of identity development and coming out among lesbian and gay youth, with initial awareness of same-sex attraction at, on average, age 10; first same-sex experiences at 13 to 15; and first self-identifying as lesbian or gay (initial “coming out”) at about age 15 to 16 (D’Augelli and Herschberger 1993; Herdt and Boxer 1993; Rosario et al. 1996).

Studies of more recent generations of lesbian and gay youth suggest that the period between becoming aware of same-sex attraction and self-identifying as lesbian or gay is much shorter than in previous generations. For youth who choose to self-disclose or are found out, coping with this stressful life event is challenging. Adolescents at this point in their lives have not developed coping strategies and are more likely than adults to respond poorly to stressors. These youth must adapt to living in a hostile environment and learn how to find positive environments (Hunter and Mallon 1999).
Special Issues for LGBT Youth

- Find out the sexual orientation of all clients.
- Allow transgender clients to use bathrooms and showers based on their gender self-identities and gender roles.

Require all clients and staff members to create and maintain a safe environment for all transgender clients. Post a nondiscrimination policy in the waiting room that explicitly includes sexual orientation and gender identity.

Notes for Slide 11-9

Timeframe: 10 minutes

Trainer Notes:

LGBT Youth of Color

- Face additional stresses and challenges in integrating their sexual, racial, and ethnic identities (Hunter and Schaecher 1995; Tremble et al. 1989)
- Interact with three separate communities—their ethnic or cultural community, LGBT communities, and mainstream culture—none of which provides support for all aspects of their multiple identities
- Have to manage more than one stigmatized identity, which increases their level of vulnerability and stress (Greene 1994).

Depression and Suicide

- As previously described, depression and risk for suicide appear to be high for many of these young people (Rotheram-Borus et al. 1994).
- In addition, a past history of abuse and neglect, severe stress, and underlying emotional disorders may influence a young person’s ability to cope.
- Hetrick and Martin (1987) have suggested that adolescents with these histories may account for the majority of gay youth who attempt suicide or who develop serious substance abuse problems.

Abuse and Homelessness

- Homelessness is a particular concern for LGBT youth because many teens run away as a result of harassment and abuse from family members or peers who disapprove of their sexual identity. Still others may be thrown out of the home when their parents learn they are gay.
Statistics are not available on the actual percentage of street youth who may be lesbian or gay, but youth service providers agree the percentage is high, and reports from various studies show ranges from 20 percent to 40 percent (Kruks 1991; Los Angeles County Task Force 1988; Seattle Commission on Children and Youth 1988; Stricof et al. 1991).

**Homeless youth are at high risk for exploitation:**

- Without an education or job skills, they may become involved with survival sex (exchanging sex for food, drugs, or shelter), drug dealing, or other illicit activities (Clatts & Davis 1999);
- Like their heterosexual peers, LGBT homeless and runaway youth have many health and social problems, often as a result of abuse and neglect. These include serious substance abuse and mental health problems and being at high risk for suicide, sexually transmitted diseases (including being at high risk for HIV/AIDS), pregnancy, and many chronic health problems (Hoffman et al. 1999).

### LG T Adolescent Assessment and Treatment Checklist

- Alcohol, tobacco, and other drug use
- The adolescents’ social environment
- Sexual identity development and stage of coming out
- Level of disclosure about sexuality
- Gender identity
- Family and social support network
- Impact of multiple identities, gender/ethnic/cultural/sexual orientation
- Knowledge and use of safer sex practices

### Notes for Slide 11-10

**Timeframe: 5 minutes**

**Trainer Notes:**

LGBT youth experience countless challenges in attempting to manage their stigmatized identity. Providing safety and giving support are essential elements in prevention and treatment of substance abuse in LGBT youth.

**For updates on LGBT Youth Issues the following organizations websites will be helpful:**

- National Youth Advocacy Coalition at [www.nyac.org](http://www.nyac.org)
- Sexual Minority Youth Assistance League at [www.smyal.org](http://www.smyal.org)
MODULE 12: 
Related Health Issues

Total Timeframe: 1 hour and 20 minutes

Clinician’s Guide

A Provider’s Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals

Based on the publication: 
(DHHS Publication No. (SMA) 01-3498)

Training Curriculum
**Health Issues Quiz**

Answer each question true (T) or False (F).

1. LGBT people are the victims of the most violent hate crimes in America.  
   - T  
   - F

2. Lesbians are at lower risk for breast and cervical cancer than heterosexual women.  
   - T  
   - F

3. Gay men are at higher risk for hepatitis A and B, and, in some cases, hepatitis C.  
   - T  
   - F

4. There is a relatively low prevalence of HIV infection among male-to-female transgender persons.  
   - T  
   - F

5. Gay men tend to smoke less than heterosexual men.  
   - T  
   - F

6. Gay and bisexual men are at higher risk for HIV but lower risk for gonorrhea and chlamydia.  
   - T  
   - F
Module 12: Handout 12-B

Case Studies

For the case study you are assigned, answer the following questions and be prepared to share your answers in the larger group discussion.

1. How would you proceed with the assessment?

2. What questions would you ask and how would you ask them?
Case Studies

Case Study 1

**Ron**, a 34-year-old African-American male, presents to your substance abuse treatment agency at the insistence of his employer for alleged difficulties at work. Apparently, he has come to work late on numerous occasions with alcohol on his breath. During his assessment, he informs you that he has been drinking excessively over the past few months and, as a result, has been unable to get to work on time. He also vaguely reports engaging in high-risk sexual behaviors. During the assessment, you notice black and blue marks on Ron's arms and neck. He tells you that for about 3 years, he has been living with another man who recently has been diagnosed with HIV and now has symptoms.

Case Study 2

**Deedee**, a 52-year-old African-American lesbian, reported to her substance abuse treatment counselor that she found a painful lump in her breast. The counselor knew that Deedee had not seen a doctor in more than 5 years and that she was extremely tense around healthcare providers. Deedee has a history of childhood sexual abuse and is not comfortable with anyone touching her. She has had bad experiences with healthcare providers and has been treated disrespectfully because of her lesbian identity. Her counselor was concerned about the pain Deedee was experiencing but unsure what to do.
Module #12: Families of Origin and Families of Choice

(Text: Chapter 12 in A Provider's Introduction)

At the end of this session, trainees will

1. Understand health issues for LGBT persons
2. Be able to list barriers to adequate health care
3. Be able to recognize and assess mental health issues
4. Understand the effect of interpersonal violence in the LGBT community

Notes for Slide 12-1

Timeframe: 3 minutes

Trainer Notes:

Before the next set of slides, have students quickly take the quiz on Handout 12-A. Ask them to try not to look ahead into the slides covered.

True or False

LGBT people are the victims of the most violent hate crimes in America.

- Hate crimes based on sexual orientation are probably among the most underreported crimes.
- Hate crimes against sexual minorities are generally more violent than other hate crimes.
Notes for Slide 12-2

Timeframe: 20 minutes for all slides

Discussion

• With the large group trainers go through the PowerPoint slides and ask trainees to respond true or false by raising their hands to ‘vote’.
• Trainers provide information on each issue.

Info on this slide:

TRUE

The FBI’s Uniform Crime Reports for 1997 show that almost 14 percent of all hate crimes are because of the victim’s sexual orientation. This is the third largest category reported, with race making up about 59 percent of all reported hate crimes, and religion making up about 17 percent. (www.metrokc.gov/health)

However, hate crimes based on sexual orientation are probably among the most underreported crimes. Additionally, hate crimes against sexual minorities are generally more violent than other hate crimes.

FALSE

Lesbians are at lower risk for breast and cervical cancer than heterosexual women.

• Lesbians may be at increased risk for HPV infection and, hence, cervical cancer, depending on their sexual practices.
• Lesbians typically see healthcare providers less frequently than do heterosexual women, and, thus, may not undergo sufficient screening.
Notes for Slide 12-3

**Trainer Notes:**

**FALSE**

Cervical cancer is, in essence, a **sexually transmitted infection** caused by human papillomavirus (HPV, which also causes genital warts). Transmission of HPV occurs from genital-to-genital skin contact, and strong evidence exists that HPV can be transmitted between women during sex.

Some lesbians may be at increased risk for HPV infection and, hence, cervical cancer, depending on their sexual practices. In addition, lesbians typically see healthcare providers less frequently than do heterosexual women and, thus, may be at increased risk for cervical cancer because precancerous cervical cell changes are less likely detected at earlier, more treatable, stages. Every woman, including lesbians and bisexual women, needs regular Pap screening.

As a group, **lesbians have a higher chance of getting breast cancer or having it go undetected for several reasons: lesbians are less likely to give birth, less likely to have mammograms, and less likely to perform breast self-exams regularly. Some studies indicate that lesbians may use alcohol more, smoke more, and have higher body weight, all of which increase a woman’s risk for breast cancer. Being a lesbian does not increase the risk for breast cancer, but having one or more of the above-cited risk factors might. A lesbian or bisexual woman without these risk factors is not at increased risk for breast cancer.**

---

**True or False**

Gay men are at higher risk for hepatitis A and B, and, in some cases, hepatitis C.

- **TRUE**
  - Hepatitis A and B can be transmitted through sexual contact.
  - Hepatitis B and C can be transmitted through sexual contact and/or sharing needles.

- **FALSE**
  - Hepatitis A and B can be transmitted through sexual contact.
  - Hepatitis B and C can be transmitted through sexual contact and/or sharing needles.
Notes for Slide 12-4

**Trainer Notes:**

**TRUE**

Gay men are higher risk for hepatitis A and B, which can spread through sexual contact, particularly through anal sex. In addition, gay men who share injection drug needles are at higher risk for hepatitis C, and there is some evidence that hepatitis C is also spread through sexual contact. Often because there is such an emphasis on HIV with gay men, other sexually transmitted infections (STIs) are neglected, so it is important to educate men who have sex with men about other STIs and to screen them.

In addition, vaccines against hepatitis A and B are effective, and men who have sex with men should get vaccinated. The vaccine for hepatitis A consists of two shots over a 6-month period, and the vaccine for hepatitis B consists of three shots over the same period.

---

**True or False**

There is a relatively low prevalence of HIV infection among male-to-female transgender persons.

- In recent San Francisco study HIV prevalence among MTF persons was 35% and 65% among African-American MTFs.
- Other recent studies of transgender health risks in urban areas around the country show similar results.

---

Notes for Slide 12-5

**Trainer Notes:** FALSE - Review info on slide.
**True or False**

**Gay men tend to smoke less than heterosexual men.**

Recent and representative studies among gay men have indicated **strikingly higher rates** of smoking among gay men than in the general male population.

---

**Notes for Slide 12-6**

**Trainer Notes:**

**FALSE**

Studies indicate that gay men have much higher rates of smoking than heterosexual men ([www.metrokc.gov/health](http://www.metrokc.gov/health)). As with studies of alcohol use, early studies of tobacco use among gay, lesbian, and bisexual people tended to use nonrandom samples (often recruited in bars) and therefore were not reliable. Unlike studies of alcohol use, however, more recent and representative studies among gay men have indicated strikingly higher rates of smoking among gay men than in the general male population.

---

**True or False**

**Gay and bisexual men are at higher risk for HIV but lower risk for gonorrhea and chlamydia.**

Even when men who have sex with men refrain from unprotected anal sex, they **may engage in other activities** such as unprotected oral sex that increases risk for both gonorrhea and chlamydia.
Notes for Slide 12-7

Timeframe: 5 minutes

FALSE

Even when men who have sex with men refrain from unprotected anal sex, they may engage in other activities such as unprotected oral sex that increases risk for both gonorrhea and chlamydia.

Cases of gonorrhea among gay and bisexual men seen at the Public Health—Seattle and King County STD Clinic more than doubled, from 64 cases in 1997 to 148 cases in 1998. Chlamydia cases increased by 50 percent. Reported cases of rectal gonorrhea in men outside the STD clinic rose fourfold, from 6 reported cases in 1997 to 25 cases in 1998 (www.metrokc.gov/health). This increase is disturbing on its own. Similar increases in gonorrhea and other STDs have been reported in Cleveland, Los Angeles, San Francisco, and other cities. Even more alarming is the implied increase in unprotected anal sex that these trends point to, an increase that could lead to higher rates of HIV transmission as well.

As was stated earlier, it is important for men who have sex with men to be educated about the range of STDs and how to protect against them and get treatment.

Barriers to Adequate Health Care

● Many gays and lesbians do not disclose their sexual orientation to their healthcare providers.
● Many LGBT persons are reluctant to use mainstream healthcare services.
● Gay and Lesbian Medical Association Survey (1994) results indicate substandard care for LGBT patients.
Notes for Slide 12-8

Timeframe: 5 minutes

Trainer Notes:

Because their sexual orientations and gender diversity have often been labeled as deviant or pathological, many gay men and lesbians do not disclose their sexual orientation to their healthcare providers.

In addition, many LGBT persons are reluctant to use mainstream healthcare services.

In a survey of the American Association of Physicians for Human Rights (now called the Gay and Lesbian Medical Association) (1994):

- 52 percent of their members had observed the denial of care or the provision of suboptimal care to lesbian and gay clients.
- 88 percent heard colleagues make disparaging remarks about their lesbian and gay clients.
- 64 percent stated that it is important for clients to reveal their sexual orientation but also noted they risk receiving substandard care when doing so.

Mental Health Issues

- Recent research on mental health issues for LGBT persons indicates that there is a higher rate of bipolar and depressive disorders in gay men than among heterosexual men.
- Atkinson et al. found higher rates of lifetime depression in homosexual males compared with heterosexual men.
- Gilman et al. found significantly higher prevalence rates of depressive disorders in lesbian women compared with heterosexual females.
- Distinct barriers to mental health service utilization have been described for sexual minorities that include:
  - A tendency to pathologize LGBT identity
  - Lack of LGBT-sensitive care
  - Discrimination and marginalization of LGBT clients
  - Unwillingness to address LGBT-related issues in treatment
  - Unwillingness to work with partners and lovers of LGBT clients.
Notes for Slide 12-9

Timeframe: 5 minutes

Trainer Notes:

- Recent research on mental health issues for LGBT persons indicates that there is a higher rate of bipolar and depressive disorders in gay men than among heterosexual men (Hellman et al.).
- Atkinson and colleagues (1988) found higher rates of lifetime depression in homosexual males compared with heterosexual men.
- Gilman and colleagues (2001) found significantly higher prevalence rates of depressive disorders in lesbian women compared with heterosexual females.
- Distinct barriers to mental health service utilization have been described for sexual minorities. These include a tendency to pathologize LGBT identity, lack of LGBT-sensitive care, discrimination against and marginalization of LGBT clients, unwillingness to address LGBT-related issues in treatment, and unwillingness to work with partners and lovers of LGBT clients (Dean et al. 2000; Dardick and Grady 1980; Hellman 1996).

Research on Interpersonal Violence in the LGBT Community

- Overall the same rate in same-sex relationships as in heterosexual relationships.
- 8% rate of partner violence in a diverse, nonclinical sample of nearly 2,000 lesbians.
- 17% of gay men reported having been in a physically violent relationship (Gay and Lesbian Community Action Council 1987).
- 40% of 228 gay male perpetrators abused drugs (Farley 1996).

Notes for Slide 12-10

Timeframe: 10 minutes

Trainer Notes:

Definition of Interpersonal Violence: The use of intentional verbal, psychological, sexual, or physical force by one intimate partner to control another; also known as domestic violence.

Research on LGBT Intercpersonal Violence

- Experts estimate that interpersonal violence occurs at about the same rate in same-sex relationships as in heterosexual relationships (Island and Letellier 1991; Lobel 1986).
• The National Lesbian Health Care Survey (Bradford et al. 1994) showed an 8 percent rate of partner violence in a diverse, nonclinical sample of nearly 2,000 lesbians.

• In a study of 90 lesbian couples, 46 percent of the couples experienced repeated acts of violence in their relationship (Coleman 1990).

• Of 1,000 gay men surveyed in the Northstar Project, 17 percent reported having been in a physically violent relationship (Gay and Lesbian Community Action Council 1987).

• In a study of 228 gay male perpetrators, Farley (1996) found the following contributing to gay interpersonal violence:
  - 40 percent abused drugs.
  - 87 percent had previous mental health treatment.
  - 93 percent reported childhood physical abuse, and 67% reported childhood sexual abuse.
  - 40 percent reported a family history of alcoholism.
  - 80 percent had a previous history of being an abuser in an adult relationship.

Discussion: Trainers now ask trainees about the implications of the above data for assessment and treatment of clients in substance abuse treatment programs.

Assessment and Intervention

• Ask about interpersonal violence in private
• Ensure confidentiality
• Ask questions in an affirming and culturally sensitive manner
• Empathize with client’s feelings
• Look for indicators of interpersonal violence
• Use third-person examples to screen possible batterers
• If a client is identified as either a victim or batterer, refer him or her to an LGBT support group, to an LGBT affirmative batterers’ intervention program, and for ongoing consultation with an LGBT domestic violence treatment expert.
Notes for Slide 12-11

Timeframe: 5 minutes

**Trainer Notes:**
- Ask about interpersonal violence in private.
- Ensure confidentiality.
- Ask questions in an affirming and culturally sensitive manner.
- Empathize with client’s feelings.
- **Look for indicators** of interpersonal violence, such as the presence of physical injuries, inconsistent or evasive answers regarding injuries when questioned, a history of relapse or noncompliance with substance abuse treatment goal, and stress-related conditions and illnesses.
- Use third-person examples to screen possible batterers, for example, “Some people think that under the right circumstances, it’s okay to hit your partner. Under what conditions do you think violence might be justified?”
- If a client is identified as either a victim or batterer, refer him or her to an LGBT support group, to an LGBT affirmative batterers’ intervention program, and for ongoing consultation with an LGBT domestic violence treatment expert.

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**CASE EXAMPLES**

See Handout 12-B

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Notes for Slide 12-12

Timeframe: 45 minutes

**Trainer Notes:**
- Refer the trainees to Handout 12-B
- Divide participants into small groups and assign one of the two case examples for discussion to each group (A Provider’s Introduction, pp. 112-113). Tell them they will have 15 minutes to discuss the case study.
- When finished, regroup and report back to the large group.
- Trainers can use the suggested interventions to inform the large group discussion.
Suggested Interventions - Case Study 1

- Conduct a standard substance abuse assessment.
- Attempt to connect interpersonal violence, the stress of being in a relationship with someone with HIV, and substance abuse using LGBT-sensitive language. This may help the client gain insight and create an environment conducive to further discussion.
- Include questions about a history of family abuse or posttraumatic stress disorder and current relationship issues such as ways of expressing anger and frustration, issues of power and control, and issues of gender roles.
- After establishing sufficient rapport, mention that interpersonal violence is not uncommon in relationships.
- Do not assume because the client has a bruise that he or she is the victim.
- Take steps to ensure the safety of the client if he or she is in danger.
- Conduct interventions for substance abuse and interpersonal violence concurrently, if possible, within the same organizational structure.
- Ensure that a female batterer of a lesbian in a women’s shelter cannot gain access to the shelter.
- Refer clients promptly to a practitioner or an agency that has expertise in interpersonal violence and that is sensitive and knowledgeable about LGBT issues.

Suggested Interventions - Case Study 2

- The counselor should ensure that Deedee is aware of the importance of being evaluated and treated for her potentially life-threatening condition.
- Substance abuse treatment programs should develop partnerships with LGBT-sensitive primary care physicians and clinicians, therapists, and psychiatrists for referring clients to other practitioners who provide sensitive care.

Other suggestions include

- Help LGBT clients be more comfortable in disclosing their sexual identity
- Integrate LGBT-inclusive language and lifestyles into curriculums
- Use gender-neutral questions, and communicate a nonjudgmental attitude
- Make sure the healthcare practitioner takes a sensitive but thorough sexual history to determine the appropriate STD screening and treatment if necessary
- Focus risk-reduction education not only on HIV and other STDs but hepatitis as well.
For Updates on LGBT Health and Related Health Issues visit:

National Coalition for LGBT Health
www.lgbthealth.net

National Coalition of LGBT Anti-Violence Projects
www.ncavp.org

Gay and Lesbian Medical Association
www.glma.org
Module 13: Case Examples: Counselor Competence in Treating LGBT Clients

Total Timeframe: 1 hour

Clinician’s Guide

A Provider’s Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals

Based on the publication:
(DHHS Publication No. (SMA) 01-3498)

Training Curriculum
Module 13: Handout 13-A

Case Studies

**Case Example #1**

**Rita**, 52, an attractive woman dressed in high heels and a form-fitting suit, is wearing tasteful, but dramatic, makeup. She looks like anything but an alcoholic. She is from the Dominican Republic and separated from her husband; she has two children but is currently living alone. She is seeking treatment for “problems I’m having because of my drinking.” She will lose her 7-year position in her company if she doesn’t stop drinking, she is estranged from her family, and she has lost all her friends because of her drinking. Rita has tried Alcoholics Anonymous (AA) but is having great difficulty finding a sponsor (“Nobody is very warm or accepting”); she is also having trouble relating to other women in the program (“They’re not very friendly. Maybe because I’m Latina.”). When asked about her relationships with others, she looks embarrassed and mumbles something noncommittal. When the counselor directly asks, “Have you been in any long-term relationship with anyone in the past 10 years?” Rita stammers out that she had lived with a friend for 5 years. The counselor then asks if Rita can say more about the nature of the relationship, the quality of it, and the reasons for its ending. Rita answers in vague terms that she and her friend argued about how much Rita drank and that the friend finally left. As Rita continues her description, her vagueness suggests that the difficulty she is having talking about it might stem from a lesbian relationship (or her fear that it might have been one). The counselor must now decide whether to ask for more information.

**Case Study Questions**

- How are common myths and stereotypes relevant to this case?
- What are the key challenges facing this client?
- What interventions would you suggest?
**Case Example #2**

**Andrea,** 23, has been drinking alcohol since she was 12. She also became addicted to her mother's Valium and uses it to “smooth out” her hangovers and to come down from her occasional cocaine highs. Andrea has known since she was about 9 that she is attracted to girls and has been sexually active since the age of 14. She is totally out as a lesbian and says she has no problems about her sexual identity. But she is troubled by her inability to sustain any relationship for longer than a few months. She also says that since she’s achieved sobriety, she doesn’t know how to meet women who want to date her. She has become shy and uncertain—she says, “retarded.” The counselor needs to help Andrea assess where she is in the development of a sober and clean identity and how that relates to her sexual orientation. She has not been able during her formative years to learn the necessary developmental lessons of adolescence. Furthermore, she tended to act out her feelings when drunk or drugged, including a lot of sexual feelings. She never learned how to date or communicate or relate emotionally to others. The counselor needs to point out to Andrea that she will probably need to go back and come out again in some form, now that she’s clean and sober, and that she will need to learn the tasks of adolescence that she missed learning.

**Case Study Questions**

- How are common myths and stereotypes relevant to this case?

- What are the key challenges facing this client?

- What interventions would you suggest?
Case Example #3

Greg is a 28-year-old, hearing-impaired, HIV-infected, Caucasian gay man living in a large west coast city in a “gay ghetto.” He works as a sign language interpreter for an AIDS organization. He is single, loves to go to parties, works out at the gym almost every day, and tries to maintain his health by following his HIV medication regime carefully. He loves to go to “circuit parties” and even helped develop a special area for other hearing-impaired participants to meet and sign the announcements made at these events. He used to drink alcohol but stopped after he learned his HIV status. He does, however, use crystal meth (amphetamines, speed, crank) to allow himself to party longer and get sexually motivated and aroused. He does not see that as a problem because he uses only on weekends, has a low sexual drive otherwise because of the many HIV medications and a low testosterone level, and has many friends who do the same thing. He has missed some Mondays and even a few Tuesdays at work, but everyone there assumes these absences are the result of his HIV status. He used to snort the crystal but now shoots it intravenously to get a more rapid effect. Again, he does not see that as a problem because he needs to be economical in his use on the weekend—“more bang for the buck.” He has a fair amount of sex, usually as a “passive” partner because the crystal makes it difficult for him to get an erection. Because he is already HIV infected, he says he does not worry about safer sex practices.

Although almost all of his friends also use crystal, a few friends have talked to Greg recently about how haggard he looks and how they think he may be “tweaking,” that is, shooting crystal too often. They don’t want to tell him what to do, but they also think he should be more careful when having sex because he might infect someone else or get a different strain of the HIV virus. Greg says they should mind their own business because he works for an AIDS organization, knows what he is doing, and can stop the crystal use any time he pleases.

Case Study Questions

• How are common myths and stereotypes relevant to this case?

• What are the key challenges facing this client?

• What interventions would you suggest?
Case Example #4

Amber, a 24-year-old African-American pre-operation transsexual presents for intake at your residential drug treatment program. She is dressed in female attire and tells you she has been living full time as a female for more than 5 years. She has had a legal name change and has identification that states she is a female. She tells you she is revealing that she is transsexual because she “doesn’t want there to be any trouble.” She also tells you she has been in treatment before and says she had a bad experience, including the fact that the staff refused to address her as female and other clients sexually and verbally harassed her. She says she has a long history of abusing heroin and alcohol and that she is ready to change her life and wants to enter your residential treatment program.

*Note: Please check your state licensing board to determine if it is legally to place a pre-op transgender individual in the same room as those who have the opposite genitalia.

Case Study Questions

- How are common myths and stereotypes relevant to this case?

- What are the key challenges facing this client?

- What interventions would you suggest?
Case Example #5

David is a 16-year-old gay youth who identified himself as gay at age 12 but did not “come out” to others until he met another gay youth on the Internet last year. His father was a heavy drinker and physically abused David and his mother. His father left home when David was 11. Since then, David has been raised by his mother, a restaurant manager, in a medium-sized city in the Midwest. David began drinking beer with friends in seventh grade and smokes marijuana when he can get it. Alcohol helps him relax in social situations and makes it easier to pretend that he’s straight. It helps reduce feelings of isolation and depression. David was afraid to come out to friends at school and had not told anyone he was gay until he found a gay youth Web site last year. Through the Web site, he connected with other gay teens who provide emotional support. This is David’s only source of support and has helped reduce his feelings of isolation, but none of these youth live nearby. His mother usually works on weekends, and David has been able to drink without anyone finding out. His drinking has increased during the last 2 years, and his grades have begun to drop. He has become increasingly irritable, and arguments with his mother are escalating. David was dropped from the track team last year for failing to attend morning practice, but no one at school or home noticed the early warning signs of substance abuse. David began having sex with young men he met in a public park when he was 14. He did not know how to meet other gay people until he heard someone joking about a park across town. David feels more comfortable having a few drinks before he has sex and rarely uses condoms.

Case Study Questions

• How are common myths and stereotypes relevant to this case?

• What are the key challenges facing this client?

• What interventions would you suggest?
Module # 13 – Counselor Competence in
Treating LGBT Clients

(Text: Chapter 13 in A Provider's Introduction)

At the end of this session, trainees will

1. How counselors can become more aware of their bias and how to manage them
2. How to provide good quality, fair, ethical, and competent treatment to LGBT clients
3. How to provide LGBT-sensitive treatment
4. Considerations for treating LGBT criminal justice clients

Notes for Slide 13-1

Timeframe: 3 minutes

Trainer Notes:

- The following case studies have been taken from each of the chapters in the clinical section of A Provider’s Introduction.
- Trainers can review the overview below before having trainees do their case studies.
- Trainers should remind trainees to pull out handouts and notes from the section of the training that is relevant to the issues of the client they are assigned.

Guidelines for Counselor Competence – Do’s

- Do create safety for LGBT clients.
- Do know the population. Read and learn about LGBT community and culture.
- Do create an atmosphere that is supportive.
- Do acknowledge clients’ significant others and encourage their participation in treatment.
- Do be guided by your LGBT clients. Listen to what they say is comfortable for them.
- Do get training to help you become less heterosexist and increase your knowledge and understanding.
Notes for Slide 13-2
Timeframe: 10 minutes

**Trainer Notes:** Review each do and give some examples of each. You may also ask trainees for examples.

**Don'ts**
- Don’t label your clients.
- Don’t pressure clients to come out. Respect their sense of where they are in this process and their need to feel safe.
- Don’t ignore significant others and family members.
- Don’t interpret on behalf of the client, e.g., “It must be hard being a lesbian,” or “You must be angry because your parents don’t accept your being a person of transgender experience.” Instead, follow your client’s lead.

Notes for Slide 13-3
Timeframe: 10 minutes

**Trainer Notes:** Review each do and give some examples of each. You may also ask trainees for examples.

**Case Studies**
- How are common myths and stereotypes relevant to this case?
- What are the key challenges facing this client?
- What interventions would you suggest?

See Handout 13-A for details.
Notes for Slide 13-4

Trainer Notes:

- Divide participants into small groups and assign one of each of the following case examples to a different group for review and discussion, answering the questions pertaining to each case.
- Have someone in the group record the responses.
- At the end of the small-group review, each group will present its case findings and recommendations to the large group for discussion.
- Trainers can then use the suggested interventions section of each case example to inform the large-group discussion.

See the following pages for notes on suggested interventions.

Suggested Interventions Case Example 1: Rita

Trainer Notes:

Suggested Interventions: A Provider’s Introduction, page 76

- Acting on the basic premise that Rita’s secretiveness indicates a high level of anxiety about this subject and that her anxiety probably makes her distance herself from others for fear of being found out, the counselor presses on. How? Not by using the term lesbian or by going directly for this particular topic. Instead, the counselor asks such questions as, “Were you close to one another? Was your friend emotionally supportive of you?”

- The counselor can empathize, saying such things as, “The breakup must have been very painful for you. When he or she left, how did you cope with the loss?”

- Now the counselor has introduced the possibility that the friend is a woman and offers Rita the opportunity to edge a little closer to being able to talk about the fact that this close relationship was with a woman. It is important to note here that the counselor is not using any label (such as lesbian) and is only indirectly exploring the quality and nature of the relationship. If and when Rita can begin to talk in more detail about this relationship, the counselor needs to continue the exploration in this restrained manner because the topic is so frightening to Rita.

- Such restraint on the counselor’s part is crucial because Rita has been able to pass for straight, something that has been of great importance to her because the Latino culture and her family are extremely homophobic. Restraint is also crucial because it creates the safety essential to engendering the patient’s willingness to participate in her treatment and recovery.
Suggested Interventions Case Example 2: Andrea

Trainer Notes:
Suggested Interventions: A Provider’s Introduction, page 77

Although the responsibilities involved in counseling substance-abusing lesbians may seem daunting, there is no denying the importance and influence of the caring counselor. Counselors who do not know a lot about lesbians can still offer much of value to their clients if they start with what they know about women and take the time and make the effort to understand the special problems of lesbians. Some suggestions for treatment are as follows:

- Empower the client—this should be the primary goal, no matter how it is reached.
- Honor diversity.
- Use nonjudgmental language.
- Avoid labeling.
- Do not confront, but support and explore.
- Respect the client’s position, whatever that may be (“I’m not a lesbian”; “I’m confused”; “I’m a lesbian and proud of it!”).

- Respect some lesbians’ unwillingness to attend AA or Narcotics Anonymous because they consider these programs male institutions with no room for them as women, and especially as lesbians, or because of the emphasis on powerlessness, which they feel emphasizes their status as victims.

Suggested Interventions Case Example 3: Greg

Trainer Notes:
Suggested Interventions: A Provider’s Introduction, page 86

This case points out many of the issues discussed in this chapter—the frequent link between substance use and social activities for gay men, the special role of amphetamines, the concerns about HIV/AIDS.

- Greg has many reasons to feel different: being deaf, being gay, being HIV positive, having a low sex drive. He has a great deal of denial and will need much support to see the impact of substance abuse on his life. The primary care provider who manages Greg’s HIV care may be the best person to intervene. Ideally, all HIV medical providers should be well versed in substance abuse treatment.

- If the primary care provider is able to refer this client to a substance abuse counselor, the counselor will need to keep many points in mind in the intervention and treatment planning including the following:
Denial is part of all substance abuse. Denial seems to be particularly strong with amphetamine use and abuse. Many gay men who use speed use it intravenously and still do not consider themselves as having a problem. Point out the current and possible effects of the amphetamine use, such as health problems, loss of time at work, and the concern of friends who want to help break the denial.

Many gay men will say they are out and quite comfortable being gay. Although this statement is usually true, gay men have not always addressed the internalized homophobia that they picked up from growing up in a homophobic society. Some gay men, such as Greg, may have subtle self-esteem problems and not recognize that their drug or alcohol use, poor selection of dates or lovers, or lack of ambition on a job may be related to shame and doubt about being gay. Just being out to others does not mean that someone really has dealt with the issues he has had to live with as a result of growing up gay. The substance abuse counselor working with Greg will have to communicate with Greg about his self-acceptance and any shame and doubt he is dealing with, even if he is out with his close circle of friends.

Gay men with disabilities and substance abuse problems face extra barriers to accessing care and to living clean and sober lives. Finding a counselor or program that has other deaf staff or staff who can sign may be difficult. Finding 12-Step programs that have services for the hearing impaired may be an additional challenge. There are, luckily, many sensitive programs for hearing-impaired gay people. The counselor working with Greg can help him find a 12-Step program with such sensitivity in their local community because most large cities have specific gay- and lesbian-identified services.

If Greg is able to accept the fact that he has a substance abuse problem, ongoing self-care will remain a challenge unless he is able to find new social outlets that do not involve alcohol and drugs or unless he is able to develop new friendships with people who do not have substance abuse problems. Greg’s counselor will need to work with him to explore other social avenues or work on a program that will allow Greg to develop the skills to avoid alcohol and drug use in his old social environment. The counselor will have to help Greg talk to his current friends about not bringing him drugs or trying to convince him it is okay to use just a little. It may be hard to make new friends, but it may be necessary. It is also the counselor’s responsibility to encourage Greg to engage in safer sex practices and to provide or refer him to information regarding such practices, including their benefits (e.g., preventing reinfection that could forfeit a successful HIV medication regime).
Suggested Interventions Case Example 4: Amber

Trainer Notes: Suggested Interventions: A Provider’s Introduction, page 98

- Accept her into your residential treatment program and house her as you would other women in your program. If rooms for women are dorm-type rooms, this should be acceptable. If smaller, more private rooms are available, housing her in a single room is also acceptable. If only group showers are available, have a special time at which she can use them. If individual showers for women are available, this is preferable.

- Insist on all staff members referring to her and treating her as female. She should also find outside support for transgender individuals, if it is available.

- Address any issues clients have with Amber, as you would any other counseling issues, in individual counseling.

- Staff and client education about transgender and transsexual issues will help alleviate some of these concerns.

Suggested Interventions Case Example 5: David

Trainer Notes: Suggested Interventions: A Provider’s Introduction, page 103

- David’s experiences are common for gay youth who use alcohol and drugs to cope with loneliness and social adjustment and to medicate themselves for depression and anxiety. Potentially, his substance abuse problem could be identified by a perceptive teacher, school counselor, or pediatrician. In many cases, however, adolescent substance abuse is not identified until youth get into trouble or alcohol and drug use escalates. In David’s case, early intervention could help prevent more severe dependency and could help him develop social and interpersonal skills, including the capacity for chemical-free intimacy and for discussing risk reduction with his sexual partners.

- Finding drug treatment programs for teens like David is a challenge. Few resources for drug treatment and aftercare exist for LGBT youth. Hunter and Haymes (1997, p. 156) noted: “With few exceptions, appropriate models for this population have not been designed. And those that exist have not been evaluated. Consequently, these youth are continually forced into straight, traditional drug treatment programs, which almost always fail to meet their needs.” Youth care providers and counselors caution that LGBT youth may be harmed by programs that lack appropriate content or experience.
MODULE 14: Policies and Procedures

Total Timeframe: 1 hour, 10 minutes

Program Administrator’s Guide

A Provider’s Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals

Based on the publication: (DHHS Publication No. (SMA) 01-3498)

Training Curriculum
Overview, Goals and Objectives

Total Timeframe: 4.5 hours

1. **Defining Agency Policies and Procedures:** In this session of the training, the trainers present the need for LGBT-affirmative policies and procedures to ensure that the delivery of fair and equitable clinical services is built into the fabric of the organization and does not depend only on personal commitment by staff members.

2. **Identifying Training and Educational Needs:** Trainees will explore their agency’s educational needs, identifying how to plan and implement an effective training program.

3. **Developing Effective Quality Improvement Measures for LGBT Clients:** Trainees will explore how their agency can assess and evaluate its programs and services for LGBT clients.

4. **Understanding How To Build Effective Alliances:** In this module, the trainers will present the rationale for alliance-building and strategies for doing so effectively.
Handout 14-A

LGBT Supportive Environment Assessment

Consider each statement below and write a T for those statements that are true in your agency, facility, or organization (herein referred to as agency) and an N for those that are not true in your agency.

- My agency offers LGBT support groups.
- My agency has a designated and identified affirming counselor for LGBT issues.
- Contributions of LGBT persons are acknowledged and shared in my agency.
- My agency’s affirmative action statement for staff and clients includes sexual orientation.
- My agency’s affirmative action statement for staff and clients includes gender identity and gender expression.
- My agency has a clear written policy that prohibits harassment and discrimination on the basis of sexual orientation and gender identity/expression, by or against staff and clients.
- There are openly LGBT persons in volunteer or peer counseling positions.
- There are openly LGBT persons on professional and/or administrative staff.
- I seldom see graffiti or hear slurs that are anti-LGBT in my agency.
- There are openly and prominently displayed materials on LGBT issues and concerns in the waiting areas and common spaces of my agency/facility.
- LGBT clients would find my agency/facility a warm and supportive place to receive services.
- Information and postings about LGBT services or issues would not be defaced at my agency/facility.
- If I were an openly LGBT staff person, I would have no reason to fear harassment, violence, or discrimination in my agency setting.
- I would feel entirely comfortable speaking in support of LGBT issues and concerns at my agency/facility.
- I would rate my agency/facility as LGBT sensitive and affirmative as follows:

(Adapted from McNally and Finnegan 2002)
Handout 14-B

Walden House Case Example

Walden House, Inc., is a large, nonprofit organization providing substance abuse rehabilitation services in San Francisco and the greater California community. Founded in 1969, Walden House has grown and thrived within the culturally diverse San Francisco environment. The agency now provides services to more than 3,500 individuals each year in its residential and outpatient programs. Approximately 20 percent of the clients in Walden House’s main city-funded programs fall into the categories of lesbian, gay, bisexual, and transgender (LGBT). In its Ryan White CARE Act programs serving individuals with HIV/AIDS as well as substance abuse issues, more than half the clients are LGBT.

San Francisco is a nationally recognized mecca for members of LGBT communities. The city’s cultural diversity and progressive politics provide opportunities for real advances in LGBT rights. Gay and lesbian elected officials are a powerful force in local politics. LGBT people are actively involved in the local decision making process regarding substance abuse, human services, and public health funding. The city actively prosecutes hate crimes, and many local businesses recognize the LGBT community through domestic partner initiatives, specific marketing campaigns, and sponsorship of events.

Recognition of LGBT lifestyles, values, and families is part and parcel of the fabric of the Walden House work and treatment community. The agency’s commitment to cultural competence for LGBT clients is demonstrated through a number of administrative, clinical, and business policies and practices. The board of directors includes openly gay and lesbian members. Staff members who are LGBT persons are frequently open about their sexual orientation, and the agency ratio of LGBT staff to LGBT clients is two to one.

As a therapeutic community, Walden House promotes an atmosphere of acceptance and celebration of all cultures represented in the treatment environment. There is no tolerance within the Walden House community for discrimination, including homophobia, transphobia, racism, sexism, or any other discriminatory practice. LGBT people are included in the agency nondiscrimination statement and mission statement. Walden House offered domestic partnership benefits to staff even before the city of San Francisco mandated it for county contractors. Agency outreach literature describes services offered to these and other specific populations. Articles in the Walden House Journal have profiled “out” clients, staff, and board members. Staff members on the Walden House Special Populations Task Force help ensure cultural competence for LGBT clients. An agency representative serves on the San Francisco city and county LGBT Task Force.

Data are collected on the number of LGBT persons served, and evaluation of the efficacy of treatment for LGBT populations is conducted on a regular basis.
In the treatment milieu, the special needs of LGBT clients are considered in the overall assessment process. LGBT clinical support groups are held bimonthly and are open to persons who are either LGBT or questioning their sexual identity. Therapists, counselors, and managers who openly identify themselves as LGBT are employed throughout the agency. LGBT clinical specialists are frequently included in the treatment planning team for LGBT clients. The client grievance procedure provides an avenue for addressing any perceived or actual wrong experienced by participants. Clients have the right to have representatives of their own choice at grievance hearings, and if LGBT issues are raised, an LGBT staff member is often made available to hear the grievance with other appropriate staff.

An example of Walden House’s active involvement in the LGBT community is its participation in the Annual San Francisco Gay, Lesbian, Bisexual and Transgender Pride Parade. Walden House clients volunteer to collect donations, staff an information table, sell beverages, and have a float and large contingent in the parade. The event caps Pride Month, during which clients participate in special educational and recreational events. Heterosexual clients and staff participate in these activities as well.

**DISCUSSION:**

1. **How does Walden House demonstrate its commitment to serving LGBT substance abusers?**

2. **What policy and procedure areas (from above) are evident?**

3. **How can you implement similar policies and procedures in your agency?**
Title Slide - Module 14-18: A Program Administrator’s Guide

Content Taken From Section 3: Chapter’s 14-18 of A Provider’s Introduction to Substance Abuse for Lesbian, Gay, Bisexual, and Transgender Individuals

Learning Objectives - Program Administrator’s Guide
to Working With Lesbian, Gay, Bisexual, and Transgender Clients in Substance Abuse Treatment
(Text: Section 3 in A Provider's Introduction)

At the end of this session, trainees will

- Defining Agency Policies and Procedures
- Identifying Training and Educational Needs
- Developing Effective Quality Improvement Measures for LGBT Clients
- Understanding How To Build Effective Alliances
Notes for Slide 14-1

Timeframe: 5 minutes

Following the review of the learning objectives, complete the following activity

Group Exercise

- Using handout14-A on **LGBT Supportive Environment Assessment**, have trainees mark a “T” for each statement that is true for their setting and “N” for each that is not.
- Ask in the large group for trainees to share a sample of what they found.
- Ask for suggestions from the group as to how each problem area might be remedied.

Relate the discussion of the assessment above to the following guidelines (Slides 2-12) for developing LGBT-Affirmative policies and procedures

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Module #1: Policies and Procedures

Learning Objective

(Text: Chapter 4 in A Provider’s Introduction)

Know agency policies and procedures for serving LGBT Clients including the following areas:
Organizational mission, outreach, advertising & public relations, community relations, administrative, personnel, staff training, program design & implementation, aftercare

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Notes for Slide 14-2

Following the review of the learning objectives, complete the following activity

Group Exercise  Timeframe: 20 minutes

- Using handout14-A on **LGBT Supportive Environment Assessment**, have trainees mark a “T” for each statement that is true for their setting and “N” for each that is not.
- Ask in the large group for trainees to share a sample of what they found.
- Ask for suggestions from the group as to how each problem area might be remedied.

Relate the discussion of the assessment above to the following guidelines (Slides 2-12) for developing LGBT-Affirmative policies and procedures
The Need for LGBT-Affirmative Agency Policies and Procedures

- LGBT-specific administrative policies and procedures can help ensure that the infrastructure of the program is sensitive to and culturally competent with lesbian, gay, bisexual, and transgender clients.

- Examine all aspects of a program for overt and covert expressions and perceptions of heterosexual bias—from outreach to aftercare.

- Make a commitment at every level of the program, from the board of directors to the direct line staff, to design and deliver services in a manner sensitive to the needs of LGBT individuals.

- Implementing LGBT-specific policies and procedures will help ensure that the delivery of fair and equitable clinical services is built into the fabric of the organization and does not depend only on personal commitment by staff members.

Notes for Slide 14-3

Timeframe: 5 minutes

Trainer Notes:

**Discussion**

- Lead the group in reviewing each section, asking the participants to identify specific ways their agencies could implement these guidelines.

- The PowerPoint slide will list the agency policy area; then trainer should ask for examples of implementation; PowerPoint slide will then provide one or two examples.
Organizational Mission

Because LGBT communities are underserved and often invisible, it is important that treatment providers make a commitment to serving this population and incorporate the commitment into the organization’s mission statement, philosophy, and service literature.

Notes for Slide 14-4

Timeframe: 5 minutes

Trainer Notes: Ask trainees for examples

Policies and Procedures Regarding Outreach and Promotional Materials

- Ensure that promotional materials include information about LGBT-specific services, if appropriate.
- Use language that specifically identifies LGBT individuals as people the program is attempting to reach.

Notes for Slide 14-5

Timeframe: 5 minutes

Trainer Notes: Ask trainees for examples
Advertising and Public Relations Policies and Procedures

- Advertise programs and events in LGBT periodicals as well as in the mainstream press and publications that are geared to particular cultural communities.

- Include articles by and about recovering LGBT individuals in newsletters.

Community Relations Policies and Procedures

- Support LGBT-specific events in the community (dances, readings by LGBT writers, theater and music performances, and LGBT pride marches) through sponsorship, staff support, advertising, and distribution of announcements or by cosponsoring such events with LGBT communities.

- Provide an information booth at LGBT street fairs, as well as at events geared to specific cultural communities.

Notes for Slide 14-6

**Timeframe:** 5 minutes

**Trainer Notes:** Ask trainees for examples

Notes for Slide 14-7

**Timeframe:** 5 minutes

**Trainer Notes:** Ask trainees for other examples
Administrative Policies and Procedures

- Create or confirm the existence of agency policies regarding freedom from discrimination and harassment based on sexual orientation, gender, and cultural background.

- Review all operational procedures, from initial phone contact through the intake process, to ensure that heterosexual bias has been eradicated and inclusive terms are available as options.

Personnel Policies and Procedures

- Include sexual orientation and gender identity in your nondiscriminatory employment policy.

- Enlist openly LGBT members to serve on the board of directors and in other leadership positions.

- Employ openly LGBT individuals as staff and consultants. Ensure that LGBT individuals of color are represented in proportions that reflect the community demographics.

- Include partners in the definition of family when writing bereavement policies or sick leave policies on caring for family members.
Staff Training Policies and Procedures

- Ensure that all new employees are familiar with agency policies regarding hiring of and providing services to LGBT clients.

- As a part of regular staff training, include such topics as “LGBT cultures and communities.”

- Have up-to-date national and local lists of resources and services available within LGBT communities and in offices and waiting rooms for easy access by clients and staff members.

Notes for Slide 14-10

Timeframe: 5 minutes

Trainer Notes: Ask trainees for other examples

Program Design and Implementation Policies

- Provide education for heterosexual clients about language and behaviors that show bias toward LGBT people.

- Establish firm guidelines regarding client behavior, and consistently enforce these guidelines to ensure a treatment atmosphere of safety for LGBT (and all) clients.

- Make all family services available for the domestic partners and significant others of LGBT clients in your program. These may include conjoint therapy, family therapy, or groups.
Aftercare Policies and Procedures

- Establish training procedures in which all staff members are educated about issues LGBT individuals face on discharge. Include workshops on relapse triggers specific to LGBT individuals in recovery.

- Ensure that discharge procedures include providing each LGBT client with a comprehensive list of LGBT-specific or LGBT-sensitive community resources and services, along with clear information about how to access these services.

Notes for Slide 14-12

Timeframe: 5 minutes

Trainer Notes: Ask trainees for other examples

Case Example: Walden House

See Handout 14-B
Notes for Slide 14-13

Timeframe: 30 minutes

Group Exercise

- Divide participants into small groups and distribute case example. Let them know they will have 12 minutes to answer the questions as a group.
- When finished, regroup and report back to large group & review answers for all three discussion questions.
Module 15: Training and Education

Total Timeframe: 1 hour, 20 minutes
(with optional exercise - 12 minutes without)

Program Administrator’s Guide
A Provider’s Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals

Based on the publication:
(DHHS Publication No. (SMA) 01-3498)

Training Curriculum
Module #15: Training and Education

(Text: Chapter 15 in A Provider's Introduction)

At the end of this session, trainees will

1. Understand training and educational issues related to serving LGBT clients
2. Know guidelines for effective training programs
3. Know how to facilitate a segment of an LGBT training curriculum

Notes for Slide 15-1
Timeframe: 3 minutes

Notes for Slide 15-2
Timeframe: 5 minutes
Trainer Notes:

In addition to ensuring that agencies have LGBT-affirmative policies and procedures, administrators have a responsibility to ensure that all staff, not only clinicians, receive training and education to improve their sensitivity toward all individuals. Working to eliminate discrimination, both overt and covert, must be an ongoing activity.
Some Tips for Providing Staff Training

1. Facilitating Controversial Material
2. Trainer’s Identity:
   - Openly identified LGBT professional
   - Experienced heterosexually identified colleague
3. Objections to Homosexuality
4. Other Resources:
   - Local LGBT community organization newsletter
   - Brochures from LGBT groups and organizations
   - A list of LGBT 12-Step meetings
5. LGBT Cultural Items
6. Assessment and Follow-up

Notes for Slide 15-3

Timeframe: 10 minutes

Trainer Notes:

Facilitating Controversial Material

LGBT training contains materials and confronts what are often controversial issues in our society about sexual orientation and gender identity so trainers need to have experience facilitating discussion and response, handling dissent, and mediating differing opinions and attitudes.

Trainers’ Identity

The ideal training situation is to have a team of at least two trainers with one of the trainers an openly identified LGBT professional who is comfortable presenting these issues without taking trainees’ opinions and lack of knowledge personally and the other a heterosexually identified colleague who is familiar with LGBT issues and adept at offering effective interventions to the LGBT population.
Objections to Homosexuality

Trainers should be aware that in offering LGBT training in this and other areas of health and human services, trainers may encounter religious or moral objections to homosexuality. Whereas trainers need to respect trainees’ religious and moral views, it is important to remain committed to increasing and enhancing accurate knowledge about LGBT persons and increasing provider sensitivity about and affirmation of LGBT person’s identities and concerns and their right to respectful and supportive substance abuse services. Trainees who are unable to tolerate this perspective may not be appropriate candidates for this training.

Other Resources

The trainers can complement training by having a list of local LGBT resources available such as the local LGBT community organization newsletter, brochures from LGBT groups and organizations, and a list of LGBT 12-Step meetings.

Examples of LGBT cultural items also enhance the training environment and send a message that an open display of LGBT culture is affirming. Examples include a rainbow flag; LGBT posters, pink triangle stickers, or buttons; pictures of famous LGBT personalities, writers, performers, elected officials; or a rainbow flag pin or button to hand out.

Assessment and Followup

Using a pretest and a posttest can help administrators assess the extent of new learning, changes in attitudes, and skills that trainees acquire.

Some portions of the training will be helpful to support staff that also may have personal contact with LGBT clients in a treatment setting and may need to be sensitized. Supervisors also need to be trained and to follow up training of line staff in supervision to ensure that training is put into practice.
Optional Training Activity – Train the Trainer

Timeframe: 70 minutes

Trainer Notes:

Materials:  Curriculum Handouts
            PowerPoint Slide Handouts
            PowerPoint Slides/LCD
            Easel Chart and Markers

- Divide participants into four small groups.
- Distribute the curriculum for Session # 1 Overview from this manual.
- Assign each group a section of the training as follows:
  - Group # 1. Introducing Ourselves and Our Concerns
  - Group # 2. Limitations of Studies and Estimates of LGBT Persons in Population
  - Group # 3. Kinsey Scale History and Meaning
  - Group # 4. Terminology Quiz

- Give groups 15 to 20 minutes to prepare a 10-minute training segment.
- Make sure each group has handout copies of the PowerPoint slides for its assigned section to refer to in its practice time.
- Set up PowerPoint slides for each group to use.
- Return to large group and allow each small group to “train” the other participants for a maximum of 10 minutes.
- Discuss together what worked well and what participants learned.
MODULE 16: Quality Improvement & LGBTC clients

Total Timeframe: 1 hour

Program Administrator’s Guide

Training Curriculum
Case Study: XYZ Hospital

XYZ Hospital is a comprehensive substance abuse treatment program in a large metropolitan area. The program includes a 125-bed inpatient unit, an intensive outpatient program, and a day hospital program.

Leaders gained awareness of the community by reading local area newspapers, noting gay-oriented businesses, and through self-identified LGBT staff members and clients.

XYZ Hospital gathered information through exit interviews with clients and regularly assessed the volume of LGBT clients served relative to the service area. Based on these assessments, three goals were set: (1) improving the comfort level of clients in groups, (2) helping clients feel more comfortable disclosing their identities, and (3) attracting more LGBT clients to the program. At the time of the initial evaluation, there were two or three openly gay or lesbian clients in each of the program components.

At about this time, the hospital was approached by a national gay- and lesbian-targeted substance abuse treatment program that wished to establish an LGBT-specific program at the hospital. Its leadership felt that the program would assist it in achieving its goals and chose to go forward.

Since the program began, there have been significant increases in the number of LGBT clients served. In the most recent survey, 10 of 90 inpatients, 6 of 20 intensive outpatients, and 10 of 60 day hospital patients identified themselves as LGBT individuals. A market survey revealed that the visibility of the program in the community has been greatly enhanced, and regular client satisfaction surveys reported that LGBT clients feel much more comfortable in treatment, particularly in group settings, and are more satisfied with hospital services overall.

The program currently monitors outcomes in terms of the number of readmissions within a set number of days, adherence to treatment plans, and the number of clients who drop out of treatment. Staff members compare data on LGBT clients with data on clients in the general population cautiously, because LGBT clients have been shown to be at much higher risk and have more complicating factors than clients from the population at large. Staff members are trying to find other ways to compare data and are using outside resources to help them adjust risk factors for better data interpretation.
Case Study: Discussion Questions

1. How did XYZ Hospital assess the LGBT community’s need for services?

2. What tools did XYZ Hospital use for monitoring client progress?

3. How could your agency more effectively expand and evaluate services for LGBT clients?
Module #16: Quality Improvement and LGBT Clients

(Text: Chapter 16 in A Provider’s Introduction)

At the end of this session, trainees will

1. Know specific questions that help define quality in providing treatment to LGBT clients
2. Understand how leaders monitor and assess efforts to improve quality

Notes for Slide 16-1

Timeframe: 7 minutes

Trainer Notes:

Any discussion on the quality of care provided for LGBT communities is, by necessity, a discussion of cultural competence. Therefore, quality indicators should be functional measures of this competence.

The central mission of accrediting bodies such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the National Committee for Quality Assurance, and CARF... The Rehabilitation Accreditation Commission is to establish standards for what they consider the key functions of substance abuse treatment centers and indeed all healthcare organizations. These standards provide frameworks for quality improvement that can be adapted to the specific task of improving service to LGBT individuals. The outline that follows shows how JCAHO standards can be used this way.
LGBT Affirmative Services Quality Checklist

- Leadership
- Human Resources
- Patient Rights and Organizational Ethics
- Education of Patients and Families
- Assessment of Patients
- Care of Patients and Continuum of Care
- Management of Information
- Performance Improvement

Notes for Slide 16-2

Timeframe: 10 minutes

Trainer Notes:

- **Leadership**
  - Do needs assessment and planning activities include LGBT clients in the community? Is their inclusion proportional to the percentage of the population they represent?
  - How does the organization design services to meet the needs of the LGBT community, and how well are these services delivered?
  - How effectively does leadership identify and cultivate community resources for LGBT clients?

- **Human Resources**
  - How does the organization measure and improve the competence of its staff in serving LGBT clients?
  - What kinds of educational and training activities address these competencies?

- **Patient Rights and Organizational Ethics**
  - Are LGBT clients’ cultural, psychosocial, spiritual, and personal values respected?
  - Do LGBT clients’ significant others or support people participate in care decisions?
  - How are privacy rights of LGBT clients protected?
**Education of Patients and Families**
- Are educational materials appropriate and relevant for LGBT clients?
- Are educational programs accessible to LGBT clients' significant others and support people?

**Assessment of Patients**: Are relevant medical issues and social issues effectively and comfortably identified for LGBT clients?

**Care of Patients and Continuum of Care**
- How do care plans demonstrate sensitivity to the needs of LGBT individuals?
- Do discharge plans take into account the lifestyles and personal support systems of LGBT clients?

**Management of Information**
- Is the information system set up to collect data important to LGBT clients?
- Do assessments of information requirements include the special needs of LGBT clients, the providers serving them, and other service agencies?
- Does the information system facilitate tracking performance and outcome data for the LGBT client base?

**Performance Improvement**: Do aspects of the performance improvement plan include specific monitors of and quality improvement activities aimed at services for LGBT clients?

**Content: Tools for Monitoring Progress**

**Timeframe: 20 minutes**

**GROUP EXERCISE: What Do We Want To Know?**

- Give the group the following scenario:

Assume your treatment center has adopted LGBT-affirmative policies and procedures, done outreach to the LGBT communities, and hired LGBT-identified staff and now a sizable percentage of your clients identify as LGBT.

- Have the group brainstorm:

What do you want to know about your clients? About effectiveness of the agency’s programs and services? What outcomes do you want to evaluate? Use the previous standards to inform the discussion.

**Trainer note**: Relate the following to the previous brainstorm and discussion.
Tools for Monitoring Progress

Collecting Baseline Data

- Measure performance against baseline data.
- Add appropriate data fields for recording one’s transgender identity, sexual behavior or identity, and information about significant same-sex relationships to forms used to collect client demographic data.
- Confidentiality should always be of concern. Clients can never be forced to provide any demographic information, but policies to preserve privacy rights should not keep people from communicating and recording their sexual orientation or transgender identity if they choose to do so.

Notes for Slide 16-3

Timeframe: 10 minutes

Trainer Notes: See highlights above.

Tools for Monitoring Progress

- Client feedback
- Client satisfaction surveys
- Guest client
- Exit interviews and patient satisfaction interviews
- Focus groups
- Examination of service utilization
Notes for Slide 16-4

Timeframe: 5 minutes

Trainer Notes:

- Client feedback is a valuable source of information in monitoring progress, identifying specific areas that need improvement, and soliciting suggestions about improvements.
- Client satisfaction surveys can include questions to assess the LGBT friendliness and competence of the staff and facility. There is a sample survey in A Provider’s Introduction, chapter 16, page 144, exhibit 16-1.
- Guest client: A volunteer who visits the facility, uses some aspect of care, and then reports his or her experiences. Guest client activities can range from a simple phone call for information to completing a formal intake.
- Exit interviews and patient satisfaction interviews are excellent ways to obtain direct feedback and solicit suggestions. All clients should be asked routinely to participate in these interviews, not just openly LGBT clients. Questions on the staff’s comfort with issues pertinent to gender or sexual orientation should be posed to all clients and in such a way that the sexual orientation of the client is not an issue.
- Focus groups run by staff or local advocacy organizations can provide important input about needed services for LGBT substance abusers.
- Examination of service utilization patterns can help determine whether LGBT clients are missing appointments, dropping out early, or showing a high incidence of complaints and grievances.

Tools for Monitoring Progress

- Evaluate specific outcome measures such as:
  - Number of LGBT clients abstaining from substance use
  - Number of LGBT clients relapsing
  - Number of LGBT clients readmitted.
- Compare outcomes for LGBT clients with outcomes in the agency’s general client population.
- Compare outcome data for LGBT clients with baseline LGBT client participation rates to measure how quality improvement activities have influenced care.
- Compare agency outcomes with outcomes of organizations that have well-established programs for LGBT clients.
Notes for Slide 16-5

**Timeframe:** 5 minutes

**Trainer Notes:**

The goal of quality improvement with respect to service to LGBT clients is to achieve better treatment outcomes. Explain more details about the difference between the last three bullets.

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**Case Example: XYZ Hospital**

See Handout 16-A

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Notes for Slide 16-6

**Timeframe:** 30 minutes

**GROUP EXERCISE: What Do We Want To Know?**

- Divide participants into small groups and let trainees know they will have 15 minutes to answer the discussion questions as a group. Ask them to appoint a spokesperson.
- When finished, regroup and report back to large group.
MODULE 17: Using Alliances and Networks to Improve Treatment for LGBT Clients

Total Timeframe: 55 minutes

Program Administrator’s Guide

A Provider’s Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals

Based on the publication: (DHHS Publication No. (SMA) 01-3498)

Training Curriculum
Handout 17-A

Case Example of Alliance Building at Work: Resource Center of Dallas

The Resource Center of Dallas (RCD), founded in 1983 in Dallas, Texas, is an excellent example of the power of alliance building within the LGBT community. It is a nonprofit corporation established by the Dallas Gay and Lesbian Alliance to promote understanding of sexual orientation and to study the effects of discrimination based on sexual orientation and their implications for public policy. As AIDS became an increasingly critical area of concern for the gay and lesbian community, RCD expanded its mission to encompass HIV, health, and substance use issues. To ensure communitywide support for its activities, it emphasized forging alliances with non-LGBT communities and with community agencies. Its board, staff, and volunteers believe in the importance of developing and maintaining alliances with those of other genders, sexual orientations, and ethnicities. More than 50 percent of its volunteers and board members are self-identified heterosexuals. There is a concerted effort to have gender and ethnic diversity at every level of the organization.

According to Jamie Schield, Co-Executive Director of RCD, the center has a history of alliance building with a wide array of organizations, ranging from those that are totally independent (resistant to alliance building), to those opting for a less formal arrangement (e.g., monthly luncheon meetings of area HIV/drug educators), to those favoring a formalized, structured alliance (e.g., the HIV Prevention Community Planning Coalition for Region III, Texas). To effectively reduce substance abuse and to promote health and wellness in the LGBT community, RCD is now creating alliances with others in the community. Schield emphasized that although “individuals or groups that are in alliance with RCD may not share similar values or perspectives, for they live, dress, recreate, and often see things very differently from RCD, it is precisely this difference in view that is most effective.” The fact that RCD is working with others as a group to address the issue of substance abuse in the LGBT community, despite cultural and individual differences, resonates with the community, adding credibility to RCD’s message. The alliance’s membership legitimizes the issue, and the public now perceives broad-based community support, effectively weakening RCD’s opponents’ ability to label RCD’s efforts as those of “special interests.”

RCD’s alliance-building process involves both LGBT and non-LGBT community groups. They include representatives from the faith community (Cathedral of Hope—
DISCUSSION:

1. How did RCD use the strategies for forming effective alliances in their community?

2. How can alliances, such as those built by RCD, help with financing and delivery of treatment services for LGBT individuals?

3. What can you take from this module to help your agency build more effective alliances in your community?
Module #17: Using Alliances and Networks to Improve Treatment for LGBT Clients

(Text: Chapter 17 in A Provider’s Introduction)

At the end of this session, trainees will

1. Understand the rationale for alliance building among LGBT communities
2. Know the essential elements of alliance building
3. Understand how alliances and networks can be used to help with the financing and delivery of treatment services for LGBT individuals

Rationale for Alliance Building

- Providers moving into this service area typically do not have strong ties to LGBT communities
- Essential to improving substance abuse treatment for LGBT individuals
- Powerful tool for LGBT community development to
  - Bring people together socially
  - Provide a culture and ideology
  - Accept same-gender orientations and behaviors and validate lifestyles.
**Notes for Slide 17-2**

**Timeframe: 8 minutes**

**Trainer Notes:**

- Providers moving into this service area typically do not have strong ties to LGBT communities or to service organizations that traditionally have provided services to these individuals.
- Building alliances both with the LGBT community and with organizations, service providers, and agencies in the community at large is essential to improving substance abuse treatment for LGBT individuals.
- Alliance building has proved to be a powerful tool for LGBT community development. These alliances
  - Bring people together socially
  - Provide a culture and ideology
  - Accept same-gender orientations and behaviors, and validate lifestyles.

**Discussion**

Have group brainstorm what alliances (types of agencies, programs, and community groups) agencies could develop to build or enhance substance abuse services for local LGBT communities.

**Trainer Note:** Candidates for alliance building can be LGBT focused (e.g., the Human Rights Campaign, LGBT community centers, LGBT social organizations) or non-LGBT focused (e.g., an HIV/AIDS organization, Alcoholics Anonymous, State and regional health departments, corporations, volunteer-based organizations, and universities).
Strategies for Building Alliances That Work

1. Recruitment
2. Decision making
3. Conflict Resolution
4. Publicity and Communications
5. Advocacy
6. Participation and Leadership

Notes for Slide 17-3

Timeframe: 15 minutes

Trainer Notes:

**Recruitment**

- Seek support from a broad cross-section of the community. Contact key community leaders early in the process. The broader the coalition, the more effective it will be.

- Encourage alliance members to view their decision to improve substance abuse treatment for LGBT people as an act of compassion and as a way to help in the recovery of all substance-abusing persons.

- Use duplicate representation strategically because individuals are greatly influenced by peers. For example, hospital administrators trust the opinions of other administrators, and counselors will sympathize with other counselors.

- Persuade member organizations to designate a representative who has decision making authority and attends meetings consistently. Involve top management, but not at the expense of leaving out lay persons and community workers in the LGBT communities.

- Do not let the presence of professionals, or any one group, dominate the vision, agenda, and outcome of the alliance.

**Decision Making**

- Identify a coordinator for large and complex alliances to facilitate meetings and the workings of the group. The coordinator should have expertise in interpersonal relations, negotiation, team-building, and group dynamics as well as the support of all alliance members.
• Insist that there be no independent decisions without the endorsement of all alliance members.

• Define a common mission and set collective goals. Consensus building is vital to alliance effectiveness.

• Define consensus building as “Can you live with this?” and not as “Do you agree with this?”

**Conflict Resolution**

• Be sure that each member appreciates the contributions of the others and acknowledges that each member has its own history, structure, and agenda. An established agency with a large budget and many members may contribute differently than does a young organization with a modest budget, few staff members, and limited membership; both types of contributions should be valued by alliance members.

• Remember that there may be a need to agree to disagree on some issues while staying focused on the common mission.

• Use subcommittees to provide a forum for discussion of conflicts. They can then formulate recommendations for the alliance and present them at subsequent meetings (where emotions are kept at bay).

• Insist that disagreements remain within the group and not be discussed in the community at large.

**Publicity and Communications**

• Disseminate decisions made at alliance meetings throughout the community as well as to the boards, staff members, and volunteers of the member organizations.

• Credit all members of the alliance on your letterhead and in any publicity materials.

• Use a catchy name and logo. Publicity material should include the names of all member organizations.

• Use community newsletters and local media to inform the community about the goals and progress of the alliance.

• Distribute background information to demonstrate the need for substance abuse treatment for LGBT people.

• Recognize potential opposition to the group’s mission, and do not underestimate the influence of people with different opinions. A common misperception is that substance abuse treatment for LGBT clients promotes homosexuality or bisexuality. Respond by explaining that LGBT treatment is not about sex but about recovering from alcohol and drug abuse.

• Anticipate opposition, and develop an alternative strategy that explains clearly the goals and activities of the alliance.
Use a variety of channels to disseminate information, including news conferences, news releases, letters to the editor, letters to legislators, and public endorsements from reputable community and professional groups.

Frame the discussion of LGBT substance abuse in easily understood terms and in a realistic cultural context.

Advocacy

Work both with and outside the government system in a coordinated fashion. Attend meetings with government officials, politicians, staff, and city councils in a small group while still maintaining broad representation. Interact with politicians on a nonpartisan basis, meet with all political parties, and use political affiliations of individual alliance members to gain access.

Remember that your goal in part is to educate others so they can advocate for your issues.

Before meeting with officials or politicians, research their positions on substance abuse treatment in the LGBT community. If they are opposed to improving treatment, try to gain their support. If they are sympathetic, enlist their support by asking for ways in which your alliance could help them accomplish the common goal. Be flexible; however, discuss any shifts in position with the alliance to gain its approval.

Always provide brief, cogently written printed materials about the alliance’s goal. Do not provide inaccurate, misleading, or self-serving information. Follow up on meetings with a letter of thanks and a summary of agreements or positions as you understand them.

Participation and Leadership

Ensure effective leadership to inspire member participation. Involvement can be improved if people feel that the alliance belongs to them and that their ideas and membership are valued.

Create a leadership development plan to increase the pool of experienced and skilled members who rotate through leadership positions so that the alliance can be sustainable and effective.

Insist that the leader delegate tasks so that participants know what needs to be done.
### Notes for Slide 17-4

**Timeframe:** 30 minutes

**Group Exercise**

- Divide participants into small groups, and assign the case example with the following discussion questions. Let participants know they will have **15 minutes** to discuss the case.

- When finished, regroup and report back to large group.