

Substance Abuse Treatment and LGBT Cultural Competence

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Chapter 14 Policies and Procedures

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What providers will learn from this chapter:

- Administrative policies and procedures for serving LGBT clients in the following areas:
 - Organizational mission
 - Outreach and promotional materials
 - Advertising and public relations
 - Community relations
 - Administrative
 - Personnel
 - Staff training
 - Program design and implementation
 - Aftercare

Introduction

This chapter addresses the specific administrative policies and procedures that need to be implemented to help ensure that the infrastructure of the program is sensitive to and culturally competent with lesbian, gay, bisexual, and transgender (LGBT) clients. Administrators should understand that in order to provide effective recovery services to LGBT individuals, all aspects of a program should be examined for overt and covert expressions and perceptions of heterosexual bias—from outreach (including public relations) to aftercare services. A commitment should be made 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.

A program committed to serving LGBT clients should first demonstrate its commitment in written administrative policies and procedures. When implemented, these 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. These policies and procedures need to be comprehensive and permeate the entire continuum of care and all agency activities.

Strategies and Recommendations

Suggested administrative policies are described below for an agency's mission, treatment programming, promotional

material, advertising and public relations, personnel, training, and aftercare services. These suggestions are not intended to be definitive; they merely provide a foundation on which organizations can base programs and policy changes. Every policy and procedure needs to be tailored to meet the specific needs of the agency and to consider the type of services (i.e., modality) being delivered and geographic area (i.e., urban or rural).

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 it into the organization's mission statement, philosophy, and service literature.

Administrators should check and edit the mission philosophy or service statement to ensure it includes a commitment to serve LGBT communities.

Policies and Procedures Regarding Outreach and Promotional Materials

Consideration of the following points is critical when preparing promotional materials to distribute to potential clients, the community at large, and policymaking and funding sources.

- 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.
- Include images in promotional materials that depict individuals identifiable as LGBT individuals.
- Enlist the assistance of focus groups composed of a culturally diverse selection

of LGBT individuals in the development of promotional materials for your agency.

Advertising and Public Relations Policies and Procedures

The following points are often overlooked in the promotional activities of mainstream substance abuse treatment organizations. Note that messages that reach LGBT individuals through mainstream media can be especially powerful.

- Advertise programs and events in LGBT periodicals as well as in the mainstream press and those publications that are geared to particular cultural communities.
- Create LGBT-sensitive public service announcements (PSAs) about your services for radio and television. Lobby the stations to carry the PSAs by personally meeting with the public service director.
- When producing cable TV programs on drug addiction and recovery for distribution to local public access cable stations, include LGBT clients and staff.
- Include articles by and about recovering LGBT individuals in newsletters.
- Submit articles about substance abuse issues in LGBT communities to LGBT periodicals as well as to the mainstream press and those publications that are geared to particular cultural communities.

Community Relations Policies and Procedures

Following are some suggestions for developing a seamless plan of communication and support between mainstream substance abuse treatment centers and LGBT communities.

- Provide speakers on substance abuse issues to LGBT organizations.

- Encourage staff to join boards, task forces, and commissions that advocate for empowerment on behalf of LGBT clients.
- 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.
- Form relationships with local LGBT and women's bookstores; provide space for them to sell books at events held at your agency.
- Provide an information booth at LGBT street fairs, as well as at events geared to specific cultural communities.
- Sponsor drug- and alcohol-free social events and sporting activities for LGBT individuals.
- Enlist the help of recovering LGBT substance abusers who might be willing to serve as mentors or sponsors for LGBT clients in your treatment facility.
- Help advocates for LGBT substance abuse services be represented on local, State, and Federal planning and policy boards.
- Ensure the enforcement of these policies at every level of the program, from the board of directors to the direct line staff, in such a way that individuals filing reports are not traumatized further.
- Investigate every complaint of discriminatory practices reported by LGBT clients and their family members.
- Ensure that all personnel from the board of directors to volunteers are trained, on a regular basis, on antidiscriminatory policies. Training should be experiential as well as didactic and include discussions of subtle forms of discrimination and harassment as well as blatant forms of this behavior. Ensure that all personnel are familiar with the procedures for reporting violations.
- 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.
- Use the phrase "clean and sober" as opposed to "straight" to refer to individuals who are drug-free, since straight is often used to refer to individuals who are heterosexual.

Administrative Policies and Procedures

Instituting the following policies and procedures helps create a climate that ensures LGBT clients do not experience or perceive discriminatory practices or harassment.

- Create or confirm the existence of agency policies regarding freedom from discrimination and harassment based on sexual orientation, gender, and cultural background.
- Create procedures for filing complaints and a process for resolving reported violations of these policies.

Personnel Policies and Procedures

Inclusion of the following policies and procedures in agency operations will help ensure a nondiscriminatory environment for both clients and staff as well as equal representation of LGBT viewpoints in program and policy development.

- Include sexual orientation and gender identity in your nondiscriminatory employment policy.
- Develop and implement grievance procedures for employee reports or

complaints of discrimination based on sexual orientation or gender identity.

- Enlist openly LGBT members to serve on the board of directors and in other leadership positions. 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.
- Ensure that the organization has a contagious-disease policy that includes HIV/AIDS (as opposed to an AIDS policy).
- Employ openly LGBT individuals as staff and consultants.
- Advertise job openings in LGBT publications.
- Establish an LGBT advisory board to help with program design, services, and community outreach to advise the board of directors, administration, and staff.
- Review the ability of staff to be inclusive and supportive; directly confront overt discrimination. Hold staff and leaders accountable for upholding the policies as set forth. The degree to which this performance goal is or is not met should be reflected in promotions and merit salary increases.

Staff Training Policies and Procedures

Establishing the following policies and procedures will ensure that new and incumbent staff are aware of the agency's LGBT-supportive stance on an ongoing basis.

- 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."
- Ensure that staff members are allowed to explore their fears and prejudices in a non-threatening environment.
- Have up-to-date national and local listings of resources and services available within LGBT communities and have them in offices and waiting rooms for easy access by clients and staff members.
- Organize cross-training between local LGBT and community groups and your agency. Exchange information about substance abuse and recovery services for information about the LGBT community and its resources.

Program Design and Implementation Policies

Implementation of the following program design and implementation policies will help ensure that adequate resources are directed toward meaningful activities for LGBT clients from diverse backgrounds.

- Ensure that child care services are designed to include LGBT parents. Design workshops on parenting that are not biased toward heterosexuals.
- Utilize focus groups of recovering LGBT individuals in designing and expanding services to ensure the services meet the specific needs of LGBT clients.
- Ensure that case conferencing and clinical supervision address any issues raised in treatment by LGBT clients.
- 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.

- Emphasize and enforce the confidentiality of all treatment services and printed materials at staff trainings and all client functions.
- 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.
- Be sure there are social events and activities appropriate and relevant to LGBT clients of diverse cultural backgrounds.
- Create opportunities for LGBT clients to attend workshops or meetings (including 12-step meetings) that are culturally specific. This can be done in conjunction with local LGBT program resources. Provide transportation for your LGBT clients to these events.
- Make sufficient financial commitment and invest adequate resources to allow your program to fully implement these policies and procedures.

Aftercare Policies and Procedures

Aftercare is critical for any client being discharged from a substance abuse treatment program. Establishing the following policies

and procedures will help ensure adequate postdischarge care for LGBT clients.

- Identify a contact person who is an openly LGBT staff member and who will be available to LGBT graduates if they face any recovery crisis after discharge.
- Establish training procedures in which all staff members are educated about issues LGBT individuals face upon discharge. Include workshops on relapse triggers specific to LGBT individuals in recovery.
- Ensure that discharge procedures help LGBT clients develop relapse prevention strategies for high-risk situations specific to them, such as reentering bar-oriented LGBT communities, coming out to their family of origin if they decide to do so, and dealing with homophobia, discrimination, and/or gay bashing.
- Ensure that discharge procedures include providing each LGBT client with a comprehensive list of LGBT-specific and/or LGBT-sensitive community resources and services, along with clear information about how to access these services.

Following is a case example of a large, California-based mainstream substance abuse treatment program that has implemented specific policies and procedures for serving LGBT clients. The coauthors appreciate the efforts of Dr. Brian Greenberg and Ms. Christine Lanieri in providing this information.

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 decisionmaking 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 competency 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 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 competency 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.

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In developing this publication, several conversations were held with representatives of Inter-Care, a New York City-based private for-profit substance abuse treatment program. Inter-Care has gained a reputation in the LGBT

community for safe and effective treatment by implementing many of the policies and procedures recommended in this chapter. Its steps included modifying history/intake/assessment forms to include LGBT-relevant issues, displaying LGBT-positive posters and reading materials at the clinic, providing staff training on issues of importance to LGBT individuals, and aggressive marketing of the program in the community. Inter-Care's efforts resulted in a fivefold increase in LGBT clients.

Chapter 15 Training and Education

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What providers will learn from this chapter:

- Training and educational issues related to serving LGBT clients
- Strategies and action steps for implementing training
- Essential LGBT-specific educational experiences for improving competencies of professionals and support staff

Introduction

This chapter presents an introduction to implementing the changes necessary to create an LGBT-sensitive substance abuse treatment environment, while at the same time improving the quality of training and education programs for substance abuse treatment practitioners and auxiliary staff. 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, should be an ongoing activity.

As lesbian, gay, bisexual, and transgender (LGBT) individuals become more accepted and visible, they are seeking culturally sensitive, if not culturally specific, substance abuse treatment services. To help develop LGBT-sensitive care, providers can find competent care standards in the Center for Substance Abuse Treatment (CSAT) Technical Assistance Publication #21, *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice* (1998b), and in the 1999 CSAT publication, *Cultural Issues in Substance Abuse Treatment* (1999b).

Training and education programs seek to improve understanding of the complex issues with which LGBT individuals struggle. To support the diverse LGBT population, educators, administrators, substance abuse treatment professionals, nurses, clinical supervisors, students, other professionals,

and local communities all should be considered in the educational process.

A holistic approach to treatment is most likely to enable LGBT individuals to effect real change in their lives. Therefore, a **multifaceted** approach is suggested to improve the present situation, wherein treatment professionals and society have incomplete and inadequate information that often leads to a misunderstanding of LGBT issues and even a denial that LGBT individuals have special needs.

Substance abuse treatment professional training programs, faculties, institutions, administrators, health care “gatekeepers,” and community settings all require education and training. Targeting certain community dimensions is crucial to the success of a training or education program.

Issues To Consider

The following information could be included in a training or educational program.

Barriers to Treatment Access

Barriers to adequate substance abuse treatment for the LGBT community have been touched on in other chapters. In addition to the reasons any prospective client might have, the reasons LGBT individuals may avoid or delay seeking professional care include fear of disclosing their sexual orientation or gender and previous experiences with health care providers who attempted to convert them to heterosexuality, who attributed their substance abuse to their sexual or gender orientation, or who were otherwise judgmental and unsupportive.

Engagement and Retention

LGBT individuals may leave treatment prematurely for the same reasons as non-LGBT clients. But LGBT clients may have additional treatment difficulties if a facility lacks

culturally specific services, if it lacks self-identified LGBT practitioners or sensitive counselors, if it has few contacts with the non-substance-abusing LGBT community, or if it fails to engage non-LGBT clients in exploring their prejudices or honoring diversity.

Relapse Prevention

While many programs address relapse prevention, LGBT clients may need additional help to find LGBT-specific resources, which may be scarce outside metropolitan areas. LGBT clients may have difficulty addressing problems with their sexual or gender orientation and may have difficulty with their families of origin, complications related to other addictive behaviors, and issues related to HIV/AIDS, such as grief and loss or medication compliance. Additional counseling referrals for these issues may be required.

Lacking specific and often essential information about the special problems of LGBT clients, professionals may attribute treatment failures to the clientele rather than to the insufficient training and education about LGBT issues that resulted in inappropriate treatment by the providers.

Strategies

An integrated training and education system addresses both content and process and uses experiential as well as didactic methods. It addresses six components:

- Trainees
- Faculty or trainers
- Program
- Institutional systems
- Professional peers
- Community.

Improving present treatment conditions for LGBT clients requires a comprehensive training approach that includes the six

components. Long-term results are more likely with an approach that addresses these components. The process of implementing training and program change begins with a commitment to action by decisionmakers.

The intention of training and continuing education is to increase the sensitivity and competence of the staff and, ultimately, to improve treatment outcomes. The learning objectives are to:

- Raise awareness of culturally specific issues and the sensitivity of all involved persons
- Identify and become fluent in LGBT-appropriate and sensitive language
- Implement explicit nondiscrimination policies and procedures
- Develop skills to support LGBT individuals in substance abuse treatment services
- Compile a resource list of local, regional, and national support services.

Training should at least result in LGBT-tolerant treatment. Beyond that, however, training can help practitioners help their clients be more comfortable with themselves and their lives. In gender-specific treatment, services should include attention to LGBT issues. Assuming that the separation of men and women will enable practitioners to address LGBT needs is false. Treatment that is LGBT antagonistic should be changed but with the realization that great effort and patience will be required.

Program content should be specifically shaped by the target audience's understanding of LGBT issues.

Addressing the Six Components Effectively

Component 1: Trainees

Trainees include behavioral health professionals; licensed and/or certified counselors; students enrolled in counseling education programs; conference and seminar attendees; staff at inservice training; primary, secondary, and tertiary caregivers; staff of health maintenance organizations (HMOs); case managers; primary care physicians; probation officers; and so forth.

Action Steps

- Recruit and select LGBT individuals of diverse ethnicity for counselor education programs and work settings.
- Develop students' awareness of the need to understand LGBT issues.
- Provide counseling and other appropriate measures for students struggling with their own homophobia or negative attitudes toward LGBT persons.

Component 2: Faculty or Trainers

The faculty or trainers are members of counseling and social work departments responsible for curriculum development, course delivery, and practicum supervision. They prepare professionals and support staff for the behavioral health professions and provide training at seminars and workshops as well.

Action Steps

- Develop faculty and agency awareness of the need for improved understanding of LGBT issues.
- Attain and maintain a diverse faculty with theoretical and practical expertise in LGBT treatment and care.

- Recruit LGBT faculty and staff who can provide instruction, supervision, and services.
- Encourage and support all faculty and staff to continue their education in LGBT treatment areas.
- Support faculty and staff research in LGBT treatment.
- Assign decisionmaking roles to faculty who are knowledgeable about LGBT issues.

Component 3: Program

Managed care organizations, consumers, and quality improvement measures demand that health care be evidence based. Therefore, any training or educational program needs to be based on current research findings. Training elements should include assessment of need, attitudinal behavior changes, skills training, methods development, training and education program evaluation, and actions to implement change.

Action Steps

- Conduct an assessment of the current level of tolerance, sensitivity, and affirmation of the treatment agency staff.
- Gather and review pertinent research and theoretical material.
- Recruit skilled professionals as trainers and educators, and/or develop an interagency training alliance.
- Develop program materials and methods that are site- or client-specific.
- Determine methods for evaluating the effectiveness of the training or educational program.

Attitudinal Behavior Changes and Skills Training

- Utilize experiential exercises that uncover hidden biases in a safe manner (e.g., roleplay a 21-year-old coming out to his parent or ask participants to introduce themselves as lesbian, gay, bisexual, or transgender individuals).
- Encourage exploration of stereotypes and language, values, and behavior differences.
- Use various methods incorporating adult learning styles to increase skill development.
- Use additional resources available on videos and films.

Methods Development

- Make LGBT sensitivity and competency training a priority in the basic curriculum or in the inservice training schedule—an important first step in implementing this type of program.
- Redesign existing programs to include LGBT-related competencies. Use a team approach involving academic and clinical staff and, if possible, a team member from the LGBT community at large.

- Develop courses awarding continuing education units (for academic and/or professional credit) for professionals and support staff.

Evaluation

- Give pretests and posttests to evaluate training.
- If possible, make videotapes or audiotapes of clinical sessions before and after training to ascertain whether there have been changes in the ability to treat LGBT clients.

- Collect client satisfaction and followup data from LGBT clients treated at the same site over time.
- Conduct quality improvement studies focusing on the effects of LGBT sensitivity and competency training.

Component 4: Institutional Systems

For the purpose of this volume, the phrase “institutional or agency systems” refers to the individuals who serve as gatekeepers: administrators of organizations, departments, and schools who are responsible for the delivery of programs and services; boards of directors; and other staff.

Action Steps

- Gain administrative awareness of the need for improved understanding of LGBT issues.
- Create an administrative environment supporting LGBT care, treatment, and confidentiality.
- Require LGBT competency and sensitivity at all levels, including policy development.
- Institutionalize a policy for ongoing recruitment and selection of LGBT administrative, professional, and support staff.
- Encourage and support the use of LGBT staff and faculty to provide instruction and supervision.
- Institute administrative and clinical policies to endorse LGBT sensitivity and competency training, LGBT treatment, and unbiased care.
- Allocate curriculums, time, and resources for training.

Component 5: Professional Peers

Effective techniques for training and skills development and “what works” often are the subject of consultations among professionals. This important dimension of the training process plays a significant role in introducing important ideas to newcomers and improving practice by long-term practitioners as well.

Action Steps

- Increase professional peers’ awareness of the need for improved understanding of LGBT issues.
- Articulate the need for implementing programs at all levels of practice in professional associations.
- Convene conferences about LGBT treatment.
- Involve LGBT professionals in policymaking.

Component 6: Community

The family, neighborhood, town, city, State, and region in which LGBT clients are treated is their “home.” The response of the community to LGBT clients is a crucial factor in their care and treatment.

Action Steps

- Provide counseling services to the families of LGBT clients at all socioeconomic levels.
- Provide information on treatment and the special needs of LGBT clients to relevant parties in the community: government officials, police, and all criminal justice professionals.
- Create task forces to work directly with LGBT interest groups.

A Training Model

The State of New York designed a model curriculum program detailed in *Working With Lesbian, Gay, Bisexual and Transgender Clients in Alcoholism and Substance Abuse Services: Trainers Manual*, (New York State Office of Alcoholism and Substance Abuse Services, Academy of Addiction Studies, 1996). This manual presents a core curriculum and specific modules for both theory and skill competency. The curriculum includes information on the need to raise consciousness about LGBT clients, stereotyping, myths, homophobia, and terminology. An example of the resources included in it is shown in exhibit 15–1, the Cass Model of Lesbian and Gay Identity Development. This model can be

especially helpful for substance abuse treatment practitioners who are treating LGBT clients and who want to understand the stages their clients may be in or moving through. This kind of understanding will help practitioners provide more sensitive and effective treatment. Other resources in the curriculum are the Kinsey Scale, the Fifield study, the McKirnan and Peterson study, and organizational development tools that address diversity in the workplace and homophobia/heterosexism assessment surveys.

To receive this curriculum see:
<http://www.oasas.ny.gov/workforce/training/manuals.cfm>

**Exhibit 15–1:
Cass Model of Lesbian and Gay Identity Development**

Stage I: Identity Confusion

Occurs when a person begins to realize that he or she may relate to and/or identify with 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 II: Identity Comparison

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

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

Stage III: Identity Tolerance

Occurs when a person comes to accept the probability that he or she is gay or lesbian.

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

Stage IV: Identity Acceptance

Occurs when a person fully accepts rather than tolerates being gay or lesbian.

- Tasks:** *Development of community and acculturation*
- Feelings:** *Rage, sadness*
- Defenses:** *Hostility toward straight culture*
- Recovery:** *Lesbian and gay recovering community building*

Stage V: Identity Pride

Occurs when a person immerses himself or herself in the lesbian and gay community and culture to live out his or her identity.

- Tasks:** *Fully experiencing being gay or lesbian, confronting internalized homophobia*
- Feelings:** *Excitement, focused anger*
- Defenses:** *Arrogant pride and rejection of straight culture as the norm*
- Recovery:** *Sexuality, identity, and recovery*

Stage VI: Identity Synthesis

Occurs when a person develops a fully internalized and integrated lesbian or gay identity and experiences himself or herself as whole when interacting with others in every environment.

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

Adapted from Cass, 1979

Chapter 16 Quality Improvement and LGBT Clients

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What providers will learn from this chapter:

- How leaders determine whether quality assurance efforts are needed
- Specific questions that help define quality in providing treatment to LGBT clients
- How leaders monitor and assess efforts to improve quality

Introduction

This chapter offers suggestions on how to incorporate an evaluation of substance abuse treatment services for lesbian, gay, bisexual, and transgender (LGBT) clients into an agency's quality improvement program. It will help leaders create questions and monitor responses about the issues and recommendations raised throughout this volume.

The conceptual framework common to all quality improvement programs includes the following steps:

- Define quality in terms of concrete functional processes and outcomes that can be assessed
- Implement some means of measuring such processes and outcomes
- Evaluate the data over time with respect to goals and/or external benchmarks
- Analyze the factors and processes that impact performance
- Identify priorities for improvement
- Make process and procedural changes as appropriate
- Continuously monitor the effects of these changes.

A Framework for Functionally Defining Quality

Because any discussion on the quality of care provided for LGBT communities is, by necessity, a discussion of cultural competence, 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 (NCQA), and the Commission on the Accreditation of Rehabilitation Facilities (CARF) is to establish standards for what they consider the key functions of substance abuse treatment centers and indeed all health care organizations. These standards provide frameworks for quality improvement that can be adapted to the specific task of improving service to LGBT individuals. In addition to ensuring a comprehensive approach, the use of standards provides the added bonus of assisting the organization during external surveys and reviews.

The outline that follows shows how JCAHO standards can be used to address quality improvement with respect to service to LGBT individuals. Standards developed by NCQA or CARF could be used similarly. Adapting the standards is fairly straightforward. For example, standards for leadership are directed at how well an organization plans, structures, and delivers its services to meet the needs of its users, who are defined by the demographics of people in the service area. This means that the organization should both know about and appropriately serve LGBT individuals within its service area.

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 competency 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?
- Do LGBT clients receive information about their condition that recognizes their special circumstances and helps them make informed decisions?
- Do policies and procedures for LGBT clients address circumstances in which care will not be given because their condition or lifestyle conflicts with staff members' values, ethics, or religious beliefs?
- 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?

Collecting Baseline Data

Quality improvement programs measure performance against baseline data. This means adding 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. Coding this information will require programs to respect consumers' wishes about confidentiality but also provide information on one's sexual orientation and gender differences, issues, and concerns.

Many people feel that this is personal information, that asking about it is awkward and inappropriate, and/or that people's right to privacy must be protected. Providers should be mindful that the guiding rationale for collecting sexual orientation and transgender identity information is to determine whether these communities are being properly served and what health problems they are experiencing. On this last point, 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.

The ability to elicit baseline demographic data about their LGBT client population is an important measure of competency for LGBT care providers. Many, if not most, staff members will need formal training on how to ask the necessary questions. Training relating to collecting this information will need to consider a variety of factors (e.g., age, culture, ethnicity, and individual consumer differences). Self-administered questionnaires could be used. By providing a blank space where they can identify their gender if they choose, the items on such questionnaires can be posed to clients so it is not necessary for them to commit to being either male or female. Eli Coleman's assessment tool (1987) shown in chapter 1 is an example of an effective form. It will be important to explore how to collect these data later in the treatment episode if they are not volunteered at intake or during assessment.

The initial staff training on data collection will provide agency leadership with an important gauge of the attitudes and comfort level of staff working with LGBT clients. The close attention and expressed commitment of leadership is, therefore, of critical importance. Because staff competency and comfort are important, baseline data on this issue should be collected at the start of training and throughout training/performance improvement efforts.

Once baseline information is gathered, the percentage of LGBT clients using the facility should be compared to the best available estimates of the percentage of LGBT individuals in the community at large. Comparing the two numbers will provide important information on how well the facility is meeting LGBT clients' needs. Even if the proportion of LGBT clients matches or exceeds the proportion of LGBT individuals in the community at large, there may be considerable room for improvement in working with LGBT individuals considering that clients may hide their identities because of lack of support or fear of persecution, especially in areas where there is no visible LGBT community. Ironically, those who are uncertain about disclosures or reluctant to disclose that they are (or might be) LGBT individuals may likely require the most support concerning these issues.

The key questions that every program should address are:

- How well does the program or staff elicit information regarding clients' sexuality? Is the atmosphere uncomfortable?
- Are LGBT outreach efforts effective?
- Are there actual disincentives for such clients to seek care at the center?

Monitoring Progress

A variety of means can be used to monitor progress with respect to quality improvement goals.

Client feedback is a very valuable source of information in the initial assessment phase of the project, in monitoring progress, in identifying specific areas that need improvement, and in soliciting suggestions on how improvements could be made. **Client satisfaction surveys** can include questions to assess the LGBT friendliness and competence of the staff and facility. Questions can be indirectly worded, as seen in the sample survey form (exhibit 16–1).

Another tool that might prove useful is the **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. Participation in group therapy is probably not appropriate. It is important to inform staff that such a program is being implemented and present it as a way of gathering information rather than as a way of checking up on people. If the agency is unable to find appropriate volunteers, seek assistance from local LGBT social service agencies or other organizations.

Exit interviews and **patient satisfaction interviews** are also excellent ways to obtain direct feedback and solicit suggestions. All clients should be asked routinely to participate in these interviews, not just openly gay, lesbian, transgender, or bisexual clients. Questions on the staff's comfort with issues pertinent to gender or sexual activity should be posed to **all** clients and in such a way that the sexual orientation of the client is not an issue. The interviews should also include questions to assess the staff's comfort with LGBT issues. This can be their last opportunity to communicate acceptance and willingness to discuss LGBT concerns. It should be made clear to clients that refusal to participate will not affect treatment in any way and that any comments will be kept in the strictest confidence.

Exhibit 16–1: Client Satisfaction Survey

Today's Date: _____

Please do not identify yourself. This is an anonymous survey. No individual person or information regarding a specific event will be identified. Declining to complete this survey in no way affects the services and care you receive.

- Did you feel comfortable discussing sexuality issues with your therapist?
 - Very comfortable
 - Somewhat comfortable
 - Somewhat uncomfortable
 - Very uncomfortable
- Did you feel comfortable discussing sexuality issues in therapy group?
 - Very comfortable
 - Somewhat comfortable
 - Somewhat uncomfortable
 - Very uncomfortable
- Did you feel that you could openly discuss your relationships and involve your significant other in treatment/discharge plans?
 - Very comfortable
 - Somewhat comfortable
 - Somewhat uncomfortable
 - Very uncomfortable
- Do you consider yourself
 - Heterosexual
 - Gay
 - Lesbian
 - Bisexual
 - Transgender
 - Unsure
 - Questioning?
- Did you discuss your sexuality at any time with any of the following? Check all that apply:
 - Therapist
 - Other clinical staff
 - Administrator
 - Other clients
- With which individuals do you feel comfortable discussing any aspects of your personal life or sexuality?
 - Therapist
 - Other clinical staff
 - Administrator
 - Other clients
- Was your significant other acknowledged?
 - Consistently and directly
 - Occasionally or indirectly
 - Not at all

Continued 

**Exhibit 16-1:
Client Satisfaction Survey (continued)**

- Was your significant other included in treatment plans?
 - Consistently and directly
 - Occasionally or indirectly
 - Not at all

- In general how comfortable are you in this facility with regard to your LGBT identity?
 - Very comfortable
 - Somewhat comfortable
 - Somewhat uncomfortable
 - Very uncomfortable

- How comfortable was your relationship with other clients with regard to your LGBT identity?
 - Very comfortable
 - Somewhat comfortable
 - Somewhat uncomfortable
 - Very uncomfortable

- If you are a transgender individual, did you feel your gender identity was acknowledged as you wished by
 - Therapist yes no
 - Other clinical staff yes no
 - Administrator yes no
 - Other clients yes no

- Did facilities such as inpatient rooms and bathrooms meet your needs? yes no

- How could we acknowledge your needs as an LGBT individual more effectively?

DEMOGRAPHICS:

Age Today: _____ Biological Sex: M F

Race/Ethnicity: White _____ African American _____

Asian _____ (Specify ethnicity) _____

Pacific Islander _____ (Specify ethnicity) _____

American Indian _____ (Specify ethnicity) _____

Hispanic _____

Primary language spoken at home: English Spanish Other (Specify) _____

Adapted from Coleman, 1987

Additional strategies could include using **focus groups** run by staff or local advocacy organizations and examination of service utilization patterns to determine whether LGBT clients are missing appointments, dropping out early, or showing a high incidence of complaints and grievances.

Information from all of these sources should go regularly to the quality improvement committee and clinical and administrative leadership. As significant issues are identified, they should be incorporated into the agency's quality improvement strategies. Again, assistance from LGBT advocacy groups and other LGBT treatment programs will be valuable in addressing specific issues. As with any quality improvement effort, continuous reassessment of the available data or information is essential to maintaining positive ongoing results.

Evaluating Outcomes

Ultimately, the goal of quality improvement with respect to service to LGBT clients is to achieve better treatment outcomes. It is important to look at measures of treatment efficacy in the overall context of the number of LGBT clients in treatment. At this point, specific outcome measures can be evaluated. These include the following:

- Number of LGBT clients abstaining from substance use
- Number of LGBT clients relapsing
- Number of LGBT clients readmitted.

Outcomes for LGBT clients can be compared with outcomes in the agency's general client population. Although it may not be possible to do this in a statistically significant manner due to the relatively low number of LGBT clients or differences in case complexity, this comparison is a functional measure of how effective the agency's program is for LGBT clients and is useful if interpreted appropriately. Outcome data for LGBT clients can also be compared, over time, to baseline LGBT client participation rates to measure how quality improvement activities have impacted care. Finally, the agency's outcomes can be compared with outcomes of organizations that have well-established programs for LGBT clients. This last comparison may be useful in establishing realistic, yet appropriately ambitious, benchmarks and goals. Contact with other agencies may also help identify technical assistance and new practices and skills that might further enhance treatment quality.

Case Example

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.

The facility is located in one of the city's most densely populated gay and lesbian areas. Its leaders gained awareness of the community by reading local area newspapers, noting gay-oriented businesses, and through self-identified LGBT staff and clients. It was principally gathering information through exit interviews with clients and regularly assessing 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.

Around 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.

Chapter 17

Using Alliances and Networks To Improve Treatment for Lesbian, Gay, Bisexual, and Transgender Clients

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What providers will learn from this chapter:

- The rationale for alliance building among LGBT communities
- The essential elements of alliance building
- How managed care affects care for LGBT individuals
- How alliances and networks can be used to help with the financing and delivery of treatment services for LGBT individuals

Introduction

This chapter provides information about the rationale for alliance building between substance abuse treatment providers and the lesbian, gay, bisexual, and transgender (LGBT) community, the steps of alliance building, the impact of managed behavioral health care for LGBT individuals, components of effective alliances, and examples of LGBT provider networks.

Rationale for Alliance Building and First Steps

Providers who are 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. It will be important to build alliances both with the LGBT community and with organizations, service providers, and agencies in the community at large.

Once the decision has been made to introduce or strengthen treatment services for LGBT individuals, a small contingent should begin to enlist support among the targeted organizations—the public health groups, local health advisory committees, and other organizations that have a stake in improving substance abuse treatment for LGBT individuals. It is important that the

treatment facility not promote itself as LGBT sensitive or providing LGBT services until this important groundwork has begun and adequately trained staff members are in place.

The LGBT community is well schooled in working together and forming alliances. These alliances serve several important functions. They bring people together socially, provide a culture and ideology, accept same-gender orientations and behaviors, and validate lifestyles. Many LGBT communities, when addressing societal problems such as substance abuse or HIV/AIDS, recognize the value of establishing alliances with other groups. Alliance building has proved to be a powerful tool for LGBT community development (see Guinier, 1994; Vaid, 1995). Candidates for alliance building can be LGBT focused (e.g., the Human Rights Campaign) or non-LGBT focused (e.g., an HIV/AIDS organization, Alcoholics Anonymous, State and regional health departments, corporations, volunteer-based organizations, and universities). Some additional candidates for alliances are LGBT community centers (several hundred are located throughout the United States), LGBT social organizations (which frequently are important resources in suburban and rural areas), AIDS service organizations, and the many LGBT Alcoholics Anonymous chapters. Primary medical care providers who provide LGBT-sensitive services are also an important resource.

Some LGBT community organizations emphasize independence and work on the same issues in isolation, creating the potential for duplicating services. In the wake of managed care's influence on behavioral health care, better case management, networking of services, and mergers, many alliances have been formed in the past decade. Other organizations have gradually moved toward cooperation and help one another to accomplish mutually beneficial goals.

Alliances exist on a continuum of cooperation, ranging from loose referral relationships to formal coalitions with set organizational structures. Alliance building starts with recruitment of members and development of a mission and goals. A summary of the essentials of forming effective formal alliances and making them work is presented in exhibit 17–1.

It is important to emphasize to staff members and potential allies that creating a culturally responsive environment for LGBT clients is integral to providing a safe setting for all clients and to helping all people in recovery learn to live in a diverse society.

To build support for the alliance, identify possible organizations and individuals in the community who have a stake in reducing substance abuse in the LGBT communities. Designate alliance members to visit these potential participants. Some will need little persuasion, whereas others will require greater efforts. Inform potential members of the advantages of minimizing LGBT substance use. Solicit letters of support from a variety of key people in the community (e.g., politicians, religious and community leaders, health providers, business persons, legal organizations) who may convince hesitant members that broad-based support for addressing LGBT substance abuse treatment already exists.

The Impact of Managed Care on Behavioral Health and LGBT Individuals

By the end of 1995, the behavioral health care benefits of 142 million individuals were provided under managed care contracts (IOM [Institute of Medicine], 1997), and the number continues to grow. Both private and public health care purchasers are largely contracting with managed behavioral health care organizations (MBHCOs) (IOM, 1996, 1997) to organize specialized mental health and

Exhibit 17–1: Forming Effective Alliances and Making Them Work

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 peers 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 decisionmaking 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.

Don't let the presence of professionals, or any one group, dominate the vision, agenda, and outcome of the alliance.

Decisionmaking

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 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, and volunteers of the member organizations.

Credit all members of the alliance on your letterhead and in any publicity materials.

Continued →

**Exhibit 17-1:
Forming Effective Alliances and Making Them Work (continued)**

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 impact 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 utilize 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 cogently written, brief, printed materials about the alliance's goal. Do not provide inaccurate, misleading, or self-serving information. Follow up 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.

Case Example**Resource Center of Dallas: Alliance Building at Work**

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—Metropolitan Community Church; Potter’s House—Transformation Treatment Center), ethnic groups (African-American Health Coalition, Dallas Intertribal Center, La Sima Foundation), volunteer-based recovery programs (Alcoholics Anonymous), substance abuse treatment councils (Greater Dallas Council on Alcohol and Drug Abuse), emergency temporary shelters (Austin Street Shelter, Welcome House, Inc., Johnnie’s Manor), drug intervention programs (Ethel Daniels Foundation, Inc., Oak Lawn Counseling Services), aftercare programs (Community Alcohol and Drug After Care Program, New Place, Inc.), public health programs (Dallas County Health and Human Services, Parkland Health & Hospital System), veterans’ organizations (Veteran Affairs—North Texas Health Care System), and non-LGBT community groups (Parents, Families and Friends of Lesbians and Gays, PFLAG Dallas).

substance abuse treatment for enrollees independently from overall health care.

Purchasers, either private or public, contract with mental health and substance abuse treatment specialist organizations or preferred provider networks to organize specialized mental health and substance abuse treatment for enrollees independently from overall health care. Typically, MBHCOs assign specialist

“gatekeepers” to assess and monitor clients’ need for access to and utilization of treatment within the network (ASAM [American Society of Addiction Medicine], 1999). Most individuals with private insurance have their behavioral health care needs met by some type of MBHCO (Schoenbaum, Zhang & Sturm, 1998).

Managed care presents challenges for all behavioral health care providers and particularly

so for those targeting LGBT individuals, because LGBT concerns are not well understood by—or even visible to—the leadership of managed care organizations.

The specific needs of LGBT individuals are not well understood by managed care organizations (MCOs). Moreover, few LGBT health care consumer organizations have overtly voiced the specific needs and concerns of this multicultural group. LGBT individuals, especially LGBT persons of color, thus remain hidden, neither accessing the health care system nor communicating honestly with health care providers—all of which has deleterious consequences for LGBT individuals needing treatment services. Clearly, providers of services to LGBT populations have much to gain by working together to make the case for improved services. Fortunately, there are many groups attempting not only to make LGBT concerns visible to managed care administrators but also to deliver improved services.

Designing and implementing successful treatment practices requires knowledge of the target populations. Thus, the critical need for administrators is to understand the existence of these subpopulations and to invite different LGBT populations to participate in the design of services and policies. Acknowledging this diversity and building appropriate mechanisms for consumer input will enhance the probability of successful treatment.

Why should a managed care and a clinical program consider a partnership between an LGBT program (LGBT-sensitive) and managed care? Managed care has recharged consumerism and awakened the health care delivery system to the requirement of providing access and quality services to an enrolled population in a culturally and linguistically appropriate manner (Kennedy, 1999). Some LGBT consumers or clients or patients (whatever terminology individuals wish to use in their self-identification) and LGBT health

care providers are highlighting the needs of these constituencies to be taken care of in an appropriate and professional manner. However, in so doing, consumers risk not only antigay bias but also the stigma of identifying predisposing health conditions, such as HIV/AIDS, addictive diseases, and mental disorders, that may alter benefits packages dramatically.

Another difficulty is that LGBT-identified persons can be seen as “high-cost-of-care” populations. Although data are not available to support or refute this supposition, several reasons can be suggested for the possibility of increased costs. First, managed care seeks to limit the number of patient visits and shorten the length of visits. As a result, a trustful provider/patient relationship may not develop and, therefore, disclosure of a person’s sexual orientation or sexual identity may not occur. The lack of this vital information may reduce the likelihood that appropriate care is provided in a timely fashion, thereby potentially raising its cost. Finally, some insurance companies have taken steps to reduce the probability of insuring an individual who may someday contract HIV (Li, 1996).

LGBT providers are also in a precarious position—self-disclosure may result in their exclusion from provider networks. The American Association of Physicians for Human Rights (now Gay and Lesbian Medical Association) (1994) found that 17 percent of self-identified gay and lesbian physicians had been fired, refused medical privileges, or denied employment because of their sexual orientation.

Despite the experiences of LGBT consumers and providers, incentives exist for MCOs to provide LGBT-sensitive services. It can be advantageous to a managed care company to attract business. Similarly, competent LGBT providers enhance the managed care company’s panel of providers and also satisfy the cultural and ethnic competency standards

articulated in some States' Behavioral Health Request for Proposal (RFP) (e.g., Iowa Substance Abuse RFP, pp. 30–17).

Concerns About Managed Care Organizations

As managed care increasingly dominates both private and public sector mental health and substance abuse treatment services, serious concerns have been expressed by key stakeholders about whether managed care financing, if not properly administered, might in fact cause greater disparities than the fee-for-service system in meeting the critical needs of individuals with behavioral problems.

Their specific concerns include the following (Surles & Fox, 1998):

- Cost-cutting, which potentially threatens the quality of care
- Restructuring of services away from local, community-based approaches
- Relocation of services, which threatens accessibility
- Services provided to consumers by mental health professionals not familiar with the language, cultural values, and multiple needs of different groups
- Consumers' lack of knowledge about how the managed care system works
- Language differences that interfere with communication and access to resources.

Professional guidelines, consumer report cards, and accrediting organizations are mechanisms that ensure provision of culturally competent health care services. Attention or inattention to cultural issues impacts both service delivery and service utilization that, in turn, affect not just quality, access, and

utilization, but also costs. There would likely be an improvement in the utilization of services if policies, procedures, and guidelines addressed the unique cultural issues of consumers and providers (Lu, 1996).

Within the Federal Government, the Health Care Financing Administration is in the process of developing standards (1998) within its Quality Improvement System for Managed Care to include a statement that speaks to nondiscrimination for managed care enrollees based on sexual orientation.

The two largest accreditation bodies for managed care organizations are the National Committee for Quality Assurance and the Joint Commission on Accreditation of Healthcare Organizations. Neither organization has yet issued professional standards of practice related to the treatment of LGBT individuals, nor has either developed standards or quality measures regarding treatment of LGBT individuals that managed care organizations would be required to meet. Thus, for the consumer member of a managed care plan, whether public or private, there is no single requirement to ensure nondiscrimination based on sexual orientation.

Beyond one very specific project in Massachusetts (see the case example following), other “position” or “issue” statements can be found within several of the national associations that represent mental health practitioners. For example, the National Association of Social Workers (NASW) has developed a Policy Statement (1996) that articulates its position that a same-gender sexual orientation should be afforded the respect and rights given an other-gender orientation. NASW also supports curriculum policies in schools of social work that eliminate discrimination against lesbian, gay, and bisexual people and encourage the implementation of continuing education programs on practice and policy issues

relevant to lesbian, gay, and bisexual people and cultures, as well as human sexuality.

The American Psychiatric Association (APA) has, since 1974, affirmed that certain sexual orientations are not a mental illnesses and has removed this diagnosis from all subsequent editions of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). The practice guidelines APA issued in 1995 prohibited specific discrimination against gay and lesbian clients (1995). In 1997, the American Psychological Association (in press) adopted a Resolution on Appropriate Therapeutic Responses to Sexual Orientation. In affirming a set of 13 principles, the American Psychological Association officially opposes portrayals of LGBT persons as mentally ill because of their sexual orientation and supports the dissemination of accurate information about sexual orientation and mental health and appropriate interventions in order to counteract bias that is based on ignorance or unfounded beliefs about sexual orientation.

A cursory review of key managed care stakeholders identified a significant number of professional associations, provider groups, private and public purchasers, accrediting groups, and others in a position to affect or advocate policy changes that specifically include **sexual orientation** or **sexual identity** as an important issue relative to clients and providers, including the following:

- Academy of Managed Care Pharmacy
- Addiction Prevention and Recovery Administration, Washington, DC
- American Medical Association Council on Scientific Affairs
- American Medical Student Association
- American Counseling Association

- Cambridge Preferred Provider Network of New York
- Council for Accreditation of Counseling and Related Educational Programs
- Employee Assistance Professional Association
- National Association of Alcoholism and Drug Abuse Counselors
- Patients' Bill of Rights
- Pacificare of California
- Seattle-King County (WA) Department of Public Health
- Waukesha (WI) Memorial Hospital, Health System and Health Care, Inc.

In addition, the American Federation of State, County and Municipal Employees (AFSCME) continues to work to promote the rights of its lesbian and gay union members via the promotion of legislation that affects domestic partner benefits and to oppose discrimination based on HIV status. AFSCME has also issued a report (1994) resulting from its Presidential Advisory Commission that clearly states consumer rights issues within managed care. The Gay and Lesbian Medical Association's (GLMA's) recent policy (1998) "strongly urges HMOs [health maintenance organizations], PPOs [preferred provider organizations], and other managed care organizations to identify and provide referrals to providers with competence in LGBT health so that optimal patient care can be rendered to LGBT people."

Advocacy Efforts and Partnerships To Improve LGBT Care

No study or organized body of literature exists documenting the success or failure of managed care relationships formed between LGBT-focused programs and MCOs. What is known is that some MCOs and many LGBT providers are reaching out to one another to improve care for LGBT individuals. Some examples are listed below, and contact information is provided in the box at the end of the chapter.

- In researching written information from managed care organizations that indicated a sensitivity to LGBT competency, some clearly stated language was found within the body of a proposal of one managed care organization stating that it will apply cultural competency standards and be “sensitive to diversity brought about by a variety of factors including ethnicity, language, lifestyle, age, sexual preference and socioeconomic status.” This proposal is to manage behavioral health care for a public sector county-based contract.
- More than 14 MCOs have formed contractual relationships for primary physical health care services with the new Lambda Medical Group in Los Angeles (Jean, 1998). The major insurance plans accepted by it include Blue Cross, CIGNA, Medi-Cal, and Medicare. The Lambda Medical Group expects to serve 4,400 patients per year.
- In Washington, D.C., The Lambda Center, with its comprehensive continuum of inpatient, partial hospitalization, and outpatient services that have been made available via a joint-venture partnership, has been highly successful in attracting the attention of MBHCOs and other MCOs in the Mid-Atlantic region. Contracted rates with more than 10 MCOs have been established for The Lambda Center’s acute care services (inpatient hospitalization, detoxification, ambulatory detoxification, partial hospitalization, and intensive outpatient programs), and future plans will include contractual arrangements with a therapist network for the outpatient services component of the continuum. Part of the success is due to a full-scale LGBT-sensitivity and -competency training and education campaign for MCO case managers and senior staff of the MCOs that is being conducted by The Lambda Center in collaboration with the Lesbian Health and Wellness Network (LHWN).
- LHWN, also based in Washington, D.C., is working closely with District of Columbia public sector programs through the Addiction Prevention and Recovery Administration, the D.C. Public Benefits Corporation, the Women’s Health Initiative, and the District of Columbia’s Medicaid program to incorporate training programs in the District’s managed behavioral health care readiness program. In addition, LHWN will be integrally involved in further network expansion efforts, and the LHWN network of providers will actually be listed in the provider directories as a block of lesbian-competent providers.
- The Pride Institute, founded in Minneapolis, Minnesota, began as a residential treatment facility for gay men and lesbians. Today, the Pride Institute manages mental health and addiction programs for LGBT individuals in several cities, including Fort Lauderdale, Chicago, Minneapolis, and New York, and in the Dallas area. Admission to Pride Institute programs is offered through a nationally advertised toll-free number. It is one of the only programs for LGBT individuals with a long-term residential treatment component; these components are based in Minnesota and Fort Lauderdale.
- ALTERNATIVES, founded in 1998, offers a dual diagnosis program for LGBT communities in Los Angeles and, now, in the

San Francisco Bay area. Similar to the Pride Institute, ALTERNATIVES contracts with hospitals to manage and staff separate inpatient units for gay men and lesbians.

LGBT Provider Networks

With the advent of managed care panels, individual providers (e.g., physicians, nurse assistants, social workers, and psychologists) may join those panels to satisfy contractual specifications negotiated with private or public purchasers. In addition, many MCOs allow practicing groups to join. Thus, different specialty networks have formed, which then collectively apply to the different MCOs in the area for enrollment in the MCO panels. Some providers affiliated with LGBT clinics have created networks that provide either MCOs or managed care panels with a cadre of providers with expertise in the treatment needs of LGBT individuals.

A variety of LGBT provider networks have formed throughout the United States. The networks are at varying levels of sophistication in developing relationships with MCOs. Examples of these provider networks are noted below.

- The Gay, Lesbian, Bisexual, Transgender Psychotherapist Association of the Greater San Francisco Bay Area is a nonprofit group of more than 175 LGBT psychotherapists covering the Bay area in California. GAYLESTA, as it is called, has developed a referral service, educational programs, peer consultation groups, a speakers' bureau, a newsletter, and a precicensed psychotherapist committee. GAYLESTA has also prepared a referral directory that is available to the public.

- The Lesbian Health and Wellness Network is a 150-member provider network based in Washington, D.C., but with members in some States. In addition to the creation of a provider manual and a referral system, this network is actively involved in providing LGBT-competency training for mainstream providers.
- The Los Angeles Lambda Medical Group is a medical center connected to the L.A. Gay & Lesbian Community Center that provides primary and preventive health care by physicians who specialize in the health care needs of lesbians and gay men.
- The Lambda Center and Therapist Network is an LGBT-specific continuum of inpatient and outpatient mental health and addictions services in Washington, D.C., that was begun by the Whitman-Walker Clinic and The Psychiatric Institute of Washington (a psychiatric hospital). The formation of a far-reaching provider network in the Baltimore-Washington area has recently been formalized.
- Fenway Behavioral Health Services in Boston is a program for gay men diagnosed with mental health and addiction problems, based in the Fenway Gay/Lesbian Community Center. Referrals are made to a network of therapists.

Substance abuse treatment programs have many potential allies. Identifying and working with these allies is extremely important, particularly in building community support for LGBT services and in successfully navigating the managed care environment.

Case Example

The Lesbian, Gay, Bisexual, and Transgender Health Access Project, a collaborative community-based program funded by the Massachusetts Department of Public Health, Boston, Massachusetts, has developed Community Standards of Practice for Provision of Quality Health Care Services for LGBT clients. The project's mission is to foster development and implementation of comprehensive, culturally appropriate, quality health promotion policies and health care services for lesbian, gay, bisexual, and transgender people and their families.

Working closely with consumers and clinicians across Massachusetts, the LGBT Health Access Project works to confront the insensitivity and ignorance that many LGBT individuals have experienced in accessing health care and related services. Additionally, the project works to support LGBT individuals in understanding and acquiring the quality care they need. The Community Standards of Practice is the outcome of this work and was developed to provide a benchmark for both providers and consumers in the development of and search for welcoming, culturally competent, and responsive care.

The Community Standards of Practice and quality indicators are meant to guide and assist providers in achieving a set of goals that include:

- The elimination of discrimination on the basis of sexual orientation and gender identity
- The promotion and provision of full and equal access to services
- The elimination of stigmatization of LGBT people and their families
- The creation of health service environments where it is safe for people to be "out" to their providers.

The standards address both agency administrative practices and service delivery components, including the following areas:

- Personnel
- Client's rights
- Intake and assessment
- Service planning and delivery
- Confidentiality
- Community outreach and health promotion.

There are 14 standards in all, accompanied by appropriate indicators for each standard. (The standards can be accessed via the Internet at <http://www.glbthealth.org>.)

Advocates for LGBT-Specific Health Care Services

Gay and Lesbian Association of Retiring Persons
Gay and Lesbian Medical Association (GLMA)
Gay, Lesbian, Bisexual Employees of the Federal Government
Human Rights Campaign
National Association of Lesbian & Gay Addiction Professionals (NALGAP)
National Lesbian & Gay Nurses Association
Parents, Families and Friends of Lesbians and Gays

Chapter 18 Recommendations

This chapter provides recommendations for:

- Additional research needs
- Clinicians on improving treatment for LGBT clients
- Improving training about LGBT issues
- Administrators on improving treatment for the LGBT community
- Managed care, program planning, and quality assurance

Introduction

Lesbian, gay, bisexual, and transgender (LGBT) individuals are entitled to services provided in a safe and appropriate environment and should not be denied services based on their sexual orientation. The treatment provided should be sensitive to and supportive of the unique needs of the client. Therefore, substance abuse treatment providers, counselors, therapists, administrators, and facility directors need to become aware of the issues facing LGBT clients. With this knowledge, they can design quality treatment programs that provide effective, ethical, and informed care for LGBT clients. This improvement in care will improve outcomes for LGBT clients, and treatment providers will reach a previously underserved population.

Recommendations for Research

LGBT populations abuse substances at rates that are the same as or higher than the rates in the general population, but more information is needed in this area. Future studies should create a clearer distinction between substance use and substance abuse, employ more vigorous sampling methodology, establish prevalence and incidence rates for the specific substances of abuse, and identify the effects that age, sexual identity, discrimination, and heterosexism have on substance use and abuse among LGBT individuals. In addition, substance abuse among lesbians, bisexual

women, and transgender individuals should be further studied and substance abuse among them distinguished from substance abuse among gay and bisexual men.

Innovative LGBT-specific intervention and treatment approaches are needed and should be researched and developed. Health care providers and delivery systems should develop new models of intervention and treatment targeted especially to LGBT individuals. Researchers, government agencies, and community-based organizations should work together to create innovative outreach efforts, prevention campaigns, and standards of treatment for LGBT individuals.

LGBT-identified researchers, scientists, and consumers should be included in public health policy formulation and resource decision matters related to substance abuse prevention and treatment.

Recommendations for Clinicians

To provide quality care for LGBT clients, treatment providers need to learn about sexual orientation and gender identity and how these are determined. Counselors need to know more about how LGBT individuals learn to acknowledge and accept their sexual orientation, about the stages of coming out, and about how to meet the needs of clients, regardless of sexual orientation. Counselors can help LGBT clients recover from substance abuse and addiction by being empathic, supportive, and nonjudgmental and assisting clients to:

- Integrate their sexual identity
- Become more self-accepting
- Heal from shame resulting from heterosexism, internalized homophobia, and substance abuse.

The counselor should help the recovering LGBT individual connect with a community that

will help him or her heal, such as 12-step or other self-help groups, other LGBT individuals in recovery, and the client's own family of choice. The counselors should learn to provide sensitive support for LGBT clients' families and partners.

Counselors should remember that LGBT clients may have additional health concerns such as co-occurring mental illnesses, HIV/AIDS, STDs, liver disease, hormone-related issues, and hepatitis B or C. Counselors should screen for other health problems and for domestic violence. Any assessment should be framed with sensitivity.

Counselors must confront their own negative or ambivalent feelings about homosexuality and learn to provide quality care that is sensitive, supportive, and comprehensive.

It is a challenging task to provide services that are appropriate, accessible, cost-effective, and quality driven. The following section includes selected recommendations for achieving this goal.

- Counselors and treatment providers need to reexamine their treatment approaches and take steps to move them to LGBT-sensitive and supportive modalities.
- Internalized homophobia, anti-LGBT bias, and heterosexism may contribute to the use of alcohol and drugs by LGBT individuals. Providers should learn the effects of these negative biases on the LGBT individual and community and how to help LGBT clients affirm themselves and address negative feelings. A better understanding is needed of the interplay between sexual orientation and the sociocultural context in relation to substance use, abuse, and treatment.
- Treatment providers should learn about substance abuse in the LGBT community. Substance use, especially alcohol, is often an integral part of the LGBT social life and

is connected to sexual identity formation, coming out, and self-acceptance processes for many LGBT persons.

- Treatment providers should work at the individual client’s comfort level related to his or her sexual orientation issues and consider how the client’s feelings about his or her sexual orientation affect the client’s recovery.
- All staff and clients should not assume that stereotypes and myths about LGBT individuals are true. Each LGBT individual is unique.

Recommendations for Training

A limited number of facilities offer LGBT-sensitive treatment. The training of professional and support staff to serve LGBT individuals in their own communities is critical for improving treatment and treatment outcomes.

Considerations for improving training to enhance treatment for the LGBT community follow.

- Provide training to staff members in cultural diversity and sexual orientation sensitivity to promote better understanding of LGBT populations. Education topics should be diverse and applicable to all LGBT populations and include topics of sexual orientation, sexual identity, gender, and sexual behaviors.
- Use LGBT-specific training and educational programs to ensure that quality care is provided. Educators and trainers with expertise in LGBT issues should develop training programs, manuals, books, videos, films, CD-ROMS, and other interactive training technology focused on LGBT treatment that can be widely disseminated.
- Provide sensitivity training when LGBT clients and heterosexual clients attend the same group therapy sessions. Counselors should protect LGBT clients from homophobic behavior. LGBT clients should not be forced to discuss sexual orientation or

behaviors if they are not comfortable doing so. If the facility provides LGBT-only groups, attendance should be voluntary and confidentiality should be respected.

- Assess staff comfort, experience, and competence in serving LGBT individuals before developing a training program, during training, and after providing training.

Recommendations for Administrators

Managed Care

Managed care and other health care provider networks should strive to improve their LGBT sensitivity.

- Managed care organizations’ (MCOs’) panels of providers should include LGBT providers and LGBT-sensitive providers.
- LGBT medical and professional organizations should request that MCOs include LGBT providers and an LGBT category as a recognized subgroup of the health insurance plan.
- Managed behavioral health care organizations should be able to inform case workers of subcategories of providers; for example, a caseworker should have enough information to be able to refer a client to substance abuse treatment services that are identified as LGBT sensitive.
- LGBT programs should join other networks to ensure culturally competent services.
- Service purchasers such as MCOs, health maintenance organizations, and employee assistance programs should identify and use resources for providing culturally competent substance abuse treatment services to LGBT clients.

Program Planning

- Program administrators, counselor training program directors, and substance abuse treatment educators should encourage planning for and implementation of training programs to serve substance-abusing LGBT clients.
- Once an LGBT-sensitive program is established, providers should develop programs for drugs such as cocaine, crack, methamphetamine, and other addictive drugs that are challenging to treat.

Quality Assurance

To ensure high-quality treatment:

- Providers should evaluate their programs. They should collect appropriate demographic data to establish baseline information about LGBT clients. They should design and implement appropriate client satisfaction measures that provide specific feedback about how well the organization is serving LGBT clients.
- Community services personnel, professional associations, and others engaged in training mental health and social work professionals and support staff should review and revise their existing policies to reflect LGBT needs.
- Service providers should review policies and procedures to improve sensitivity toward and effectiveness in serving LGBT clients.

- Providers should develop better LGBT-specific outcome data. They should compare the numbers of clients served, overall satisfaction results, and treatment outcomes among identified LGBT clients with data pertaining to the general treatment population.
- Providers should consult with persons with expertise in LGBT issues, such as clients, staff, advocacy groups, or organizations, to provide assistance in developing an LGBT program that is sensitive, supportive, and effective.
- Providers should promote application of standards by accrediting bodies such as the Joint Commission on Accreditation of Healthcare Organizations, the National Committee for Quality Assurance, and the Commission for the Accreditation of Rehabilitation Facilities to specifically acknowledge and address the needs of LGBT individuals and provide appropriate education for surveyors from these bodies. Treatment accreditation bodies should mandate demonstrated proficiency in LGBT health and safety issues.

It is hoped that this volume will assist administrators and clinicians in forming a better understanding of LGBT people, their problems with substance abuse, and the unique challenges they face and that the knowledge gained about designing programs for LGBT clients will be used to create a more comfortable environment for LGBT clients.