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

Lesbian, gay, bisexual, and transgender (LGBT) individuals with substance abuse problems are doubly stigmatized. As substance abusers, they are viewed by many as weak in character and moral fiber. As lesbian, gay, bisexual, and transgender individuals, they are reviled by some as deviant and immoral. They may encounter bigotry from employers, human service workers, criminal justice officials, the general public, and even their own families.

Two Federal (and a number of State) statutes protect recovering substance abusers from many forms of discrimination. However, in most areas of the country, LGBT individuals have no legal protection against discrimination in employment, housing, or access to social services. Protections fought for and won by women, racial minorities, and individuals with disabilities simply are not available for LGBT persons. Disclosure of sexual orientation can lead to an individual’s being fired or being denied access to housing and social services—all with legal impunity. LGBT individuals may even lose custody of their children if their sexual orientation becomes known during a custody dispute.

Even in those States that have enacted statutes prohibiting discrimination on the basis of sexual orientation, LGBT individuals have sometimes been denied protection. Little wonder that LGBT individuals regard protecting information about their sexual orientation and substance abuse histories as
Legal Issues for Programs Treating LGBT Clients

Critically important. Programs that treat this special population need to be particularly sensitive about maintaining clients’ confidentiality, for the consequences of an inappropriate disclosure can be far reaching. (For a compendium of the law regarding discrimination against LGBT individuals, see www.lambdalegal.org.)

This chapter examines ways programs can safeguard information about clients’ substance abuse histories, sexual orientation, and HIV status. It then describes how the lack of legal protection against discrimination can affect LGBT individuals in a variety of areas and how programs can help these clients protect themselves. Finally, the chapter outlines the laws protecting clients with histories of substance abuse and/or HIV/AIDS from discrimination.

Protecting the Confidentiality of LGBT Individuals in Substance Abuse Treatment Programs

Confidentiality Requirements

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

The Federal law and regulations severely restrict communications about identifiable clients by “programs” specializing, in whole or in part, in providing treatment, counseling, and/or assessment and referral services for substance abuse problems (42 CFR §2.11). Although the Federal regulations apply only to programs that receive Federal assistance, this includes indirect forms of Federal aid, such as tax-exempt status or State or local government funding coming (in whole or in part) from the Federal Government.

The regulations for communications are more restrictive in many instances than, for example, either doctor-patient or attorney-client privilege. They protect any information about an individual who has applied for or received any substance abuse-related assessment, treatment, or referral services from a program. They apply from the time the individual makes an appointment and apply to former clients as well. They apply to any information that would identify the individual either directly or by implication as a substance abuser. They apply whether or not the person seeking information already has that information, has other ways of getting it, has some form of official status, is authorized by State law, or comes armed with a subpoena or search warrant. Violating the regulations is punishable by a fine of up to $500 for a first offense and up to $5,000 for each subsequent offense (§2.4).

Programs can find detailed information about compliance with the regulations in Technical Assistance Publication 13 Confidentiality of Patient Records for Alcohol and Other Drug Treatment (CSAT [Center for Substance Abuse Treatment], 1999a), available from the Substance Abuse and Mental Health Services Administration’s (SAMHSA’s) National Clearinghouse for Alcohol and Drug Information (NCADI) at 800–729–6686. What follows is a brief description of some of the regulations’ major provisions.

When May Confidential Information Be Shared With Others?

The confidentiality regulations permit disclosure without the client’s consent in several situations, including medical emergencies, reporting child abuse, and communications among program staff. (For a full discussion of these exceptions, see CSAT, 1999a.)
Consent: Rules About Obtaining Consent To Disclose Treatment Information

The most frequently used exception to the regulations’ general rule prohibiting disclosure is client consent. (Parental consent must also be obtained in some States. See below.) The regulations’ requirements regarding consent are strict and somewhat unusual and must be carefully followed.

Most disclosures are permissible if a client has signed a valid consent form that has not expired or been revoked (§2.31). To be valid, a consent form must be in writing and must contain each of the items specified in §2.31:

1. The name or general description of the program(s) making the disclosure
2. The name or title of the individual or organization that will receive the disclosure
3. The name of the client who is the subject of the disclosure
4. The purpose or need for the disclosure
5. How much and what kind of information will be disclosed
6. A statement that the client may revoke (take back) the consent at any time, except to the extent that the program has already acted on it
7. The date, event, or condition upon which the consent will expire if not previously revoked
8. The signature of the client (and, in some States, his or her parent)
9. The date on which the consent is signed (§2.31(a)).

A general medical release form, or any consent form that does not contain all of the elements listed above, is not acceptable. (See the sample consent form in exhibit 3–1.)

A number of items on this list deserve further explanation and are discussed under the bullets below.

• The purpose of the disclosure and how much and what kind of information will be disclosed

These two items are closely related. All disclosures must be limited to information that is necessary to accomplish the need or purpose for the disclosure, and this purpose or need must be specified on the consent form. It would be improper to disclose everything in a client’s file if the recipient of the information needs only one specific piece of information.

Once the purpose or need has been identified, it is easier to determine how much and what kind of information will be disclosed, tailoring it to what is essential to accomplish the specified need or purpose. That, too, must be written into the consent form.

As an illustration, if a client needs to have his or her participation in counseling verified in order to be excused from school early, the purpose of the disclosure would be “to verify treatment so that the school will permit early release,” and the amount and kind of information to be disclosed would be “times and dates of appointments.” The disclosure would then be limited to a statement saying, “Susan Taylor (the client) is receiving counseling at XYZ Program on Tuesday afternoons at 3 p.m.”

• The client’s right to revoke consent

The client may revoke consent at any time, and the consent form must include a statement to this effect. Revocation need not be in writing. If a program has already made a disclosure prior to the revocation, acting in reliance on the client’s signed consent, it is not required to try
Exhibit 3–1:
Consent for the Release of Confidential Information

I, __________________________________________________________________, authorize
(Name of client)

_______________________________________________________________________________
(Name or general designation of program making disclosure)

to disclose to ____________________________________________________________________
(Name of person or organization to which disclosure is to be made)

the following information:___________________________________________________________
(Nature of the information, as limited as possible)

_______________________________________________________________________________
_______________________________________________________________________________

☐ I understand that the program will NOT be disclosing information about my sexual orientation.
☐ I understand that the program will be disclosing information about my sexual orientation.

____________________________
(Client’s initials)

The purpose of the disclosure authorized herein is to: ____________________________________

_______________________________________________________________________________
(Purpose of disclosure, as specific as possible)

_______________________________________________________________________________

I understand that my records are protected under Federal regulations and cannot be disclosed without my
written consent unless otherwise provided for in the regulations. I also understand that I may revoke this
consent at any time except to the extent that action has been taken in reliance on it, and that in any event
this consent expires automatically as follows:

_______________________________________________________________________________
(Specification of the date, event, or condition upon which this consent expires)

____________________________/________________________
(Signature of client) (Date)

_______________________________________________________________________________
(Signature of parent, guardian, or authorized representative when required)
to retrieve the information it has already disclosed.

The regulations also provide that “acting in reliance” includes the provision of services while relying on a consent form permitting disclosures to a third-party payer. (Third-party payers are health insurance companies, Medicaid, or any party other than the adolescent’s family that pays the bills.) Thus, a program can bill the third-party payer for services provided before the consent was revoked. However, a program that continues to provide services after a client has revoked a consent authorizing disclosure to a third-party payer does so at its own financial risk.

- **Expiration of consent form**

  The form must also contain a date, event, or condition on which it will expire if not previously revoked. A consent must last “no longer than reasonably necessary to serve the purpose for which it is given” (§2.31(a)(9)). Depending upon the purpose of the consented disclosure, the consent form may expire in 5 days, in 6 months, or in a longer period.

  The consent form does not have to contain a specific expiration date but may instead specify an event or condition. For example, if an adolescent has been placed on probation at school on the condition that she attend counseling at the program, the consent form can be drafted to expire at the completion of the probationary period. Or, if a client is being referred to a podiatrist for a single appointment, the consent form should stipulate that consent will expire after he or she has seen “Dr. X.” (See below for further discussion about making referrals.)

- **The signature of the client (and the issue of parental consent)**

  A minor must always sign the consent form in order for a program to release information even to his or her parent or guardian. The program must get the signature of a parent, guardian, or other person legally responsible for the minor in addition to the minor’s signature only if the program is required by State law to obtain parental permission before providing treatment to a minor (§2.14).

  In other words, if State law does not require the program to get parental consent in order to provide services to a minor, then parental consent is not required to make disclosures (§2.14(b)). If State law requires parental consent to provide services to a minor, then parental consent is required to make any disclosures.

  Note that the program must always obtain the minor’s consent for disclosures and cannot rely on the parent’s signature alone. (For a full discussion of this issue and what programs can do when minors applying for treatment refuse to consent to parental notification in those States requiring parental consent to treatment, see “Legal and Ethical Issues,” in Treatment Improvement Protocol 32 Treatment of Adolescents With Substance Use Disorders (CSAT, 1999c).

  Where LGBT minors are concerned, the issue of parental consent can be a particularly delicate matter. Minors in States requiring parental consent for treatment can specify on the written consent form that their sexual orientation will not be disclosed to parents (see exhibit 3–1).

- **Required notice against redisclosing information**

  Once the consent form has been properly completed, there remains one last formal requirement. Any disclosure made with patient consent must be accompanied by a written statement that the information is protected by Federal law and that the recipient cannot further disclose or release such information unless permitted by the regulations (§2.32).
This statement, not the consent form itself, should be delivered and explained to the recipient of the information at the time of disclosure or earlier. (Of course, a client may sign a consent form authorizing a redisclosure.)

**Using Consent Forms**

The fact that a client has signed a valid consent form authorizing the release of information does not mean that a program must make the proposed disclosure, unless the program has also received a subpoena or court order (§§2.3(b)(1); 2.61(a)(b)). In most cases, the decision whether to make a disclosure authorized by a client’s signed consent is up to the program, unless State law requires or prohibits a particular disclosure once consent is given. The program’s only obligation under the Federal regulations is to refuse to honor a consent that is expired, deficient, or otherwise known to be revoked, false, or incorrect (§2.31(c)).

In general, it is best to follow this rule: Disclose only what is necessary, for only as long as is necessary, keeping in mind the purpose for disclosing the information.

- **Using consent forms to seek information from collateral sources**

Making inquiries of families, partners, schools, employers, doctors, and other health care providers might, at first glance, seem to pose no risk to a client’s right to confidentiality. But it does.

When a program that offers assessment and treatment for substance abuse asks a family member (including a parent), partner, employer, school, or doctor to verify information it has obtained from the client, it is making a disclosure that the client has sought help for substance abuse. The Federal regulations generally prohibit this kind of disclosure unless the client consents.

How then is a program to proceed? The easiest way is to get the client’s consent to contact the family member (including a parent), partner, employer, school, health care facility, etc. In fact, the program can ask the client to sign a consent form that permits the very limited disclosure that he or she has sought assessment or treatment services in order to gather information from any one of a number of entities or persons listed on the consent form. Note that this combination form must still include “the name or title of the individual or name of the organization” for each collateral source the program may contact. If program staff are making inquiries by telephone, they must inform the parties at the other end of the line orally and then by mail about the prohibition on redisclosure.

Of course, the program should never disclose information about the client’s sexual orientation to a collateral source, unless the client specifically consents to disclosure to that particular person or agency. The consent form provided in exhibit 3–1 allows the client to choose whether to consent to disclosure of this information.

- **Using consent forms to make periodic reports or coordinate care**

Programs serving LGBT individuals may need to confer on an ongoing basis with other agencies, such as mental health or child welfare programs. Again, the best way to proceed is to get the client’s consent (as well as parental consent when State law requires). Take care in wording the consent form to specify the purpose of the communication and the kind and amount of information to be disclosed. For example, if the program needs ongoing communications with a mental health provider, the “purpose of the disclosure” would be “coordination of care for Simon Green” and “how much and what kind of information will be disclosed” might be “treatment status, treatment issues, and progress in treatment.”
If the program is treating a client who is on probation at work and whose continued employment is contingent on completing treatment, the “purpose of disclosure” might be “to assist the patient to comply with the employer’s mandates” or to “supply periodic reports about attendance,” and “how much and what kind of information will be disclosed” might be “attendance” or “progress in treatment.”

Note that the kinds of information that will be disclosed in these two examples are quite different. The program might well share detailed clinical information about a client with a mental health provider if that would help in coordinating care. Disclosure to an employer should be limited to a brief statement about the client’s attendance or progress in treatment. Disclosure of detailed clinical information to an employer would, in most circumstances, be inappropriate.

The program should also give considerable thought to the expiration date or event the consent form should contain. For coordinating care with a mental health program, it might be appropriate to have the consent form expire when treatment by either agency ends. A consent form permitting disclosures to an employer might expire when the client’s probationary period ends.

Programs should exercise great care about sharing information about clients’ sexual orientation. Disclosure of such information might be therapeutically important when a substance abuse program is coordinating a client’s care with a mental health provider. It would not be appropriate to disclose this information to a client’s employer. Programs should get clients’ consent in writing before making any disclosures about sexual orientation.

- **Using consent forms to make referrals**

Programs treating LGBT individuals may need to refer clients to other health care or social service agencies. The program can, of course, give the client the name and telephone number of an outside gynecologist, psychologist, or training program and allow him or her to initiate the call. However, if a staff member at the program makes the call to set up an appointment, he or she must keep in mind that such a call may result in disclosure that the client has a substance abuse problem. If the staff member identifies the client as attending a substance abuse treatment program, directly or by implication, the referral requires the client’s consent in writing (as well as parental consent in States requiring it).

Unless the client has consented, the program should not disclose the client’s sexual orientation when making a referral.

**HIV and Confidentiality**

Almost all States now have laws protecting information about individuals’ HIV status. The laws vary widely in the strength of the protection they offer. All allow for disclosure of HIV-related information in certain circumstances. Administrators should educate themselves about the HIV confidentiality protections offered by their individual States.

**Discrimination Against LGBT Individuals**

In much of the United States, discrimination against individuals because of their sexual orientation is legal. Although some States have extended their laws against racial and gender discrimination to cover discrimination on the basis of sexual orientation, in most places LGBT individuals can be denied employment or fired, barred from housing, and excluded from health and social services.

LGBT individuals are disadvantaged legally in other areas as well. In most States, same-sex couples in a committed relationship are prohibited from marrying. This means that same-sex partners must make special
arrangements if they wish to bequeath their assets to each other after death. Few jurisdictions provide unmarried partners of employees the health insurance benefits married partners take for granted; even fewer require private employers to offer unmarried partners these benefits. Partners may have difficulty visiting their loved ones in hospitals that have “family only” policies. LGBT individuals are often denied the right to adopt children.

Because of the lack of protection under the law, LGBT individuals may suffer severe or painful consequences if their sexual orientation becomes known. They risk losing custody of their own children in disputes with former spouses or families of origin because of their sexual orientation. (A diagnosis of substance abuse can be yet another strike against them in such cases.) In addition, LGBT individuals can be discharged from the military if their sexual orientation becomes known.

Thus far, only one State has enacted legislation that recognizes what it terms “civil union” between two individuals of the same sex. The statute was passed in response to a decision of the Supreme Court of Vermont (Baker v. State of Vermont) finding that the State’s denial of marriage licenses to same-sex couples “effectively excludes them from a broad array of legal benefits and protections incident to the marital relation, including access to a spouse’s medical, life, and disability insurance, hospital visitation and other medical decisionmaking privileges, spousal support, intestate succession, homestead protections, and many other statutory protections.” The court held that “the State is constitutionally required to extend to same-sex couples the common benefits and protections that flow from marriage under Vermont law.”

The Vermont Supreme Court did not order the State to offer marriage licenses to same-sex couples. Rather it required the State legislature to “craft an appropriate means of addressing this constitutional mandate [through any one] potentially constitutional statutory scheme from other jurisdictions [that provide] an alternative legal status to marriage for same-sex couples, impose similar formal requirements and limitations, create a parallel licensing or registration scheme, and extend all or most of the same rights and obligations provided by the law to married partners.” Ultimately, the State legislature chose to enact a “civil union” (cu) statute, and same-sex couples in Vermont have already been “cu’ed.” (It remains unclear whether other States will recognize such unions between individuals who travel to Vermont for the purpose of being cu’ed.)

The Vermont Supreme Court based its decision squarely on the common benefits clause of the Vermont constitution, a provision it interpreted as offering stronger protection to Vermont citizens than the Federal equal protection clause. The advantage of the court’s resting its decision on the Vermont constitution is that the U.S. Supreme Court cannot review or overturn the decision. The disadvantage is that other States lacking a similar clause are less likely to adopt the court’s reasoning.

For up-to-date information on the laws regarding discrimination against LGBT individuals, see www.lambdalegal.org.

What Can Be Done To Help LGBT Clients?

There are a number of ways that programs can adjust their policies and procedures to protect clients, educate them, and help them deal with the discrimination they may face.

1. Confidentiality

Programs should establish written policies that ensure that information about sexual orientation is confidential. The policy should prohibit disclosure of such information to anyone outside the program, unless the client
consents. Any exceptions to this rule should be approved in advance by the program director.

2. Caution on Self-Disclosures

As part of the recovery process, substance abuse treatment programs often encourage clients to acknowledge to others that they have abused alcohol and drugs. Of course, disclosure of this information is not always advisable. While there are laws protecting alcoholics and former drug abusers from discrimination in employment, housing, and access to health care (see below), it is not always easy to enforce those legal protections. Clients should be advised to think carefully before disclosing information about their substance abuse histories.

LGBT clients should also be cautioned to think carefully before disclosing their sexual orientation to others. Such disclosures will rarely be advisable unless clients are fairly sure how the information will be received. Because LGBT clients often have no legal protection against discrimination on the basis of sexual orientation, they should continue to share this information only with those they are confident will respect them and their privacy.

3. Education

Programs should educate staff and clients about State and local laws and regulations regarding LGBT persons. Some jurisdictions have enacted statutes protecting LGBT individuals from some forms of discrimination. Other jurisdictions have enacted statutes designed to make life more difficult for LGBT individuals. The confidentiality afforded HIV-related information also varies from place to place. Programs should use the resources listed at the end of this chapter to educate themselves and their clients about LGBT legal issues. The Web site maintained by the Lambda Legal Defense and Education Fund is particularly informative.

4. Legal Inventory

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

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

The program should encourage Barbara to share information about her sexual orientation and substance abuse treatment with her attorney. Depending on Barbara’s relationships with her spouse and the children’s grandparents, her attorney may advise her to consider seeking a negotiated custody agreement. Information about her sexual orientation (and substance abuse history) is less likely to be used against Barbara in this context than during a heated court battle.

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

The program can help Harry explore the options available to him, which may include (depending upon State law) signing “advance directives” about his health care and/or signing a legal document appointing Stephen his proxy, enabling him to make health care decisions should Harry become incapacitated. This legal document is often called a “health care proxy” or a “medical power of attorney.”
Example 3: Ellen W. and Jean C. have grown old together. Ellen has a considerable fortune she inherited from her father; Jean has few assets. Ellen wants to make sure Jean will inherit her property.

State law generally controls rules of inheritance. However, in most (although not all) instances these rules can be overridden once an individual makes a will naming a beneficiary or establishes a trust for the benefit of a named individual. In this respect, LGBT individuals are no different from heterosexuals who are unmarried and have only distant blood relatives. They, too, must make a formal will or set up a trust if they do not want a third cousin to inherit their assets.

5. Respect for LGBT Clients

Programs treating LGBT individuals should take steps to ensure that staff and other clients respect the privacy, safety, and humanity of this population.

- Programs should screen staff members to ensure that they are willing to work with LGBT individuals. Written descriptions of job responsibilities should include treatment of LGBT individuals.

- Program rules should require that clients exhibit respect for one another without regard to race, gender, religion, national origin, or sexual orientation. Programs should establish grievance procedures for clients who want to complain about violation of the rules. All complaints should be handled promptly.

- Programs should treat the partners of LGBT clients as they do members of traditional families. Many LGBT clients are alienated from their families of origin and will not want them to visit. However, visits by a partner may be welcomed.


6. Program Safety for LGBT Individuals

All clients should be informed at admission that the program will not tolerate sexual harassment or sexual overtures between persons of the same or different gender. Programs should establish effective grievance procedures and respond to any violations of the rules promptly.

Written personnel policies should include prohibition of harassment in the workplace, including harassment of LGBT staff by other staff and sexual harassment between persons of the same (or different) gender. Programs should establish effective disciplinary procedures and respond to complaints promptly.

Programs treating minors should be particularly attentive to this issue, as an incident involving a minor can result in serious legal consequences. The minor’s parents may sue a program that is negligent in this area, and child protective services may intervene if there is an allegation of abuse.

7. Affirmative Action/Cultural Competency

Providing effective treatment for LGBT individuals requires programs to make every effort to employ LGBT individuals in visible jobs. Personnel policies should include a nondiscrimination hiring clause that encompasses LGBT persons (see chapter 14, Policies and Procedures), and programs should offer domestic partner benefits whenever possible.
Do LGBT Individuals in Substance Abuse Treatment Have Any Legal Protections?

Yes, in areas unrelated to sexual orientation, they do. The Federal Rehabilitation Act (29 U.S.C. §791 et seq. (1973)) and the Americans with Disabilities Act (ADA) (42 U.S.C. §12101 et seq. (1992)) prohibit discrimination against individuals with “disabilities,” a group defined as including individuals who are alcoholics or have a history of drug abuse. Together, these laws prohibit discrimination based on alcoholism or a history of drug abuse in the services, programs, or activities provided by:

- State and local governments and their departments, agencies, and other instrumentalities (29 U.S.C. §794(b) and 42 U.S.C. §§12131(1) and 12132)
- Most providers of “public accommodations,” including hotels and other places of lodging, restaurants and other establishments serving food or drink, places of entertainment (movies, stadiums, etc.), places the public gathers (auditoriums, etc.), sales and other retail establishments, service establishments (banks, beauty shops, funeral parlors, law offices, hospitals, laundries, etc.), public transportation depots, places of public display or collection (museums, libraries, etc.), places of recreation (parks, zoos, etc.), educational establishments, social service centers (day care or senior citizen centers, homeless shelters and food banks, etc.), and places of exercise and recreation (42 U.S.C. §§12181(7) and 12182).

The Rehabilitation Act and ADA (Rehabilitation Act and key implementing regulations: 29 U.S.C. §793 and 29 CFR Part 1630; §794(a), (b)(1), (b)(3)(A) and 45 CFR Part 84; Americans with Disabilities Act and key implementing regulations: 42 U.S.C. §§12111(2) and (5) and 12112 and 28 CFR Part 35, Subpart C, and 29 CFR Part 1630) also provide protection against discrimination by a wide range of employers, including:

- Employers with Federal contracts worth more than $10,000
- Employers with 15 or more employees
- Federal, State, and local governments and agencies
- Corporations and other private organizations and individuals receiving Federal financial assistance
- Corporations and other private organizations and individuals providing education, health care, housing, or social services and parks and recreation sites
- Labor organizations and employment committees.

The Rehabilitation Act and ADA also classify individuals with HIV/AIDS as individuals with disabilities and prohibit employers, government agencies, and places of public accommodation from discriminating against them on the basis of seropositivity. Because gay men, other men who have sex with men, and injection drug users constitute the largest portion of persons diagnosed with AIDS in the United States, this protection is important. For a detailed discussion of the scope of protection offered and how these statutes have been applied in cases of individuals with HIV/AIDS, see Treatment Improvement Protocol 37 Substance Abuse Treatment for Persons With HIV/AIDS (CSAT, 2000), available from SAMHSA's NCADI at 800–729–6686. Many States also have laws protecting people with HIV/AIDS from discrimination. Local HIV/AIDS and gay and lesbian advocacy groups and resource centers are often able to provide information and advice about both Federal and State laws in this area.
These laws can be helpful to LGBT clients and the programs treating them. If a program refers a client to a vocational rehabilitation training program or a dentist and he or she is rejected because of a history of drug abuse or HIV positivity, there is legal recourse. Programs should also be aware that they, too, are most likely covered by these laws; for example, they may not discriminate against clients with HIV/AIDS or against job applicants or employees with HIV/AIDS or histories of substance abuse.

(Note that ADA specifically excludes “transvestism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairments, and other sexual behavior disorders” from the definition of “disability.” Psychoactive substance use disorders resulting from current illegal use of drugs are also excluded.)

Case History #1

Bill is a 41-year-old African-American man who has applied for admission to an inpatient alcohol treatment facility. Bill’s history of substance abuse goes back 20 years but includes several years of sobriety and active participation in Alcoholics Anonymous. He is in a committed relationship with Harold (36), his partner of 5 years. Bill’s wife died of a drug overdose 3 years ago, and he has custody of his two young children, Melissa (6) and Philip (4). The children live with Bill and Harold in their rented townhouse. Bill’s late wife’s parents have never accepted him and have always blamed Bill for their daughter’s drug problems.

Bill has been teaching seventh grade English for the past 10 years. Only a very few colleagues in the school system know about his sexual orientation and his relationship with Harold. Bill was referred to the treatment facility by the school district’s Employee Assistance Program (EAP); his employer-provided Health Maintenance Organization (HMO)-based health insurance will cover his treatment. He must satisfactorily complete treatment to retain his job. Bill has signed a form consenting to disclosures about his progress in treatment to the district’s EAP.

What legal issues does this case present?

1) Disclosures of treatment information to the district’s EAP: Bill should sign a consent form that complies with 42 CFR Part 2 so that the facility can release information to the district’s EAP about his progress in treatment. The consent form should be limited to disclosure of general assessments of Bill’s progress in treatment. Giving the EAP detailed treatment information would not be appropriate and should not be authorized by the consent form Bill signs. There should be no disclosure of any information about Bill’s sexual orientation or his living arrangements. Public school systems are generally reluctant to employ an openly LGBT person. Disclosure of this information could result in Bill’s losing his job (and his health insurance). Bill should sign a consent form that gives him the option of permitting or prohibiting disclosure of this information (see exhibit 3–1).
2) **Disclosures of treatment information to the district’s HMO**: The HMO will require information about Bill’s need for treatment in order to make a decision about covering that treatment. It will also demand that the facility update the information periodically. Bill must sign a consent form to permit the program to disclose information to the HMO. Disclosures to the HMO should be as limited as possible, but this may prove difficult. Many managed care organizations require programs to submit detailed information periodically before they will authorize continued treatment (or benefits). Bill has every reason to be concerned that his admission to treatment may trigger a flow of information that might, through school reviews of personnel or HMO records, result in his losing his job. The Federal rules prohibit HMOs from redisclosing information to the district, but there is no assurance that the HMO will refrain from doing so. Therefore, and although this can be difficult, there should be no disclosure of any information to the HMO about Bill’s sexual orientation or his living arrangements. Bill should sign a consent form that gives him the option of permitting or prohibiting disclosure of this information (see exhibit 3–1).

3) **Disclosure of information about Bill’s sexual orientation to his in-laws**: Disclosure could spark an attempt to challenge Bill’s custody of his children. In many States, the combination of Bill’s sexual orientation and his history of alcohol abuse could be used by relatives to try to wrest custody from him. If Bill’s in-laws do file a court case seeking custody and their attorney issues a subpoena for Bill’s treatment records, the program can, working with Bill’s attorney, ask the court to issue an order restricting the scope of the information the program will be required to provide. For detailed information on dealing with subpoenas and court orders, see Treatment Improvement Protocol 24 *A Guide to Substance Abuse Treatment for Primary Care Clinicians* (CSAT, 1997a), available from SAMHSA’s NCADI at 800–729–6686.

**What policy issue does this case present?**

**How will Harold be listed on the intake form: as “spouse” and/or next of kin?**

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

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**Case History #2**

Denise is a 16-year-old white female who entered an inpatient treatment program after being hospitalized twice: once for alcohol poisoning and once after a suicide attempt. Denise’s parents are working professionals with a comfortable income and large home in the suburbs. Denise has been living at home but does not get along with her two older sisters or her younger brother. She has been habitually truant.

Denise has confided in her counselor that for some time she has been having a hard time with her attraction to and feelings about other girls. Denise characterizes her parents as homophobic and is terrified about what might happen if they find out. Once, when her father found her watching an episode of the TV program “Ellen,” he screamed at her: “Why would you want to watch that disgusting smut? I will not have that stuff in my house!”

Denise has signed a consent form permitting her counselor to speak with her parents about her substance abuse treatment.

After Denise has been in the program for a month, a staff member discovers her acting out sexually with another girl.

Continued
What legal issues does this case present?

1) **Does the facility have to tell Denise’s parents about her sexual attraction to other girls?** No. Denise has consented to communications with her parents about her substance abuse treatment. Denise’s fears about her parents’ reaction may be entirely realistic. Disclosure of this information to Denise’s parents at this time would certainly destroy any therapeutic relationship developing between Denise and her counselor. Such disclosure may also be a violation of professional ethics.

Now that Denise’s counselor knows Denise’s concern, she could ask her to sign a new consent form that specifically requires the program to withhold information about her sexual orientation from her parents (see exhibit 3–1).

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

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

What policy issues does this case present?

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

2) **Preventive measures.** The program director should consider whether the program can take additional steps to ensure such incidents do not occur in the future.
Case History #3

Frankie is a 66-year-old retired postal worker who has been in and out of 12-step programs and outpatient treatment for 10 years. This will be his first inpatient treatment episode. Frankie came to the intake session with Janice, his female partner of 16 years. The couple lives together in a home they purchased 12 years ago. They are not legally married, but their friends and family consider them husband and wife. They have two grown children (one each from previous marriages) and five grandchildren. Frankie expects that Medicare will pay for his treatment. Janice works for the city and is covered by the city’s HMO plan.

After intake, Frankie is settled in a room with another male patient. On Frankie’s first night at the facility, a nurse observes that Frankie has female genitals. Frankie’s roommate demands that he be moved out of the room. The nurse has told her supervisor that she’s not going to work “with that ‘weirdo’ in Room 112.”

What legal issues does this case present?

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

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

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

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

What policy issues does this case present?

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

2) **Should the program move Frankie away from his objecting roommate?** Yes. No one should have to endure a hostile roommate. Moving Frankie avoids a difficult situation and helps with his treatment. With Frankie’s consent, the program should conduct a sensitivity session to educate clients about transgendered individuals as well as those who are lesbian, gay, or bisexual.
Recommendations

The following are some recommendations for improving substance abuse treatment for LGBT clients.

1. Improve knowledge among staff members about the laws affecting LGBT individuals with substance abuse histories. These include:
   a. Federal and State antidiscrimination laws protecting individuals with disabilities that apply to alcoholics and individuals with histories of drug abuse
   b. Federal and State antidiscrimination laws protecting individuals with disabilities that apply to individuals with HIV/AIDS
   c. Federal confidentiality laws and regulations
   d. State laws protecting HIV-related information
   e. State and local laws that apply to LGBT individuals.

2. Ensure that staff members respect LGBT clients by:
   a. Establishing written job descriptions that require treatment of all clients without regard to their sexual orientation
   b. Screening out job applicants who express overt bias
   c. Establishing clear, written program policies requiring equal treatment of clients without regard to their sexual orientation and enforcing program policy through a disciplinary process
   d. Providing staff members with training to increase their awareness of and sensitivity to LGBT issues
   e. Establishing a procedure for clients to complain about bias.

3. Ensure that clients respect LGBT individuals by:
   a. Establishing program rules requiring respect for clients without regard to their race, gender, religion, national origin, or sexual orientation
   b. Providing clients with education and information about LGBT individuals
   c. Establishing grievance procedures for clients wishing to lodge complaints
   d. Enforcing program rules promptly.

4. Ensure that LGBT staff and clients are safe while attending the program by:
   a. Establishing personnel policies prohibiting harassment in the workplace, including harassment of LGBT staff by other staff and sexual harassment by persons of the same or a different gender
   b. Informing clients at admission that the program does not tolerate sexual harassment or sexual overtures or activities by persons of the same or a different gender
   c. Enforcing the rules promptly
   d. Establishing grievance procedures for both staff and clients who may wish to complain about harassment and responding promptly to complaints.
5. Take all steps necessary to ensure the confidentiality of information about clients’ substance abuse treatment as well as their sexual orientation by:

a. Providing staff with training about the Federal confidentiality regulations

b. Establishing written policies about the confidentiality of information about sexual orientation and instructing staff about those policies

c. Educating clients about the importance of respecting the confidentiality of their fellow clients.

6. Establish personnel policies that attract and retain LGBT staff by:

a. Actively recruiting such individuals

b. Offering such individuals’ partners the same benefits offered married couples.

7. Educate LGBT clients about:

a. The confidentiality protections they enjoy (and those they lack)

b. The antidiscrimination laws that protect them, as well as the ways in which their rights are not protected

c. The steps they can take to protect themselves.

Resources

Confidentiality of Substance Abuse Treatment Records

Confidentiality of Patient Records for Alcohol and Other Drug Treatment. Technical Assistance Publication (TAP) 13 (CSAT, 1994b), 36 pp. BKD156.

This guide provides an overview of Federal alcohol and drug treatment confidentiality laws and regulations as well as options for dealing with a wide variety of situations. The appendix includes sample forms for patient consent and qualified service organization agreements. (Although the printed version of this publication is currently out of stock, it can be viewed and printed from PREVLINE, at www.health.org.)

Checklist for Monitoring Alcohol and Other Drug Confidentiality Compliance. TAP 18 (CSAT, 1996), 52 pp. PHD722X.

This TAP is a reference for the substance abuse treatment provider on maintaining and protecting patient confidentiality and records.


This report provides guidance for alcohol and drug treatment providers on resolving confidentiality issues that arise in the context of welfare reform.


This publication summarizes the legal issues that substance abuse treatment service and mental health providers address in organizing provider-sponsored managed care organizations (MCOs) and implementing managed care programs through contract negotiation and the delivery of services and care through provider contracts.

Legal Action Center

153 Waverly Place
New York, NY 10014
Ph: 800–223–4044
www.LAC.org
The Legal Action Center is the only law and policy organization in the United States that fights discrimination against people with histories of addiction, AIDS, or criminal records and advocates for sound public policies in these areas. The center provides:

- Legal services, including impact litigation
- Policy advocacy and research
- Training, technical assistance, and education.

**LGBT Rights**

*A Legal Guide for Lesbian and Gay Couples (10th Ed.)* (Curry et al., 1999).

This manual outlines the differences between legally married couples and same-sex partners.

Advocates for Youth  
1025 Vermont Avenue, NW, Suite 200  
Washington, DC 20005  
Ph: 202–347–5700, Fax: 202–347–2263  
www.advocatesforyouth.org

Advocates for Youth (formerly Center for Population Options) is dedicated to creating programs and promoting policies that help young people make informed and responsible decisions about their sexual and reproductive health. It provides information, training, and advocacy to youth-serving organizations, policymakers, and the national and international media. Advocates for Youth also sponsors the Youth Resource Web site at www.youthresource.com (for LGBT youth).

American Civil Liberties Union (ACLU)  
132 West 43rd Street  
New York, NY 10036  
Ph: 212–944–9800  
www.ACLU.org

The American Civil Liberties Union is a nonprofit, nonpartisan, 275,000-member public interest organization devoted exclusively to protecting the civil liberties of all Americans and extending those rights to groups that have traditionally been denied them. It files court cases to expand and enforce individuals' civil rights and educates legislatures and the public on a broad array of issues affecting individual freedom in the United States.

ACLU Lesbian and Gay Rights Project  
125 Broad Street  
New York, NY 10004  
Ph: 212–549–2627

The goal of the ACLU Lesbian and Gay Rights Project is equal treatment and equal dignity for lesbians, gay men, and bisexuals. That means even-handed treatment by the government; protection from discrimination in jobs, housing, hotels, restaurants, and other public places; and fair and equal treatment for lesbian and gay couples and families.

Human Rights Campaign (HRC)  
919 18th Street, NW  
Washington, DC 20006  
www.hrc.org

HRC is the largest national lesbian and gay political organization. Its mission is to create an America where lesbian and gay people are assured of basic equal rights and where they can be open, honest, and safe at home, at work, and in the community. With a national staff and volunteers and members throughout the country, HRC:

- Lobbies the Federal Government on gay, lesbian, and AIDS issues
- Educates the public
- Participates in election campaigns
• Organizes volunteers

• Provides expertise and training at the State and local levels.

Lambda Legal Defense and Education Fund
120 Wall Street, Suite 1500
New York, NY 10005–3904
Ph: 212–809–8585, Fax: 212–809–0055
www.lambdalegal.org

Lambda is the Nation’s oldest and largest legal organization working for the civil rights of lesbians, gay men, and people with HIV/AIDS.

National Center for Lesbian Rights (NCLR)
870 Market Street, #510
San Francisco, CA 94103
www.NCLRights.org

NCLR is committed to advancing the rights and safety of lesbians and their families through litigation, public policy advocacy, free legal advice and counseling, and public education. NCLR also provides representation and resources to gay men and bisexual and transgendered individuals on key issues that affect lesbian rights.

National Gay and Lesbian Task Force (NGLTF)
(Main office)
1700 Kalorama Road, NW
Washington, DC 20009–2624
Ph: 202–332–6483, Fax: 202–332–0207
TTY: 202–332–6219

National Gay and Lesbian Task Force (Policy Institute)
121 West 27th Avenue, Suite 501
New York, NY 10001
Ph: 212–604–9830, Fax: 212–604–9831
www.ngltf.org

NGLTF is a leading progressive civil rights organization that has supported grassroots organizing and advocacy since 1973. Since its inception, NGLTF has been at the forefront of every major initiative for lesbian, gay, bisexual, and transgender rights. In all its efforts, NGLTF works to strengthen the gay and lesbian movement at the State and local levels while connecting these activities to a national vision of change.

Servicemembers Legal Defense Network
P.O. Box 65301
Washington, DC 20035–5301
Ph: 202–328–3244, Fax: 202–797–1635
www.sldn.org

On July 19, 1993, the Clinton administration announced a new policy regarding gays in the military. Dubbed “Don’t ask, don’t tell, don’t pursue,” the policy was intended to stop military officials from asking troops about their sexual orientation, end witch hunts, and stop harassment of lesbian and gay service members. Suspect service members still face an untimely end to their careers. Most service members do not realize that the new policy affords little protection or privacy for lesbian and gay personnel, and most service members do not know what their legal rights are under the new policy.

It’s Time, America! (ITA!)
www.gender.org/ita/

ITA is the first nationally organized grassroots civil rights group seeking to secure and safeguard the rights of all transgender individuals. The mission of It’s Time, America! is to educate and influence the U.S. Congress, State and local governments, and transgender and nontransgender political organizations on the issues and concerns of transgender people and to take steps to safeguard and secure their rights as American citizens.

Queer Resources Directory
www.qrd.org
Queer Legal Resources
www.qrd.org/www/legal/
The Queer Resources Directory contains tens of thousands of files about various topics of interest to LGBT individuals. It bills itself as having one of the most extensive collections of materials devoted to LGBT legal issues on the Internet. The collection includes:

- Tables listing the important legal cases dealing with LGBT and AIDS issues for each year from 1992 to the present
- Case and issue archives by subject
- Statewide gay rights statutes and same-gender marriage resources
- Lesbian/Gay Law Notes, edited by Professor Arthur Leonard, a monthly summary of the cases important to gay/lesbian and HIV/AIDS jurisprudence
- National Journal of Sexual Orientation Law, an electronic legal journal devoted to sexual orientation and the law
- QueerLaw and QueerLaw-Digest, with information about companies with nondiscrimination policies that include sexual orientation; companies and organizations that provide domestic partner benefits; States that criminalize sexual acts between people of the same gender; State laws on age of consent for sexual acts between people of the same gender; and sodomy and age-of-consent laws worldwide
- Lists and links to groups that work on legal issues of interest to LGBT individuals.

Gay, Lesbian, Bisexual and Transgender Health Access Project
JRI Health
100 Boylston Street, Suite 860
Boston, MA 02116
Ph: 617–988–2605
Fax: 617–988–2629
www.glbthealth.org

The Gay, Lesbian, Bisexual and Transgender Health Access Project is a collaborative, community-based program funded by the Massachusetts Department of Public Health. The Project's mission is to foster the development and implementation of comprehensive, culturally appropriate, quality health promotion policies and health care services for gay, lesbian, bisexual, and transgendered people and their families.
The following terms are meant to guide the reader by providing clarity. However, it should be noted that some of the definitions continue to evolve over time as language changes from generation to generation.

**Acculturation**—Accommodation to the rules and expectations of the majority culture without giving up cultural identity entirely.

**Ageism**—Discriminatory behavior relating to age.

**Assimilation**—Adaptation to a new culture by taking on a new identity and abandoning the old cultural identity.

**Biphobia**—Irrational fear and dislike of bisexuals.

**Bisexual**—Man and woman with a sexual and affectional orientation toward people of both genders.

**Circuit Party**—Weekend dance party usually attended by urban gay males. These parties typically occur on a holiday weekend, and just as with many dance clubs and bars, many of their patrons are involved in substance use and abuse.

**Coming Out**—Individual and personal process by which a person accepts his or her homosexual or bisexual orientation and transforms it from a negative to a positive thing in a culture that is homophobic and does not validate and affirm diversity and difference. It is a process of healing from homophobia and heterosexism and taking on a positive identity. It may include sharing this process and its outcome with others or it may be private.

**Confidentiality**—Restriction against disclosure to certain persons or institutions of medical or personal information about a client without his or her consent.

**Co-occurring Disorders**—Condition in which a person has more than one disorder or disease.

**Countertransference**—Process of counselors seeing themselves in their clients, overidentifying with their clients, meeting their own personal needs through clients, or reacting to a client because of unresolved personal conflicts.

**Cultural Competence**—Broad-based and diverse understanding of, and ability to respond and relate to, culturally specific nuances, communication styles, traditions, icons, experiences, and spiritual traditions of a given culture or cultures.

**Denigrate**—To cast aspersions on, to defame, or to deny the importance or validity of something or someone.

**Dysphoria**—State of feeling unwell or unhappy.

**Epidemiology**—Incidence, distribution, and control of disease in a population.

**Family of Choice**—Persons an individual sees as significant in his or her life. It may include none, all, or some members of his or her family of origin. In addition, it may include individuals such as significant others or partners, friends, coworkers, etc.
Family of Origin—Birth or biological family or any family system instrumental or significant in an individual’s early development.

Gender Identity—Sense of oneself as male or female. As a comparison, a person may be born biologically male yet have a female gender identity.

Hermaphrodite—A person born with both male and female reproductive organs.

Heterosexism—Value and belief that heterosexuality is the only “natural” sexuality and that it is inherently healthier than or superior to other types of sexuality. Heterosexism is the ideological system that denies, denigrates, and stigmatizes any nonheterosexual form of behavior, identity, relationship, or community.

Heterosexuals—Term used to describe those individuals with a primary sexual and affectional orientation toward persons of the opposite gender. Heterosexuals are often referred to as straight.

Holistic—Consideration of the entire individual (physical, intellectual, emotional, spiritual, and environmental).

Homophobia—Irrational fear or dislike of homosexuals. This includes the discomfort and dislike that some heterosexuals have toward lesbian, gay, bisexual, and transgender individuals.

Homosexual—Term used to describe an individual with a primary sexual and affectional orientation toward persons of the same gender. Male homosexuals are often referred to as gay, whereas female homosexuals are referred to as lesbians.

Internalized Homophobia—Accepting and believing the negative messages of the dominant group as they relate to gay men and lesbians; the internalized self-hatred that gays and lesbians struggle with as a result of heterosexual prejudice.

Life Cycle—Stages of development (infancy, childhood, adolescence, young adult, adult, elder).

Lookism—Prejudice that some people harbor based on a limited and narrow definition of what physical traits are desirable.

Methamphetamine—Powerful central nervous system stimulant. A synthetic drug that has a high potential for abuse and dependence. It is illegally produced and sold in pill form, capsules, powder, and chunks. Methamphetamine was developed early in this century from its parent drug amphetamine and was originally used in nasal decongestants, bronchial inhalers, and the treatment of narcolepsy and obesity. In the 1970s, methamphetamine was classified a Schedule II drug—a drug with little medical use and a high potential for abuse.

Next of Kin—Person or persons designated in case of emergency. Traditionally this designation has been used only for immediate family of origin or married partners.

Nonoperative—The status of a transsexual individual who will not undergo sex reassignment surgery. Also called non-op.

Out or Out of the Closet—Refers to varying degrees of being open about one’s homosexual or bisexual orientation.

Passive Partner—Term frequently used in reference to male-to-male sexual behavior, specifically the receptive partner during sexual intercourse.

Postoperative Person—Transsexual who has completed gender reassignment surgery.

Power of Attorney—Legal document in which one person authorizes another person to act on the former’s behalf.
**Preoperative Person**—Transsexual who is contemplating gender reassignment surgery.

**Quality Improvement Program**—A systematic effort undertaken by an organization to analyze processes and procedures and identify and implement changes in order to achieve more desirable outcomes.

**Rave**—Type of dance party at which many of the patrons are involved in substance use and abuse.

**Ryan White Care Act**—Federal legislation that authorizes funding for the support of people with HIV/AIDS.

**Seropositive**—Serotype that suggests someone has experienced infection in the past.

**Sex Industry Workers**—Individuals (either male or female) who work as prostitutes, hustlers, or escorts and are in the business of providing sex for money, drugs, or housing.

**Sexual Harassment**—An illegal act that occurs in a place of employment when one person inflicts on another conversations or actions of a sexual nature. This behavior can either involve the condition of concrete employment benefits for sexual favors or create a hostile or offensive working environment for those involved and can be grounds for legal recourse.

**Sexual Identity or Orientation**—The erotic, physical, and emotional attraction to members of one’s own gender, the opposite gender, or both genders and one’s conscious or subconscious decision to define and label this affinity and attraction.

**Significant Other**—A life partner, domestic partner, lover, boyfriend, or girlfriend. Because gays and lesbians still are not allowed to be legally married in the United States (although they are allowed to in some European countries), significant other is equivalent to the term “spouse.”

**Sodomy Laws**—State statutes (which vary by State) that prohibit contact between the mouth or anus of one person and the sexual organs of another person (consensually or otherwise).

**Synthesis**—Combining of often diverse conceptions into a coherent whole.

**Transference**—Redirection of feelings and desires.

**Transgender Person**—One whose gender identity is not congruent with his or her biological gender, regardless of the status of surgical and hormonal gender reassignment processes. Sometimes used as an umbrella term encompassing transsexuals, transvestites, cross dressers, and others. The term transgender refers to a continuum of gender expressions, identities, and roles, which expand the current dominant cultural values of what it means to be female or male.

**Transphobia**—Irrational fear or dislike of transgender individuals.

**Transsexual**—Individual with biological characteristics of one sex who identifies himself or herself as the opposite gender. There are female-to-male and male-to-female transsexuals: Transsexuals usually desire to change their bodies to fit their gender identities and do this through hormone treatment and gender reassignment surgery.

**Treatment Readiness**—Stage or phase that an individual may be in related to changing alcohol and drug use activities (i.e., decrease harmful alcohol- and drug-related behaviors).
Appendix B  References


American Federation of State, County, and Municipal Employees (AFSCME), 1994. Managed Care: Community-Based Strategies for Improving Quality. Washington, DC: AFSCME.


Appendix B–References


Center for Substance Abuse Treatment (CSAT), 2000. Substance Abuse Treatment for Persons With HIV/AIDS. Treatment Improvement Protocol Series 37. DHHS Publication No. (SMA) 00-3410. Rockville, MD: CSAT.


Center for Substance Abuse Treatment (CSAT), 1999c. Treatment of Adolescents With Substance Use Disorders. Treatment Improvement Protocol 32. BKD307. Rockville, MD: CSAT.


Center for Substance Abuse Treatment (CSAT), 1997b. *Proceedings of the National Consensus Meeting on the Use, Abuse, and Sequelae of Abuse of Methamphetamine With Implications for Prevention, Treatment, and Research*. Rockville, MD: CSAT.


Appendix B–References


Hughes, T., 1999. *Sexual Identity and Alcohol Use: A Comparison of Lesbians’ and Heterosexual Women’s Patterns of Drinking*. Presentation conducted at the National Institute of Mental Health (November), Bethesda, MD.


## Appendix C: Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA</td>
<td>Alcoholics Anonymous</td>
</tr>
<tr>
<td>ACLU</td>
<td>American Civil Liberties Union</td>
</tr>
<tr>
<td>ACOA</td>
<td>Adult Children of Alcoholics</td>
</tr>
<tr>
<td>ADA</td>
<td>Americans with Disabilities Act</td>
</tr>
<tr>
<td>ADM</td>
<td>alcohol, drug abuse, and mental health</td>
</tr>
<tr>
<td>AFSCME</td>
<td>American Federation of State, County, and Municipal Employees</td>
</tr>
<tr>
<td>AIDS</td>
<td>acquired immunodeficiency syndrome</td>
</tr>
<tr>
<td>AMBHA</td>
<td>American Managed Behavioral Healthcare Association</td>
</tr>
<tr>
<td>APA</td>
<td>American Psychiatric Association</td>
</tr>
<tr>
<td>API</td>
<td>Asian/Pacific Islanders</td>
</tr>
<tr>
<td>ASI</td>
<td>Addiction Severity Index</td>
</tr>
<tr>
<td>CARF</td>
<td>The Rehabilitation Accreditation Commission</td>
</tr>
<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
</tr>
<tr>
<td>CEU</td>
<td>continuing education unit</td>
</tr>
<tr>
<td>CMA</td>
<td>crystal methamphetamine</td>
</tr>
<tr>
<td>CSAP</td>
<td>Center for Substance Abuse Prevention</td>
</tr>
<tr>
<td>CSAT</td>
<td>Center for Substance Abuse Treatment</td>
</tr>
<tr>
<td>DSM</td>
<td><em>Diagnostic and Statistical Manual of Mental Disorders</em></td>
</tr>
<tr>
<td>EAP</td>
<td>employee assistance program</td>
</tr>
<tr>
<td>ERISA</td>
<td>Employment Retirement Income Security Act</td>
</tr>
<tr>
<td>FFS</td>
<td>fee-for-service</td>
</tr>
<tr>
<td>FTM</td>
<td>female-to-male</td>
</tr>
<tr>
<td>GHB</td>
<td>gamma hydroxybuturate</td>
</tr>
<tr>
<td>GID</td>
<td>gender identity disorder</td>
</tr>
<tr>
<td>GLMA</td>
<td>Gay and Lesbian Medical Association</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Health Plan Employer Data and Information Set</td>
</tr>
<tr>
<td>HIV</td>
<td>human immunodeficiency virus</td>
</tr>
<tr>
<td>HMO</td>
<td>health maintenance organization</td>
</tr>
<tr>
<td>IDU</td>
<td>injection drug user/intravenous drug user</td>
</tr>
<tr>
<td>IOM</td>
<td>Institute of Medicine</td>
</tr>
<tr>
<td>IPA</td>
<td>Individual Practice Association</td>
</tr>
<tr>
<td>ITA</td>
<td>It's Time America!</td>
</tr>
<tr>
<td>IV</td>
<td>intravenous</td>
</tr>
<tr>
<td>JAMA</td>
<td><em>Journal of the American Medical Association</em></td>
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<tr>
<td>JCAHO</td>
<td>Joint Commission on Accreditation of Healthcare Organizations</td>
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<tr>
<td>LGBT</td>
<td>lesbian, gay, bisexual, and transgender</td>
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<tr>
<td>LHWN</td>
<td>Lesbian Health and Wellness Network</td>
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<tr>
<td>MAP</td>
<td>member assistance program</td>
</tr>
<tr>
<td>MAST</td>
<td>Michigan Alcohol Screening Test</td>
</tr>
<tr>
<td>MBHC</td>
<td>managed behavioral health care</td>
</tr>
<tr>
<td>MBHCO</td>
<td>managed behavioral health care organization</td>
</tr>
<tr>
<td>Acronym</td>
<td>Definition</td>
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<tr>
<td>---------</td>
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<tr>
<td>MCO</td>
<td>managed care organization</td>
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<tr>
<td>MSM</td>
<td>men who have sex with men</td>
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<tr>
<td>MTF</td>
<td>male-to-female</td>
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<tr>
<td>NA</td>
<td>Narcotics Anonymous</td>
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<tr>
<td>NAADAC</td>
<td>National Association of Alcohol and Drug Abuse Counselors</td>
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<tr>
<td>NALGAP</td>
<td>National Association of Lesbian and Gay Addiction Professionals</td>
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<td>NASW</td>
<td>National Association of Social Workers</td>
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<td>NCQA</td>
<td>National Committee for Quality Assurance</td>
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<td>NGLTF</td>
<td>National Gay and Lesbian Task Force</td>
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<td>NHSDA</td>
<td>National Household Survey on Drug Abuse</td>
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<td>NIDA</td>
<td>National Institute on Drug Abuse</td>
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<tr>
<td>OAS</td>
<td>Office of Applied Studies</td>
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<tr>
<td>ONDCP</td>
<td>Office of National Drug Control Policy</td>
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<tr>
<td>PAWS</td>
<td>postacute withdrawal syndrome</td>
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<tr>
<td>PCCM</td>
<td>primary care case management</td>
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<td>PFLAG</td>
<td>Parents, Families and Friends of Lesbians and Gays</td>
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<tr>
<td>PHO</td>
<td>physician hospital organization</td>
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<tr>
<td>PMS</td>
<td>premenstrual syndrome</td>
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<td>POS</td>
<td>point of service</td>
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<tr>
<td>PPO</td>
<td>preferred provider organization</td>
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<td>PSA</td>
<td>public service announcement</td>
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<td>PSN</td>
<td>provider-sponsored network</td>
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<tr>
<td>PSO</td>
<td>provider-sponsored organization</td>
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<tr>
<td>QISMC</td>
<td>quality improvement system for managed care</td>
</tr>
<tr>
<td>RCD</td>
<td>Resource Center of Dallas</td>
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<td>RET</td>
<td>rational-emotive therapy</td>
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<td>ROTC</td>
<td>Reserve Officers’ Training Corps</td>
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<tr>
<td>RWJF</td>
<td>Robert Wood Johnson Foundation</td>
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<tr>
<td>SAMHSA</td>
<td>Substance Abuse and Mental Health Services Administration</td>
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<tr>
<td>SASSI</td>
<td>Substance Abuse Subtle Screening Inventory</td>
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<tr>
<td>STD</td>
<td>sexually transmitted disease</td>
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<tr>
<td>TAP</td>
<td>Technical Assistance Publication</td>
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<tr>
<td>TIP</td>
<td>Treatment Improvement Protocol</td>
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<tr>
<td>WWATS</td>
<td>Whitman-Walker Clinic, Inc., Addiction Treatment Services</td>
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## Appendix D

### Studies on LGBT Substance Abuse

<table>
<thead>
<tr>
<th>Study</th>
<th>Study Population</th>
<th>Substance Use/Abuse</th>
<th>Methodology</th>
<th>Comparison Group</th>
<th>Outcome Description</th>
<th>Comments on Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Saghir et al., 1970&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Lesbians N=200</td>
<td>Alcohol</td>
<td>Convenience sample</td>
<td>None</td>
<td>33% reported having a problem with alcohol</td>
<td>No comparisons can be made at this time</td>
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<tr>
<td>Fifield et al., 1977&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Lesbians N=57</td>
<td>Alcohol</td>
<td>Convenience sample</td>
<td>None</td>
<td>35% reported having a problem with alcohol</td>
<td>No comparisons can be made at this time</td>
</tr>
<tr>
<td>Lewis et al., 1982&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Lesbians N=57</td>
<td>Alcohol</td>
<td>Convenience sample</td>
<td>None</td>
<td>28% reported having a problem with alcohol</td>
<td>No comparisons can be made at this time</td>
</tr>
<tr>
<td>Morales &amp; Graves, 1983&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Lesbians N=129</td>
<td>Alcohol</td>
<td>Convenience sample</td>
<td>None</td>
<td>27% reported having a problem with alcohol</td>
<td>No comparisons can be made at this time</td>
</tr>
<tr>
<td>Bradford &amp; Ryan, 1987&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Lesbians N=1,917</td>
<td>Alcohol</td>
<td>Population-based</td>
<td>None</td>
<td>6%—daily drinkers 25%—drink 1+/wk 30%—drink 1+/mo 17%—abstainers</td>
<td>No comparisons can be made at this time</td>
</tr>
<tr>
<td>McKirnan &amp; Peterson, 1989&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Lesbians N=748</td>
<td>Alcohol</td>
<td>Convenience sample</td>
<td>General population women (Clark &amp; Midinak, 1992&lt;sup&gt;1&lt;/sup&gt;)</td>
<td>76% vs. 59%—Moderate 9% vs. 7%—Heavy 23% vs. 8%—Problems</td>
<td>Lesbians had greater alcohol use than general population women</td>
</tr>
<tr>
<td>Bloomfield, 1993&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Lesbians N=58</td>
<td>Alcohol</td>
<td>Convenience sample</td>
<td>Heterosexual women (N=397)</td>
<td>69% vs. 74%—Moderate 11% vs. 10%—Heavy 13% vs. 3%—In recovery 20% vs. 16%—Abstainers</td>
<td>Lesbians had greater alcohol use than heterosexual women</td>
</tr>
<tr>
<td>Study</td>
<td>Study Population</td>
<td>Substance Use/Abuse</td>
<td>Methodology</td>
<td>Comparison Group</td>
<td>Outcome</td>
<td>Comments on Outcome</td>
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</tr>
<tr>
<td>Skinner, 1994</td>
<td>Lesbians &amp; gay men</td>
<td>Alcohol, cigarettes, marijuana &amp; other illegal drugs</td>
<td>Convenience sample</td>
<td>Heterosexuals</td>
<td>32% vs. 28%—1-4 drinks/mo 26% vs. 11%—5-19 drinks/mo 12% vs. 2%—20-30 drinks/mo 28% vs. 9%—5+ drinks/occasion</td>
<td>Lesbians &amp; gay men had greater substance use than heterosexuals</td>
</tr>
<tr>
<td>Skinner &amp; Otis, 1996</td>
<td>Lesbians N=500</td>
<td>Alcohol</td>
<td>Convenience sample</td>
<td>General population women N=725</td>
<td>26% vs. 11%—5-19 drinks/mo</td>
<td>Lesbians used more alcohol than general population women</td>
</tr>
<tr>
<td>Hughes et al., 1997</td>
<td>Lesbians N=284</td>
<td>Alcohol or drug problems</td>
<td>Convenience sample</td>
<td>Heterosexual women N=134</td>
<td>10% vs. 2%—Light/moderate 2% vs. 2%—Heavy</td>
<td>Lesbians used more substances than heterosexual women</td>
</tr>
<tr>
<td>Clements et al., 1998</td>
<td>Transgender persons (N=515)</td>
<td>Intravenous drug use</td>
<td>Convenience sample</td>
<td>None</td>
<td>34% MTF w/lifetime IV drug use</td>
<td>No comparisons can be made at this time</td>
</tr>
<tr>
<td>Woody et al., 1999</td>
<td>Men who have sex with men (MSM) and are at specific risk for HIV/AIDS (N=3,212)</td>
<td>Alcohol, nitrite inhalants, hallucinogens, stimulants, sedatives, tranquilizers, marijuana, cocaine</td>
<td>Convenience sample</td>
<td>General population men</td>
<td>This nongeneral sample of MSM who were specifically at risk for contracting HIV disease was 21 times more likely to use nitrite inhalants, 6 times more likely to use hallucinogens, 4 times more likely to use stimulants, 7 times more likely to use sedatives, and 5 times more likely to use tranquilizers</td>
<td>MSM used more substances than general population men</td>
</tr>
<tr>
<td>Cochran &amp; Mays, 2000</td>
<td>Same gender (male) partners (N=98) Same gender (female) partners (N=96)</td>
<td>Alcohol dependence (DSM–IV) Drug dependence (DSM–IV)</td>
<td>Population-based (1996 National Household Survey of Drug Abuse)</td>
<td>Opposite-gender (female) partner(s) only (N=3,922) Opposite-gender (male) partner(s) only (N=5,792)</td>
<td>10% of males with partners of the same gender vs. 7.6% of males with partners of the opposite gender exhibited symptoms of alcohol dependence. 7% of females with partners of the same gender vs. 2% of females with partners of the opposite gender exhibited symptoms of alcohol dependence. 5.7% of males with partners of the same gender vs. 2.8% of males with partners of the opposite gender exhibited symptoms of drug dependence. 5% of females with partners of the same gender vs. 1.3% of females with partners of the opposite gender exhibited symptoms of drug dependence.</td>
<td>Same-sex partners used more substances than opposite-sex partners</td>
</tr>
<tr>
<td>Study</td>
<td>Study Population</td>
<td>Substance Use/Abuse</td>
<td>Methodology</td>
<td>Comparison Group</td>
<td>Outcome</td>
<td>Comments on Outcome</td>
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</tr>
<tr>
<td>Cochran et al., in press</td>
<td>Same gender partners (gay and lesbian) (N=194) Opposite gender partners (N=9,714)</td>
<td>Alcohol dependence (DSM-IV)</td>
<td>Population-based (1996 National Household Survey of Drug Abuse)</td>
<td>Same gender partner (male) vs. opposite gender partners (male) Same gender partner (female) vs. opposite gender partners (female)</td>
<td>Lesbians were 2 times more likely to use alcohol in the past month, 3.5 time more likely in the past year, 5 times more likely to use alcohol every day, 2.25 times more likely to get intoxicated, and 4 times more likely than heterosexual women to get intoxicated weekly. There were no differences between gay and straight men.</td>
<td>Lesbians were at higher risk for alcohol use than heterosexual women</td>
</tr>
<tr>
<td>Welch, Howden-Chapman &amp; Collings, 1998</td>
<td>New Zealand lesbians N=200</td>
<td>Drugs</td>
<td>Survey</td>
<td>None</td>
<td>76% reported using cannabis once (lifetime) and 33% reported use in the last year 31% used recreational drugs other than alcohol and cannabis at some time, and 4.5% reported past year use</td>
<td>No comparisons can be made at this time</td>
</tr>
</tbody>
</table>

1As cited in Hughes, T. (November 1999). Sexual Identity and Alcohol Use: A Comparison of Lesbians' and Heterosexual Women's Patterns of Drinking. Presentation conducted at the National Institute of Mental Health.