Substance Abuse

Healthy People 2010 Goal

Reduce substance abuse to protect the health, safety, and quality of life for all, especially children.

Overview

Substance abuse is pervasive and affects all populations, youth to elderly, in the United States. It takes an enormous toll on the Nation—in both human and economic terms—and remains a significant concern to the lesbian, gay, bisexual, and transgender (LGBT) community. Although no national data are available, a recent review of the literature based on smaller population studies suggests that lesbians and gay men may still be at heightened risk for substance abuse.[1] Much less is known about bisexual or transgender women and men, but these groups also may be at increased risk for substance abuse. In addition to being discriminated against by many heterosexuals, they are frequently further marginalized by the gay and lesbian community.[2, 3] Like the general population in the United States, substance abuse in the LGBT community is associated with a myriad of public health challenges, including human immunodeficiency virus (HIV) and acquired immonudeficiency syndrome (AIDS), sexually transmitted diseases (STDs), violence (of particular concern, acts committed by and against the LGBT community), and chronic disease conditions such as cirrhosis of the liver. This chapter addresses substance abuse as it affects all populations, but particularly the disparities and issues affecting LGBT populations.

LGBT youth use alcohol and other drugs for many of the same reasons as their heterosexual peers: to experiment and assert independence, to relieve tension, to increase feelings of self-esteem and adequacy, and to self-medicate for underlying depression or other mental health problems.[4] Adolescents grow up in an environment that assumes heterosexuality of everyone*. There is scant acceptance available to LGBT youth within most sectors of their world (e.g., families, peers, schools, churches). Youth of color face additional stresses and challenges in integrating their sexual, gender, racial, and ethnic identities.[5]*

To become visible as LGBT, youth risk painful repercussions with few or no avenues of support. Subsequently, homelessness is a serious consequence for gay youth for a variety of reasons. For many, simply being LGBT is the reason why they may be banished from their

families of origin. Homeless youth are at high risk for exploitation. Without an education or job skills, they may engage in illicit behaviors, such as exchanging sex for food, drugs, or shelter.[6]

Abusing substances can occur at any age although the focus of most substance abuse prevention programs is on the adolescent. Ironically, substance abuse often is undetected or neglected among older adults, particularly older LGBT people. LGBT elders may feel vulnerable and under pressure to appear heterosexual. Efforts to self-medicate simply increase the invisibility of this segment of the senior community and their particular health needs—including treatment of their substance abuse.

Issues and Trends

Epidemiological data and information related to substance abuse among the LGBT population are, for the most part, limited to regional or local studies of specific populations (e.g., lesbians, men living with or at risk for HIV). The two most commonly cited substance abuse data sets—the National Household Survey on Drug Abuse and the Monitoring the Future Study—at present do not include sexual orientation or gender identity as demographic variables in their data sets, nor do they ask questions that would yield data for the different populations within the LGBT community. Moreover, the same challenges that confront substance abuse research in general also pertain to studies designed to result in a reliable, accurate picture of the incidence and prevalence of substance abuse among LGBT populations. These include:

- Clear and consensus-based terms and definitions for "lesbian," "gay," "bisexual," and "transgender." Although widely recognized and accepted, these terms are often clouded by ambiguity when used for research purposes. Similarly, in most existing studies, definitions of sexual orientation are based on self-report, or no mention is made of how this variable was assessed[7]
- The impact of stigma and, in some jurisdictions, the fear of legal impact on those individuals participating in and accurately reporting for studies of substance abuse
- Ethical issues, particularly related to assurances of confidentiality for those participating in prevention and treatment programs, which are important sources of information on use patterns and factors that influence recovery
- A lack of standard diagnostic criteria to assess substance abuse or substance dependence

Studies of alcohol and other drug use in the LGBT community have focused primarily on lesbians and gay men. Few have been designed specifically to include bisexual or transgender persons. The relative lack of national data—and of data for the bisexual and transgender population in particular—is due largely to the cost of oversampling smaller populations in general and concerns regarding the statistical significance of the data obtained. This renders comparison of substance abuse indicators and risk factors among these populations difficult. However, a synthesis of available research indicates that

substance abuse is at least as serious a public health problem for the LGBT community as it is for the general population in the United States.[8] Data on substance use, together with information regarding barriers to care and factors that contribute to recovery, inform culturally relevant and effective prevention and treatment strategies.

Early research on substance abuse among lesbians and gay men reported alarmingly high rates of drinking and other drug use.[9, 10] These qualitative research studies were carried out in the absence of disaggregated data for this population from national data sets. However, because of the nature of the research (relatively small, nonrepresentative samples and lack of comparison groups), the results could not—nor were they intended to —be generalized to the LGBT population. Studies conducted in the 1980s reported lower rates of heavy drinking among lesbians than earlier studies. However, these studies suggested that, compared with heterosexual women, lesbians were more likely to drink and more likely to experience alcohol-related problems.[11, 12, 13] Overall, recent data suggest that substance use among lesbians and gay men—particularly alcohol use—has declined over the past two decades. However, both heavy drinking and use of drugs other than alcohol appear to be prevalent among young lesbians and gay males, and among some older groups of lesbians and gay men.[14, 15] Reasons for this may include greater awareness and concern about health and more moderate drinking among women and men in the general population, some lessening of the social stigma and oppression of lesbians and gay men, and changing norms associated with drinking in some lesbian and gay communities.

"Club" drugs such as amyl nitrite, ketamine, and ecstasy, or 3,4-methylenedioxymethamphetamine (MDMA), are receiving national attention. Many of these drugs have been in use for several decades, but the prevalence seems to have increased sharply, especially at late-night dance clubs and at dance parties known as "raves."[16] Although no national studies can verify the prevalence of ecstasy, among LGBT people, Cohen, who has written one of the most definitive books on ecstasy, alluded to its popularity among gay and lesbian populations.[17] Klitzman and colleagues explored the association between abuse of ecstasy and high-risk sexual behaviors among gay men. Although the study had many methodological limitations, the results suggested there was a strong association with high-risk sexual behaviors and MDMA.[18] The National Institute on Drug Abuse is funding a study to investigate methamphetamine and other drug abuse patterns of men who have sex with men in relation to HIV risk behaviors.[19]

Few substance abuse studies have included sufficient numbers of bisexual persons to permit separate analyses, and no studies to date have focused exclusively on this subset of the population. Data from bisexual men and bisexual women are usually combined with that of gay men and lesbians, respectively. This most likely reflects an unexplored assumption that bisexual men and bisexual women share more in common with gay men and lesbians, respectively, than with heterosexual men or women. Therefore, many of the studies of presumed gay men or lesbians are likely to include some proportions of bisexual men or bisexual women. Notably, bisexual men are included in studies of gay men in much greater numbers than bisexual women in studies of lesbians. One reason for this is the

disproportionately high number of studies that have as a major aim greater understanding of risk factors associated with STDs, including HIV/AIDS, among men who have sex with men. Thus, it is *behavior*, rather than *identity*, that is of primary concern in most of the research on substance use among gay and bisexual men.

Scant research has been carried out concerning substance abuse among transgender persons,[20] and the few studies that do exist have been conducted as part of HIV-related research. These studies have typically employed convenience samples from large urban areas, and their conclusions cannot be generalized to transgender persons as a whole. Nevertheless, they do provide evidence of the extent of substance abuse problems in some urban transgender groups. One 1999 study done in San Francisco by the Department of Public Health found that, in the preceding 6 months, the drugs most commonly used by male-to-female (MTF) transgender persons were: marijuana (64 percent), speed (30 percent), and crack cocaine (21 percent); female-to-male (FTM) transgender persons reported using only marijuana frequently (43 percent).[21] Another study, the results of which were publicized in 1999, reported that alcohol, cocaine/crack, and methamphetamines were the drugs most commonly used by MTF transgender persons in Los Angeles.[22] Another study, published in 1997 by the San Francisco Department of Public Health, of transgender individuals participating in focus group discussions in San Francisco found that lack of educational and job opportunities and low self-esteem were important factors contributing to drug and alcohol abuse.[23]

Disparities

There is evidence to suggest that gay men and lesbians perceive themselves to be at increased risk for alcoholism and substance abuse, that they have an increased need for treatment, and that they face barriers to treatment. Gay men and lesbians report alcohol problems nearly twice as often as heterosexuals, even though heavy drinking patterns do not seem to differ significantly by sexual orientation.[24] Alcohol consumption rates among gay men and lesbians do not seem to decrease with age as quickly as they do among heterosexuals.[25, 26, 27, 28]

Too few studies of substance use or abuse in LGBT populations have included sufficient numbers of racial/ethnic minority persons to permit separate analyses. However, the interaction of gender and race/ethnicity also is apparent in LGBT populations, though not always in the same form as in the general population. There is some evidence to suggest that African American men are more likely than White men to trade sex for drugs.[29] Because heavy drinking is prevalent in the Latino heterosexual culture and gay male culture, Latino gay men may have higher rates of drinking than either group alone.[30]

Some studies done in the early 1990s indicated that treatment facility staff members often are not trained in providing gay- and lesbian-specific treatment and that facilities often have few or no gay staff members.[31] Meanwhile, other studies done during the same period and in 1997 suggest that gay, lesbian, and bisexual clients are more willing to participate in treatment programs that address gay issues and are less likely to adhere to treatment

recommended by homophobic mental health care providers.[32, 33] Additional research is needed to better understand the unique treatment needs of LGBT populations and the role of cultural factors in shaping and influencing patterns of substance use and sexual behavior. Such factors—such as reliance solely on bars and clubs as a means of socialization, stress caused by discrimination and prejudice, and advertising by liquor companies in magazines and publications that target gay men and lesbians—have been documented but continue to be insufficiently understood.[34, 35]

Notwithstanding the urgent need to address substance abuse among the LGBT adolescent population, there continues to be a serious lack of alcohol-free and drug-free alternative activities for both coming-out or questioning youth and the LGBT adult population. In part because of this lack of opportunities, coming-out youth may have few other options than to enter LGBT society via clubs and bars, where they are susceptible to exposure to the use of tobacco, alcohol, and illicit drugs. Without question, LGBT communities share the responsibility for establishing safer and healthier opportunities for LGBT individuals to gather and socialize. At the same time, there are indications that LGBT communities are to be among those populations apparently targeted by the alcohol industry.[36]

Environmental as well as individually oriented prevention is useful for reducing consumption among youth and reducing alcohol-related problems among adults. Many environmental prevention strategies that have demonstrated effectiveness in the general population may also be appropriate for LGBT communities. These strategies might include responsible beverage services, promotion of alcohol-safe community events, and development of policies related to alcohol and other drugs in LGBT service and social organizations.[37] LGBT communities may also consider developing guidelines for organizations and community events on limiting alcohol and tobacco sponsorship and promotions.[38]

Accessible substance abuse treatment may be most problematic for transgender individuals. Many substance use programs are not sensitive to the needs of transgender individuals, and few have the capacity to address the realities faced by the transgender population.[39, 40] For example, the Transgender Substance Abuse Treatment Policy Group of the San Francisco Lesbian, Gay, Bisexual, Transgender Substance Abuse Task Force reported that transgender clients in substance abuse treatment programs experienced verbal and physical abuse by other clients and staff; requirements that they wear only clothes judged to be appropriate for their biological gender; and requirements that they shower and sleep in areas judged to be appropriate for their biological gender.[41] The reality is that transgender individuals tend to be “invisible” in program evaluation, intake, assessment, and other points in substance abuse prevention and treatment. Culturally sensitive instruments need to be designed and tested to evaluate the effectiveness of substance use programs at all levels (e.g., prevention, treatment, outpatient, inpatient, detoxification). This is especially important for programs serving youth.

Opportunities

Healthy People 2010 states that the direct application of prevention and treatment research knowledge is particularly important in solving substance abuse problems. Developing adaptations of research-proven programs for diverse racial and ethnic populations, field-testing them with high-quality process and outcome evaluations, and providing them where they are most needed are critical. Interventions appropriate to the population to be served, including interventions to address gaps in substance abuse treatment capacity, must be identified and implemented by Federal, tribal, regional, State, and community-based providers in a variety of settings.

For LGBT populations, however, it is unclear if prevention and treatment strategies that have demonstrated success in heterosexual populations will yield the same benefits for LGBT individuals. For example, studies indicate that school-based programs focused on altering perceived peer-group norms about alcohol use[42, 43] and developing skills in resisting peer pressures to drink[44, 45, 46] do reduce alcohol use among participating students. Communitywide programs involving school curricula, peer leadership, parental involvement and education, and community task forces also have reduced alcohol use among adolescents.[47] It is not known, however, if these strategies are equally successful in preventing alcohol and other drug use among LGBT students.

Many opportunities to prevent drug-related problems have been identified. Core strategies for preventing drug abuse among youth include raising awareness, educating and training parents and others, strengthening families, providing alternative activities, building skills and confidence, mobilizing and empowering communities, and employing environmental approaches. All of these strategies hold promise for preventing alcohol and other drug use among LGBT and questioning youth. In particular, creating and sustaining safer, alternative venues for LGBT and questioning youth to "come out" would represent a major step forward.

For substance abuse prevention to be effective, people need access to culturally, linguistically, and age-appropriate services; job training and employment; parenting training; general education; more behavioral research; and programs for women, dually diagnosed patients, and persons with learning disabilities. Particular attention must be given to young persons under age 18 who have an addicted parent because these youth are at increased risk for substance abuse. Because alcoholism and drug abuse continue to affect lesbians, gay men, and transgender persons at two to three times the rate of the general population,[48] culturally competent programs that address the special risks and requirements of LGBT individuals are needed.

Discussion of Healthy People 2010 Objectives

26-9: Increase the age and proportion of adolescents who remain alcohol- and drug-free.

Available data related to youth who identify as lesbian, gay, or bisexual; who have had same-sex experiences; or who are perceived by their peers as being lesbian, gay, or bisexual and are subsequently harassed show a significantly higher prevalence use of alcohol and other drugs than their peers who identify as heterosexual or who have had no sexual experience. In a 1997 Massachusetts Youth Risk Behavior Survey of lesbian and gay youth and those who reported having same-gender sex, 46 percent reported ever having used hallucinogens, 77 percent reported ever having used marijuana, and 33 percent reported having ever used cocaine.[49]

Illicit drug use among LGBT youth. One school-based study, which used CDC's Youth Risk Behavior Survey and was the first to examine the association between sexual orientation and health-risk behaviors, found that self-identified lesbian, gay, and bisexual youth, who made up 2.5 percent of the cohort, were more likely than heterosexual youth in the sample to have used multiple substances. The study also found that lesbian, gay, and bisexual youth were more likely to have been victimized, threatened, and engaged in a variety of risk behaviors, including suicidal ideation and attempts as well as high-risk sexual behavior.[50] A longitudinal study of African American and Hispanic gay and bisexual adolescent males found that protective factors and reduced sexual risk-taking were associated with reduced substance use, anxiety, and depression as well as increased self-esteem.[51]

The 1997 Vermont Youth Risk Behavior Survey found that youth with same-gender sexual experience used drugs and alcohol significantly more than other youth. Some 64 percent smoked cigarettes in the past 30 days; 16 percent drank alcohol daily for the past 30 days; 22 percent reported smoking marijuana 10 or more times in the past 30 days; 29 percent reported using cocaine in the past 30 days; and 19 percent injected illegal drugs two or more times in their life.[52]

The 1997 Wisconsin Youth Risk Behavior Study compared 9th through 12th graders who reported having been threatened or hurt because someone thought they were lesbian, bisexual, or gay with those who reported no such harassment. Of those who reported harassment based on the perception of being lesbian, bisexual, or gay, 53.3 percent had smoked cigarettes in the last 30 days; 51.7 percent had used marijuana in the past 30 days; 38.3 percent had sniffed inhalants (glue, aerosol cans, paints) ever; 25.0 percent had used LSD ("acid") ever; and, 23.3 percent had used cocaine (powder, freebase, or crack) ever.[53]

CDC's Youth Risk Behavioral Survey and its Behavioral Risk Factor Surveillance System questionnaire would serve as an ideal future data collection survey for past-month use among LGBT individuals. The Center for Substance Abuse Treatment (CSAT) has invited the National Association of Alcoholism and Drug Abuse Counselors and five other professional associations (the American Association of Marriage and Family Therapists, the American Counseling Association, the American Psychological Association, the American

Psychiatric Association, and the National Association of Social Workers) to gather the information needed to develop a national plan on addictions. Each association will collect information specific to CSAT's needs through a practitioner research network—a group of professionals from a variety of settings/services who provide information on clinical and service delivery issues. The questionnaire asked gender identity and sexual orientation questions of both providers and the clients they treat. (More information is available online at www.lewin.com/naadac.)

26-10: Reduce past-month use of illicit substances.

Past-month use of illicit substances is a measure used in nearly all standardized national, State, and local surveys. However, these surveys do not measure past-month use using sexual orientation or gender identity as demographic variables.

In 1996, the National Household Survey on Drug Abuse (NHSDA), administered by the Substance Abuse and Mental Health Services Administration (SAMHSA), asked one question that focused on sexual behavior and the relationship between substance use and the risk of HIV transmission. Because the question was asked during only one survey year, longitudinal analyses are not available. Even if NHSDA had continued to ask the question, only longitudinal analyses regarding sexual behavior—not sexual orientation—would have been possible.

CDC, which administers the Youth Risk Behavior Survey and the Behavioral Risk Factor Surveillance System survey, permits States to add additional questions, including questions related to sexual orientation or gender identity. Several States, such as Massachusetts and Vermont, have subsequently revised their surveys to include questions specific to sexual orientation. To date, no States measure gender identity as a demographic variable in data collection.

There is a need to develop a simple, standardized way to obtain valid, LGBT-specific data from a variety of venues across the United States, including the use of quantitative and qualitative research methods to elicit information on use patterns, effective prevention programs, and treatment-seeking and recovery behaviors.

Qualitative research can yield critical information for prevention and treatment programs targeting the LGBT community. For example, such research can be used to gather information regarding the role of alcohol and other drugs in the LGBT socialization process, including bars and "circuit parties"—large, international dance events organized and attended by gay and bisexual men. Held at primarily urban venues across the United States, circuit parties have become an increasingly popular alternative to the more traditional local club and bar scene, with participants often flying thousands of miles to attend any one of a number of weekend-long annual events held across the country.

Illicit substance use among gay and bisexual men. An analysis of NHSDA data found that people with same-sex partners were more likely to use illicit substances than people with opposite-sex partners.[54] About one-third of nearly 170 gay and bisexual men who

participated in a survey on MDMA (ecstasy) reported using the drug at least once a month.[55] A survey conducted at the April 2000 Millennium March in Washington, D.C., asked 730 men who self-identified as gay males, "How often are party drugs used in your close circle of friends?" Some 26.3 percent reported that party drugs are used once a month, 13.4 percent reported party drugs are used one or more times a week, 21.9 percent reported one or two times a year, and 38.4 percent reported that party drugs are never used in their circle of friends.[56]

There is also evidence that, even though drug use and heavy alcohol use may decline as gay and bisexual men get older, levels of substance use still remain high and may continue to jeopardize the health of gay and bisexual men.[58]

Most gay and bisexual men living with HIV infection and substance use disorders either discontinue or reduce substance use before or subsequent to finding out they are HIV-positive, most likely in an attempt to adopt a healthier lifestyle; however, persistent substance abuse or dependence among some HIV-positive men is accompanied by higher levels of distress and diminished quality of life, which underscores their need for treatment.[59] Meanwhile, of 3,220 HIV-negative men who have sex with men who participated in an HIV vaccine preparedness study, 49 percent reported using marijuana, 29 percent reported using nitrate inhalants, 21 percent reported using amphetamines or similar stimulants, 14 percent reported using cocaine, and 14 percent reported using hallucinogens. Nearly 90 percent of all participants reported alcohol use.[60]

The 1992 Research Symposium on Alcohol and Other Drug Problem Prevention Among Lesbians and Gay Men Proceedings (California Department of Alcohol and Drug Programs) included consensus among participating researchers that there was more heavy drinking among lesbians and gay men than in the general population and that it persisted later into life than is typical in general population samples. In fact, lesbians were shown to drink more heavily than either nonlesbian women or straight men and more like gay men.[57]

Illicit drug use among lesbians and women who have sex with women. Comparisons of data on lesbians and women from the general population show that lesbians tend to drink more than other women. It is important to note that lesbians and gay men are less likely to abstain from alcohol use. Lower rates of abstention show up more consistently in studies than higher rates of "heavy" drinking and may contribute to higher rates of reported problems.[61] Lesbians also report greater difficulties related to alcohol consumption.[62] The 1988 National Household Survey on Drug Abuse data on the prevalence of 12 illicit and licit drugs by sex and age group and the demographic predictors of past-year frequency of marijuana, alcohol, and cigarette use in a southern State found differences between gay men and lesbians in the use of specific substances and the demographic predictors of drug use.[63]

A Seattle-based study comparing risk factors for HIV and other STDs in women who reported having had sex with both men and women to women who reported having had sex with men found only that women with a history of bisexual behavior were more likely to

report past-month drug use than exclusively heterosexual women.[64] Meanwhile, a self-report survey of 263 lesbians found that levels of stress, social support, and coping styles were not predictive of problematic substance use.[65] The K-Y Community Health Survey asked 307 self-identified lesbians, "How often are party drugs used in your close circle of friends?" Although 61.9 percent reported that party drugs are never used in their group of friends, 11.4 percent reported once a month, 5.9 percent reported one or more times a week, and 20.8 percent reported one or two times a year.[66] These findings add to the growing, yet preliminary, body of knowledge that party drug use among lesbians is on the rise.

Illicit substance use among transgender people. Except for studies that specifically examined transgender people, there is little information about illicit substance use among transgender individuals. One study examining the past month substance use of 209 transgender women found that 37 percent used alcohol, 13 percent used marijuana, 11 percent used methamphetamine, 11 percent used crack, 7 percent used powdered cocaine, and 2 percent used heroin.[67] Generally, other studies of substance use are not designed to identify transgender persons within the study sample. It should be noted that asking about sexual orientation or the number of lesbian and gay clients served does not identify transgender men and women.

26-12: Reduce average annual alcohol consumption.

Long-range trends on apparent per capita ethanol consumption by beverage type provide a historical perspective on national patterns of alcoholic beverage consumption. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) uses a drinking population aged 14 and older to calculate per capita consumption rates. NIAAA, with the National Institute of Child Health and Human Development, announced in May 2000 the results of their first study to determine whether future drinking may be predicted by response to stress during infancy. According to NIAAA Director Enoch Gordis, M.D., "If borne out in humans, these findings elucidate the alcohol-stress relationship in two ways: They confirm that early life stress can influence later alcohol consumption, and they offer a promising biological marker of risk for excessive drinking."[68]

The K-Y Community Health Survey conducted in the year 2000 asked more than 1,030 respondents about their weekly alcohol use. Among 730 self-identified gay male respondents, 45.1 percent reported that they consume alcohol once a week or less, 28.4 percent reported using alcohol two or three times a week, and 14.6 percent reported using alcohol four times a week. Among 307 self-identified lesbian respondents, 57.4 percent reported using alcohol once a week or less, 20.5 percent reported consuming alcohol two or three times a week, and 14.6 percent reported using alcohol four times a week. Nearly 12 percent of gay males and nearly 6 percent of lesbians who participated in the survey reported that they never use alcohol. Lesbians ranked alcohol abuse as the second highest health concern for the community, and more than 30 percent of gay men reported the same concern.[69]

26-13: Reduce the proportion of adults who exceed guidelines for low-risk drinking.

Most States in the United States and the District of Columbia collect data on alcoholic beverage sales data. For States with no such data, shipment data are obtained from the Beer Institute (which also includes data from the Distilled Spirits Council of the United States). State population estimates for persons aged 14 and older were obtained from the U.S. census. (To calculate State-level estimates of per drinker ethanol consumption, estimates of abstainers are taken from CDC's Behavioral Risk Factor Surveillance System.)

Future potential data sources for collecting LGBT-specific data relevant to this objective include the following:

- Alcohol Epidemiologic Data System, from NIAAA. Specific instruments include the National Alcohol Survey, a multistage-area probability sample of adult respondents, aged 18 and older whose ninth issuance was in 1995-96. (One variable was quantity/frequency measures of total alcohol consumption.)
- NIAAA and CDC's National Center for Health Statistics, National Health Interview Survey, Alcohol Sections, 1983 and 1988. Variables included detailed information on quantity and frequency of alcohol consumption.
- SAMHSA's National Household Survey on Drug Abuse. Variables include detailed information on consumption.
- National Institute of Child Health and Human Development and 17 other Federal agencies' National Longitudinal Study on Adolescent Health, Wave I (1994) and Wave II (1995), which includes a variable on alcohol consumption.
- U.S. Department of Labor, National Opinion Research Center and Center for Human Resource Research's National Longitudinal Survey of Youth (1979-97), a multistage, stratified area probability sample of youth aged 14 to 21. Variables include consumption of various alcoholic beverages.
- CDC's Youth Risk Behavior Survey.

Many of these surveys will be repeated in the future depending upon funding and interest. The dates given should be used only as reference points for previous iterations of the surveys.

26-17: Increase the proportion of adolescents who perceive great risk associated with substance abuse.

The perception of risk in using illegal drugs is an important factor in decreasing drug use. As perception of harm decreases, use tends to increase.[70] Therefore, youth, including LGBT and questioning youth, need to be informed of the many risks, such as HIV infection, associated with substance use. People who use or abuse drugs or alcohol sometimes reported being so high or intoxicated that they forgot to use a condom.[71] Therefore,

informing youth about the connection between substance use and other problem behaviors, such as unsafe sex, dating violence, and suicide, is critically important.

The 1998 National Household Survey on Drug Abuse found the percentage of adolescents aged 12 to 17 who perceive great risk associated with substance abuse is on the decline.[72] The percentage perceiving great risk in using marijuana once a month decreased from 40 percent in 1990 to 30.8 percent in 1998. The percentage of youth perceiving great risk in using cocaine once a month decreased from 63 percent in 1994 to 54.3 percent in 1998. Perception of risk in having five or more drinks once or twice a week decreased from 58 percent in 1992 to 47 percent in 1998.[73] Because NHSDA does not include sexual orientation or gender identity as a demographic variable in its data set, data on LGBT and questioning youth are not available. The attitude of influential adults about alcohol and other drugs is another critical predictor of attitudes in youth. It is important that surveys measure both identity and behaviors because questions about identity, behavior, and attraction often yield different response rates. Identity questions generally have the lowest response rate because many people involved in same-sex relationships do not identify with terms commonly used in surveys. Questions about behavior and attraction may be less intimidating or invasive for the respondent, and as a result, may produce more accurate information.[74]

Many adults who have regular contact with youth communicate ambivalent messages about alcohol and drug use.[75] This may be particularly true for LGBT and questioning youth whose primary venues for "coming out" are bars and clubs. LGBT adults who consume alcohol, drugs, and tobacco products may have a powerful role in influencing young LGBT people's perception of risk. As a result, the messages about harm and risk that they receive are sometimes impacted by LGBT community dynamics and denial. Risk and harm messages targeted to youth, including LGBT youth, therefore, must take this into account.

26-18: (Developmental) Reduce the treatment gap for illicit drugs in the general population.

Healthy People 2010 defines treatment gap as "the difference between the number of persons who need treatment for the use of illicit drugs and the number of persons who are receiving treatment in a given year." The document estimates that, given this definition—which includes illicit drugs only—5.3 million Americans are in need of treatment services that are not available.

Healthy People 2010 also addresses the critical gap in treatment services for alcohol problems, but does not estimate the number of individuals for whom services are not available, suggesting only that ". . . availability of resources and access to clinically appropriate and effective treatment for alcohol problems are limited." However, an estimated 5.6 million individuals meet the diagnostic criteria for alcohol abuse, and it can be assumed that a significant proportion of them do not have access to treatment. There have been no specific studies of treatment gaps for the LGBT population; there are therefore no precise numerical estimates of treatment gaps. Although there have been rough estimates of needs for treatment for specific populations based on proportions in the general population, these are not considered to be of adequate validity.

There is evidence that "gay men and lesbians . . . have increased need for drug and alcohol treatment, and that they face particular barriers in accessing it."[76] The barriers to treatment for both illicit drugs and alcohol, several of which are cited in Healthy People 2010 for the general U.S. population, are essentially the same for the LGBT communities:

- Financial barriers that result from public funding mechanisms (e.g., Substance Abuse Prevention and Treatment Block Grant Program, Medicaid, Medicare, demonstration programs) and from private-sector funding sources (which may allocate only a limited number of treatment slots)
- Financial barriers related to inadequate health and disability insurance coverage
- Lack of culturally appropriate treatment methods
- Lack of trained personnel
- Lack of knowledge and information regarding treatment effectiveness

26-21: (Developmental) Reduce the treatment gap for alcohol problems.

Little attention has been paid to the lack of treatment programs designed to reach LGBT populations. There are presently no requirements that block grant programs, or other Federal grant programs, include LGBT populations in the classification of "vulnerable" populations that could be targeted through these funding mechanisms. Through demonstration research programs (e.g., CSAT-sponsored targeted capacity grants), several treatment programs that target LGBT populations have been funded and are participating in cross-site studies of treatment effectiveness. Some treatment programs funded through other federally funded initiatives (e.g., Residential Programs for Women and Their Children) and other State-funded programs have services that meet the specific needs of LGBT populations. However, most of these are outpatient programs.

Self-help groups are another source of treatment. According to Beatty and colleagues, as of 1999, the Fellowship of Alcoholics Anonymous (AA) reported that, in addition to the more than 500 AA gay groups in the United States, many AA groups are "gay-friendly," and Women for Sobriety, although not as widespread as AA, is increasingly used by lesbians, who find the support more culturally appropriate. However, the authors note, "gay-specific inpatient treatment centers are scarce, considering the number of gay individuals with alcohol and drug abuse problems."[77]

Education and training of treatment program staff in cultural issues related to and appropriate services for the LGBT population are critical if the availability of effective services is to be enhanced. Whether or not the number of treatment slots is increased, treatment staff must be adequately prepared to provide culturally appropriate and LGBT-competent treatment services for alcohol and other drug use as well as for the physical, mental health, and other service needs associated with substance abuse. Citing a 1991 report, Dean suggests that "Assessments of alcohol and drug treatment facilities have

documented lack of staff training in treatment issues for gay and lesbian alcoholics, and few or no gay staff."[78]

There also is a need for LGBT-specific standards of care and protocols that are generally acceptable or sanctioned by national accreditation bodies (e.g., American Society of Addiction Medicine, Health Care Quality Assurance). Such standards could be used as the basis for certification of clinical staff or licensing of treatment programs as well as the basis for staff training programs.

Adequate data are needed to estimate the need for, demand for, access to, and availability of treatment facilities for LGBT populations. As with Healthy People 2010, this Companion Document recommends that the National Household Survey on Drug Abuse be reviewed as a potential data source. In order to use this periodic survey to obtain useful data on various aspects of treating LGBT populations for substance abuse, specific questions regarding gender identity, gender presentation, sexual orientation, and sexual practices would have to be added to the current survey instrument. In addition to this survey, three additional federally supported surveys are potential sources of data: (1) Treatment Episodes Data System (SAMHSA), (2) National Hospital Ambulatory Medical Care Survey (CDC), and (3) National Health Interview Survey (CDC). As with NHSDA, questions regarding gender identity/presentation and sexual orientation/practices would have to be added to these surveys. For the latter two, specific questions regarding access to and use of alcohol and other drug treatment would be added.

In addition to these national data sets, both public (Federal and State) and private (foundation, corporation, and third-party payer) funding should be significantly expanded to support research related to treatment-seeking behavior by the LGBT population. Additional research is also needed on the availability of culturally appropriate alcohol and other drug treatment services and effectiveness of treatment in the LGBT population. These studies could be supported through existing Federal initiatives (e.g., CSAT Expanding Capacity program) or through new initiatives directed toward the LGBT population. The studies could include both quantitative and qualitative research methods.

There are no available research studies that have identified best practices among alcohol and other drug treatment programs. LGBT-specific standards for existing treatment services are severely lacking, and LGBT-identified and LGBT-appropriate programs for those who need and could benefit from them are not widely available. Anecdotal evidence suggests that alcohol and other drug treatment programs frequently fail to consider the identities and needs of transgender persons, thereby compromising effectiveness. Treatment personnel may inappropriately require transgender persons to conform to the gender of their birth sex. In the case of inpatient treatment programs, this may result in persons who live full-time as women being housed with men or being required to use male rest rooms. Such policies predictably interfere with the treatment relationship and are not conducive to recovery. Programs may also inappropriately require transgender persons to stop using cross-gender hormones as part of a treatment or detoxification protocol. This can cause significant mental distress and can reduce treatment adherence and effectiveness.

26-23: (Developmental) Increase the number of communities using partnerships or coalition models to conduct comprehensive substance abuse prevention efforts.

According to Healthy People 2010, "a comprehensive program of interventions at the community level is crucial to effective substance abuse prevention." Citing a study of 48-community partnerships funded by SAMHSA's Center for Substance Abuse Prevention (CSAP), Healthy People 2010 describes seven characteristics that are shared among partnerships in communities showing statistically significant reductions in substance abuse. These characteristics have been adapted to include treatment and prevention foci as well as findings of other studies of integrated (comprehensive) health and social service delivery programs and systems. Therefore, apparently successful partnerships or coalitions in communities showing statistically significant reductions in substance abuse treatment have:

- A communitywide vision that reflects the consensus of diverse groups and citizens throughout the community
- A strong core of community partners
- An inclusive, broad membership of organizations from all parts of the community
- Specific mechanisms for avoidance or resolution of conflict
- Decentralized groups that implement a large number of locally tailored prevention and treatment programs that effectively target local causes of drug use and empower residents to take action and made decisions
- Services that are culturally appropriate for the population(s) served
- Low staff turnover
- Clearly defined and implemented agreements among programs for referrals and shared resources
- Extensive prevention and treatment activities and support for improvements in local prevention and treatment policies

Neither this CSAP-funded research nor any readily available studies regarding community partnerships and coalitions related to substance abuse disaggregate information to indicate the level of involvement of LGBT organizations and individuals in such community partnerships and coalitions. There are examples of involving LGBT organizations (primarily gay organizations) in community coalitions formed to address HIV/AIDS. However, there is no evidence that LGBT representatives or organizations have been involved on a routine basis in the planning and implementation of programs funded by federally supported initiatives related to integrated services (e.g., Starting Early Starting Smart, HIV Outreach).

Research on the impact of partnerships and coalitions on the incidence and prevalence of alcohol and other drug use and on treatment effectiveness is minimal. The only available

study of impact of prevention-focused programs is the CSAP-funded study cited above. That study, however, does not provide data regarding the involvement of LGBT organizations or individuals in the partnerships. Because of the increasing attention to community-based partnerships and integrated services, it is important that research related to the impact of these efforts on substance abuse treatment outcomes among the LGBT population be supported.

Services—RECOMMENDATIONS

- Health education and prevention-oriented materials on health risks related to substance abuse should be developed for and directed to LGBT youth.
- On college campuses, where binge drinking often occurs, LGBT students or local LGBT-friendly health clinics need to be included in health education and prevention programs aimed at reducing binge drinking.
- Providers should review how consumer data are collected for statistical purposes, program reporting requirements, and funding or reimbursement sources and should discuss with the data collection entities how best to collect baseline data on health needs and services usage by LGBT consumers.

Education and Training—RECOMMENDATIONS

- Mental health and substance abuse counselors should receive cultural competency training that includes addressing the health and other needs of LGBT youth and adults.
- Substance abuse and mental health providers, as well as LGBT persons, need to be made aware that people who meet the "disability" eligibility criteria in Medicare may be eligible for Medicare-covered alcohol and other drug treatment services.
- Culturally competent health education materials on low-risk drinking, or responsible alcohol use, and high-risk drinking need to be developed for and directed to the LGBT community.

Policy—RECOMMENDATIONS

- Federal and State funding for health services programs need to be linked to community-based prevention and treatment efforts; LGBT persons need to be included in the community-based planning process along with representatives from other underserved or unserved populations; and cultural competency guidelines need to be established so that individuals are not denied access to care based on their sexual orientation or gender identity.
- Community partnerships and coalitions should seek cultural competency training and technical assistance from LGBT organizations and service agencies so community planners may better understand and incorporate the health care needs of LGBT populations into planning efforts.

- Federal and State governments should develop demonstration projects that support community partnerships and coalitions that are convened to address the substance abuse prevention and treatment needs of LGBT communities.

Research—RECOMMENDATIONS

- Sexual orientation and gender identity should be included as demographic variables in national substance abuse surveys, such as NHSDA and the Monitoring the Future Study.
- Model programs for school youth education programs that address homophobia and drug abuse should be developed.
- Additional studies are needed to assess the drinking habits of midlife and older LGBT individuals.

Terminology

Alcohol abuse: A maladaptive pattern of alcohol use that leads to clinically significant impairment or distress, as manifested by one or more of the following occurring within a 12-month period: recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home; recurrent alcohol use in physically hazardous situations; recurrent alcohol-related legal problems; or continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol. In the literature on economic costs, alcohol abuse means any cost-generating aspect of alcohol consumption; this definition differs from the clinical use of the term, which involves specific diagnostic outcomes.

Alcohol dependence: A maladaptive pattern of alcohol use that leads to clinically significant impairment or distress, as manifested by three or more of the following occurring at any time in the same 12-month period: tolerance; withdrawal; often taking alcohol in larger amounts or over a longer period than was intended; persistent desire or unsuccessful efforts to cut down or control alcohol use; spending a great deal of time in activities necessary to obtain alcohol or recover from its effects; giving up or reducing important social, occupational, or recreational activities because of alcohol use; or continued alcohol use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.

Binge drinking: Defined by the National Household Survey on Drug Abuse as drinking five or more drinks on the same occasion on at least 1 day in the past 30 days; defined by the Monitoring the Future Study as drinking five or more drinks on the same occasion during the past 2 weeks.

Co-occurring disorders: The simultaneous presence of two or more disorders, such as the coexistence of a mental health disorder and substance abuse problem.

Drug dependence: A pattern of drug use leading to clinically significant impairment or distress, as manifested by three or more of the following occurring at any time in the same 12-month period: tolerance; withdrawal; use in larger amounts or over a longer period of

time than intended; persistent desire or unsuccessful efforts to cut down; spending a great deal of time in activities necessary to obtain drug(s); giving up or reducing important social, occupational, or recreational activities; or continued use despite knowledge of having a persistent or recurrent physical or psychological problem.

Inhalants: Fumes or gases from common household substances, such as glues, aerosols, butane, and solvents, that are inhaled to produce a high.

Injection drug use: The use of a needle and syringe to inject illicit drugs (e.g., heroin, cocaine, steroids) into the vein, muscle, skin, or below the skin. Injection drug use places the user at great risk for transmitting or contracting a number of blood-borne infectious diseases, including HIV, hepatitis B, and hepatitis C.

Substance abuse: The problematic consumption or illicit use of alcoholic beverages, tobacco products, and drugs, including misuse of prescription drugs.

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