NAOMI LEVITSKY The College at Brockport State University of New York

Looking into the Prevalence of Substance Abuse among the LGBTQIA+ Population

In this essay, I explore the prevalence of and reasons for substance abuse among the Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, & Asexual, or LGBTQIA+ community and ways to lessen the stigma and provide for more adequate treatment opportunities.

Introduction

In this essay, I explore the prevalence of and reasons for substance abuse among the Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, & Asexual (or LGBTQIA+) community and ways to lessen the stigma and provide for more adequate treatment opportunities. This topic is important because marginalized voice and perspectives matter, and this topic has not nearly garnered the attention and research it deserves. I hope that readers will become more informed and educated on this topic, and hopefully feel compelled to inform others and spread the word. My research is comprised of a case study with a health professional who works at a community health center serving LGBTQIA+ populations, as well as literature to inform my findings. It is crucial as a researcher for me to acknowledge my location to my research: I do not identify as LGBTQIA+ or as someone in recovery, however, I double major in Alcohol and Sub-

stance Studies and Woman and Gender Studies, and I want to work with and feel a deep passion to learn and advocate for marginalized populations.

As a preface to the research, I consulted with Jess Cohen, a health educator at Trillium Health, which is a "Federally-Qualified Health Center Look-Alike" (personal communication, March 4, 2021). Trillium Health's mission is to "promote health equity by providing affordable and extraordinary primary and specialty care, including LGBTQ+ health care" (Trillium Health, n.d.). I chose to speak with Cohen because Trillium Health represents a progressive stance on substance abuse treatment and LGBTQIA+ affirming healthcare, and Cohen's insight is valuable in understanding factors that may lead to the prevalence of substance use among the LGBTQIA+ community. In addition, she helps give insight on different approaches to treatment and healthcare to better serve and support this community.

What is the Prevalence of Substance Abuse among the LGBTQIA+ Population?

My research suggests there is not much dispute or disagreement among researchers that the prevalence of substance use among the LGBTQIA+ community is higher than that among the heterosexual population. Some estimates are as high as 20% to 30% (Hunt, 2012, p. 1). Further, Phillips et al. (2020) reference a 2015 national survey on drug use in which 41.1% of sexual minority women and 36.3% of sexual minority men reported drug use within the past year. Phillips et al. also acknowledge higher levels of substance abuse among the transgender community. They find that this population is difficult to measure, so researchers lack statistics pertaining to the research.

It is important to point out that the prevalence of different drug substances changes across different demographics, such as lesbian women, bisexual men, transgender women, and transgender men. I do not want to generalize or group together different populations who may face very different struggles, which is important to consider when reading this paper. Published research on the relationship between the LGBTQIA+ population and substance use is relatively modern. Studies lack generalizable numbers of sub-categories of participants for me to speak with certainty on different sub-populations within the LGBTQIA+ community.

The real question that I will be exploring is why LGBTQIA+

individuals may be at higher risk for substance use. If we are aware that the prevalence is higher, what are we doing to combat this and provide LGBTQIA+ identifying people the resources and help they need? Current literature only partially answers these questions, as research on the prevalence of substance use among the LGBTQIA+ population is lacking. More studies and research is needed to make any generalizable claims. So, I first want to walk through the multitude of reasons I've found in my research thus far that summarizes why the LGBTQIA+ community is disproportionately affected by substance use disorders.

Theories on Prevalence

A re-occurring theory on why substance abuse among the LGBTQIA+ population is higher than the general population is the minority stress theory (Felner et al., 2019). Drabble and Eliason (2012) suggest that minority stress relates to the internal and external factors relating to one's sexual orientation or gender identity that correlates with stress. Felner et al. (2019) note that LGBTQ-related stressors may lead to negative mental health outcomes and associated maladaptive coping behaviors that include substance use. To give some understanding of what these stressors may look like, Drabble and Eliason (2012) use the examples of internalized heterosexism stemming from feelings of shame, alienation, guilt, and isolation rooted in religious or moral attitudes of sexual and gender minority individuals. Drabble and Eliason also suggest that minority stress stems from external heterosexism that may look like harassment, discrimination, or violence.

To further understand this theory, Cohen gave insight into her observations as a clinician on different aspects that may contribute to the marginalization of LGBTQIA+ people, which in turn may lead to maladaptive coping mechanisms. Cohen was able to offer insight on why substance use prevalence may be higher among the LGBTQIA+ population, based on her clinical experience:

> Through observation, I would say that stigma stress is a large contributor to alcohol and substance use in the LGBTQ+ community. Lack of family support, housing insecurity, food insecurity, the experience of discrimination, harassment, and bullying—all of these things can result in use of unhealthy coping tools. Internalized homophobia and transphobia can also increase alcohol and substance use, as it may lower inhibitions and soothe anxiety while folks are exploring their gender identity and/or sexual orientation (J. Cohen,

personal communication, March 4, 2021).

Stigma stress and minority stress can be used somewhat interchangeably, and the wording varies between sources (Chaney & Brubaker, 2012; Felner et al., 2019

). Another factor that contributes to this stress is "high rates of HIV and diminished mental health" (Chaney & Brubaker, 2012, p. 235). HIV and AIDS disproportionately affect LGBTQIA+ individuals than the general population and may add stress to their day to day lives. Adding to this, an analysis done by Klein and Ross (2014) finds that "more than 90% of LGBTQ patients had a co-occuring Axis 1 mental health disorder" (p. 311). For clarity however, it is important to note that this study only collected a small sample of data, and the sample was too small to look for differences between the LGBTQIA+ community.

Through analyzing the literature from different sources, it is apparent that the stigmatization and discrimination faced by the LGBTQIA+ population at a higher rate contributes and relates to the high levels of mental illness and substance abuse among this population. Despite this, other research indicated that minority stress theory (Felner et al., 2019) may not be the only reason behind the prevalence of substance abuse among the LGBTQIA+ community. Cohen was able to give other insight on why she believes that the prevalence of substance abuse is higher among this community:

Normalization of alcohol and substance use within the community is also a factor. The biggest sponsors of Pride events often are alcohol companies—Absolut Vodka, Barefoot wine, Stoli, etc. It is common to go to a pride event and see freebies from alcohol companies being worn by both adolescents and adults. Free rainbow Mardi Gras beads are, of course, coveted by newly out teens. Most teens do not care that they also have a large sticker on the medallion advertising an alcohol company. Folks from marginalized communities like to see themselves represented in media, marketing, etc. Alcohol companies have been good at marketing to this community.

This is such a significant finding and was not something that I was familiar with prior to this research, but while reading literature, I came to find that this phenomenon has been going on for very long in this country and relates to the "gay bar" scene as well. Seinreich and Vairo (2014) note that substance use patterns at social gatherings and the availability of illicit substances and

alcohol at gay bars and clubs throughout history have served as social reinforcement for the use of these illicit substances for LGBTQIA+ individuals. Some of the literature (Phillips et al., 2020) suggests that gay bars may serve as a safe space for individuals to socialize and interact with other LGBTQIA+ people, and holds significant historical context. But, with the readily available alcohol and other substances at bars and clubs, I question if these spaces are actually catalyzing addiction for people in these communities. Both of these reasons for the prevalence among this community have been researched and studied. I believe that clinicians and researchers need to now apply what has been learned to developing substance abuse treatments that will better serve the LGBTQIA+ population.

What Can Be Done?

Research suggests that there are many different ways that substance abuse counselling could be more effective to the LGBTQIA+ population. My interview with Cohen about the programs offered at Trillium Health informed me that the implementation of progressive, harm-reduction treatment options. I believe these methods need to be more widespread and universal in health care.

A significant study by Felner et al. (2019) used 59 qualitative interviews with individuals identifying as LGBTQIA+, who met criteria for a substance use disorder, to conceptualize their substance use and how it related to their identity. Based on the findings of this study, Felner et al. provided treatment recommendations for health providers working with the LGBTQIA+ population:

> Providers should explicitly address experiences of multilevel LGBTQ-related stressors and sociocultural influences and concurrent substance abuse during identity development…Identification of harmful or avoidant coping strategies may be especially useful for preventing the development of substance use disorders among young adults (p.118).

My interpretation of the preceding statement is that clinicians need to incorporate the clients gender identity or sexual identity, or both, and the experiences that go along with that identity into counselling, as it can be a very important part of treatment and healing. Felner et al. (2019) also suggest that "providers should embrace 'cultural humility' as a guiding approach to their interactions with clients" (p. 118). The research notes that in many states across the United States, the number of hours

of cultural competency required for clinicians is fifteen, as well as yearly ongoing competence of twenty hours (Seinreich & Vairo, 2014). I do not believe this is enough, and I emphasize the importance of ongoing education when it comes to counselling different marginalized groups.

Another suggestion Felner et al. (2019) makes pertaining to counselling considerations is that "providers should stay abreast of current LGBTQ rights-related policies, because they may profoundly affect clients' mental health and substance use" (p. 118). Their research suggests treatment providers should inquire about the clients' social network and support as well as the type of role substance use plays in their interactions (Felner et al., 2019). This relates to the idea of gay bars and the prevalence of illicit substances available in these spaces. The last suggestion Felner et al. make is that treatment facilities be welcoming and open to LGBTQIA+ people, using LGBTQIA+ affirming practices with clients. This would include the provision of gender-neutral bathrooms, LGBTQIA+-specific reading materials, LGBTQ-inclusive screening procedures, more options on questionnaires than just female, male, or other, as well as HIV preventative health care. Those are just a few examples, but there are many more small and big changes that could be implemented in treatment facilities to make them more inclusive and welcoming. It is important to acknowledge the limitations in Felner et al.'s study, as it only included 59 participants. This sample size is not generalizable, but the study still yields important knowledge that is relevant and useful.

Through conversation with Cohen, I was able to further understand that her position at Trillium Health includes "providing education to health care professionals with the aim of reducing healthcare disparities experienced by LGBTQ+ communities" (personal communication, March 4, 2021). Cohen told me about multiple Trillium services offering gender affirming and inclusive options, such as: Transgender affirming primary care, Hormone replacement therapy, trans-specific medical care, an LGBTQ+ Care Manager, trans support group, behavioral wellness, letters for surgery (for patients only), name change and gender marker assistance, Coming Out Kits for individuals and families, a Sober Space program aimed to increase sober socialization outside of the 12-step groups, specialty care for those with HIV/AIDS, as well as off-site gynecological and wellness care, and the

MOCHA center. The MOCHA center stands for "Men of Color Health Awareness Project" (Trillium Health, n.d.). It began in 1996 to serve a more specific population of men, but partnered with Trillium Health and expanded its services into a community health center for LGBTQIA+ People of Color (Trillium Health, n.d.).

Trillium also offers a harm reduction program that offers "safe disposal of used syringes, acquisition of new, unused, clean syringes; referral to local substance abuse treatment; Opioid-overdose-reversal kits and education (Narcan); and education on safer injection, including access to new 'works'" (J. Cohen, personal communication, March 4, 2021). For context, the works are the "kit" that people use to take certain drugs, such as a spoon, syringes and other supplies to ingest drugs. As can be seen from the multiple services offered at Trillium, they strive for inclusivity among many different underserved communities in Rochester, NY. Trillium continues to expand their services through application of many of the recommendations of Felner et al. (2019) to their ethics, such as gender expansive and inclusive healthcare as well as the provision of safe and sober spaces for LGBTQ+ people to connect and socialize. Trillium's harm reduction approaches to addiction, such as needle exchange, are approaches still considered to be somewhat taboo in the addiction community, due to the view that abstinence is the only goal in treatment. Trillium Health reflects a very progressive stance on substance abuse and how we can more effectively counsel and support the LGBTQIA+ community. Trillium Health models a clinic that every clinic should strive for in terms of cultural competency and expansive and inclusive health care.

Obstacles to Progress

There are many barriers to access to this kind of health care. Research suggests that an aspect that affects access to more affirming health care is location and demographics. Willging et al. (2018) note that the distance an individual lives from services and resources can be a barrier for LGBTQIA+ individuals seeking culturally competent treatment. In addition, social support from other LGBTQIA+ peers may not be available in more rural areas, as these individuals may not be comfortable being visible. Another obstacle Cohen faces in her job is funding:

> This is a grant-funded position, so money is always a barrier. Additionally, our agency is able to provide many of

> the patient-centered services through 340-B funding (NY prescription drug reimbursement program) that is now in danger of being axed in the state budget (personal communication, 2021).

Only one of these barriers could make it harder to access treatment, but if you are struggling with both money and a rural geographic location with inadequate resources, it would be incredibly difficult to seek the medical care you need.

Another obstacle for people seeking effective treatment is the view that insurance companies may have on substance abuse treatment. Cohen explains:

> It is frustrating that folks are kept from adequate treatment because of financial and insurance limitations. If insurance companies said that folks with breast cancer only were able to access 28 days of care per year, there would be outrage. We need to step away from the idea that addiction and/or recovery is a choice. In my opinion, even within some recovery communities, there is an enormous amount of responsibility put on an individual for 100% of their recovery. Telling someone that they relapsed because they "just didn't want recovery" is not helpful or true. Do we continue the current substance use/dependence treatment protocol because it is truly what we think will help folks recover, or is it because there are external limitations (such as insurance, financial, etc.) that prevent us from providing care that people need (personal communication, 2021)?

Cohen's insight was truly invaluable to me from a clinician standpoint, as I do not have much familiarity with insurance coverage. Putting it in a perspective of what insurance covers pertaining to cancer versus substance abuse treatment helped open my eyes to how systemic the stigma on addiction is. Some individuals may need treatment that spans months to years, but may not be able to have this continuum of treatment which may contribute to more inadequate treatment outcomes and possible relapse.

Intersectionality

An important variable in the lives of many LGBTQIA+ individuals is intersectionality. The term intersectionality was coined by Kimberlé Crenshaw, an activist and law professor, over three decades ago (Satovec, 2017). In Crenshaw's own words, "race, gender, and other identity categories are most often treated in mainstream liberal discourse as vestiges of bias or domination-that is, as intrinsically negative frameworks in which social power works to exclude or marginalize those who are different" (1991, p. 1242).

It is crucial to my research to include an intersectional perspective on the prevalence of substance use among the LGBTQIA+ population, as many people have multiple, intersecting identities that can be oppressive. Seinrich and Vairo (2014) suggests that non-white LGBTQIA+ individuals may be using substances as a way to cope with not only oppression pertaining to their sexual orientation, but racism as well. Understanding the relationship between intersecting factors of identity and substance abuse prevalence is important in conceptualizing a solution.

LGBTQIA+ people of color are an understudied population, and finding research that pertains specifically to this population is few and far between. However, I was able to find some significant research that shines light on these intersectional experiences that many face. A first important note to make is that although African American and Latinx populations have lower rates of illicit drug use than that of white individuals, the rates of arrest and length of sentencing is disproportionally affected by people of color (Drazdowski et al., 2016). Although arrest rates do not specifically pertain to LGBTQIA+ people of color, I argue that this population is disproportionally impacted by racism in the prison industrial system, which makes LGBTQIA+ individuals more vulnerable in this regard. Reflecting on minority stress (Felner et al., 2019) and how LGBTQIA+ people of color may face this stress in two or more aspects of their identities, and then compounded with the threat of going to prison and being disenfranchised at disproportionate rates, I believe that this population will stay at a disadvantage until society changes in major, systemic ways. The MOCHA Center is one Trillium Health resource that Cohen shared with me. Cohen explained that "the MOCHA Center, located at 470 West Main Street, provides LGBTQ+ communities of color a safe place to network, socialize, and address any health issues you face" (personal communication, 2021) Resources like these can be crucial for LGBTQIA+ people of color to find support and community. I suggest that resources like the MOCHA Center need to become more widespread in this country. You cannot grow and thrive as a person if you are not supported, understood, and validated.

Another aspect of intersectionality that may lead to oppression of individuals in treatment is the possible lack of diversity in clinicians. Dominguez (2017) observes that diversity among clinicians' identities

continues to lag behind the growing diversity of the general population. This lack of diversity among clinicians may lead to cultural mismatching in the client/clinician relationship, which increases the likelihood of miscommunication and inadequate treatment outcomes for these individuals (Dominguez, 2017). Speaking from knowledge gained as an Alcohol and Substance Abuse Studies major, I have learned that the therapeutic relationship between client and clinician is a crucial part of recovery. Without that strong therapeutic foundation, I cannot conceptualize treatment being as successful, which leads into the increased need of cultural competence for counselors. As stated above, the requirements for counselors in most states are between 15-20 hours as well as yearly ongoing competency trainings, but I think it goes beyond that. To become culturally competent, you need to possess cultural sensitivity, humility, and competency (Dominguez, 2017). Cultural sensitivity pertains to "the clinician's approach to patient interactions, encouraging a constant awareness that cultural differences exist, with a desire to understand them without passing judgement" (Dominguez, 2017, p. 207). Sensitivity comes from discarding the view that western ways of living are the norm and best practice, and making the effort to understand a different lens and worldview based on their experiences.

A last aspect of intersectionality I will discuss is the identity of being LGBTQIA+ with a low socio-economic status and seeking substance abuse treatment. Coming from a low socio-economic status can create many barriers when trying to access treatment. Knowing the barriers and available resources for this population may lessen the gap of adequate treatment. Through my research on this topic, it seems that results are limited. More research needs to be done to draw any hallmark conclusions.

Ross et al. (2018) analyze mental health experiences and the outcomes of LGBTQIA+ individuals living in poverty in ways that relate closely to substance abuse treatment. The data suggests that LGBTQIA+ individuals living in poverty are correlated to employment discrimination and other disruptions of education or employment related to mental distress (Ross et al., 2018). There are many other factors that intersect and that may point to why LGBTQIA+ people face poverty and may be unable to access adequate mental health treatment. The findings of Ross et al. (2018) suggest that access to mental

health services may not be the main disparity for individuals with intersectional identities, but instead, having unmet needs during health care relating to complex intersecting identities. This relates to the counselling considerations discussed previously regarding the need for clinicians to be culturally sensitive, competent, and also demonstrate humility. Another aspect discussed in the literature is the stigmatization that low socio-economic people may be incorrectly labeled as lazy or unmotivated and therefore undeserving of government assistance (Ross et al., 2018). This notion, compounded with the stigma surrounding LGBTQIA+ identities, may be compounded for individuals with complex, intersecting identities and might lead to further oppression. The literature emphasizes the need to counteract the stigma by highlighting the resilience and hard work of low-income LGBTQIA+ individuals to succeed and thrive.

Call to Action

Now that you know all this information, the question is, what can you do to combat these disparities? As a student, I cannot help but feel powerless at times to these systemic issues in our society. However, I find my voice in writing and speaking on topics that I am passionate about. This essay has been a very empowering process to speak on behalf of individuals who may not share the platform. I asked Cohen what she believes we can do to make meaningful change and end the stigma surrounding LGBTQIA+ oppression and addiction issues:

> Continue to talk about alcohol and substance use disorders. I often speak about addiction as I would any other illness/disease. I think it is important to not de-humanize folks living with alcohol and substance use disorders. But everyone is someone. Just as cancer may make someone incredibly ill to the point of being almost unrecognizable, the same is true for addiction. But that doesn't mean that folks will stay ill. We just need to continue to support and increase access to treatment.

The compounded and complex identities that I have discussed based on my research may lead to de-humanization of individuals, and that is a harmful and oppressive mindset. To create meaningful change surrounding addiction, we need to look for the root of what may cause individuals to start using substances. Identify where, as a society, we can better support these individuals both before and after substance use. This may include funding

continued research on substance use disorders as well as the clinics supporting LGBTQIA+ and low-income individuals such as Trillium Health. It also may include educating yourself on LGBTQIA+ issues and terminology, as well as having tough conversations with friends and family who may not understand. The way we lessen stigma is by normalizing conversation on LGBTQIA+ issues and speaking up for others whose voices and perspectives have historically not been listened to and valued.

What can you do? Where in your community can you have an impact? Who is responsible for making change in your network? What resources are available in your community for LGBTQIA+ individuals? From the wise words of Nelson Mandala: "We can in fact change the world and make of it a better place" (2009a), and "It is in your hands to make a difference" (2009b). Thank you for taking the time to read this, and I hope you feel empowered to make change.

References

CHANEY, M. P. & BRUBAKER, M. D. (2012). Addiction in LGBTQ communities: Influences, treatment, and prevention. *Journal of LGBT Issues in Counseling, 6*(4), 234-236, DOI: 10.1080/15538605.2012.725649

DOMINGUEZ, M. L. (2017). LGBTQIA people of color: Utilizing the cultural psychology model as a guide for the mental health assessment and treatment of patients with diverse identities. *Journal of Gay and Lesbian Mental Health*, *21*(3), 203-22, https://doi.org/10.1080/19359705.2017.1320755

DRABBLE, L. & ELIASON, M. J. (2012). Substance use disorders treatment for sexual minority women. *Journal of LGBT Issues in Counseling, 6*(4), 274-292, DOI: https://doi.org/10.1080/15538605.2012.726150

DRAZDOWSKI, T., PERRIN, P., TRUJILLO, M., SUTTER, M., BENOTSCH, E., & SNIPES, D. (2016). Structural equation modeling of the effects of racism, LGBTQ discrimination, and internalized oppression on illicit drug use in LGBTQ people of color. *Drug and Alcohol Dependence*, 159, 255–262. https://doi.org/10.1016/j.drugalcdep.2015.12.029

FELNER, J. K., WISDOM, J. P., WILLIAMS, T., KATUSKA, L., HALEY, S. J., JUN, H. & CORLISS, H. L. (2019). Stress, coping, and context: Examining substance use among LGBTQ young adults with probable substance use disorders. *Psychiatric Services. 71*(2), 112-120, DOI: https://doi.org/10.1176/appi.ps.201900029

KLEIN, A. A. & ROSS, B. L. (2014). Substance use and mental health severity among LGBTQ individuals attending Minnesota model-based residential treatment. *Journal of Gay & Lesbian Social Services. 26*(3), 303-317, DOI: https://doi.org/10.1080/10538720.2014.924459

CRENSHAW, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review, 43*(6), 1241-1300.

HUNT, J. (2012). *Why the Gay and Transgender Population Experiences High Rates of Substance Use: Many Use to Cope with Discrimination and Prejudice*. Center for American Progress. https://cdn.americanprogress.org/wp-content/uploads/issues/2012/03/pdf/lgbt_substance_abuse.pdf

MANDELA, N. (2009a, January 20). *Congratulatory message to President Obama* [Speech transcript]. The Nelson Mandela Foundation Archive at the Centre of Memory. http://atom.nelsonmandela.org/index.php/za-com-mr-s-1044

MANDELA, N. (2009b, April 20). *Statement by H.E. Nelson Mandela, former President of South Africa, to be read at the official opening ceremony of the Durban Review Conference, 20 April 2009*. The Nelson Mandela Foundation Archive at the Centre of Memory. http://atom.nelsonmandela.org/index.php/za-com-mr-s-1494

PHILLIPS, G., FELT, D., MCCUSKEY, D. J., MARRO, R., BROSCHART, J., NEWCOMB, M. E., & WHITTON, S. E. (2020). Engagement with LGBTQ community moderates the association between victimization and substance use among a cohort of sexual and gender minority individuals assigned female at birth. *Addictive Behaviors*. 107, 1-10, DOI: https://doi.org/10.1016/j.addbeh.2020.106414

ROSS, L., GIBSON, M. F., DALEY, A., STEELE, L. S., & WILLIAMS, C. C. (2018). In spite of the system: A qualitatively-driven mixed methods analysis of the mental health services experiences of LGBTQ people living in poverty in Ontario, Canada. *PLoS ONE 13*(8), https://doi.org/10.1371/journal.pone.0201437

SATOVEC, M. L. (2017). The necessity of intersectionality: A profile of Dr. Kimberle Crenshaw. *Women in Higher Education, 26*(3).

SEINRICH, E., & VAIRO, E. (2014). Assessment and treatment of lesbian, gay, and bisexual clients with substance use disorders. In S. L. A. Straussner (Ed.), *Clinical work with substance-abusing clients* (pp. 466-494). The Guilford Press.

TRILLIUM HEALTH. (n.d). About us. *Trilliumhealth.org.* March 8th, 2021. https://www.trilliumhealth.org

WILLGING, C. E., HARKNESS, A., ISRAEL, T., LEY, D., HOKANSON, P. S., DEMARIA, C., JOPLIN, A. & SMILEY, V. (2018). A mixed-method assessment of a pilot peer advocate intervention for rural gender and sexual minorities. *Community Mental Health Journal. 54*(4), 396-409, DOI: http://dx.doi.org.brockport.idm.oclc.org/10.1007/s10597-017-0168-x