SUPPORT ACT GRANT
101:19
SUD & LGBTQ+ CLIENTS
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DISCLAIMER

• The information contained in this material can change as we learn more about the brain and the ways it is impacted by the environment, trauma, medications, substances of misuse, and other things.

• Always follow the guidelines of your agency, ethical and legal standards of your certifying Board, evidence-based practice methods; local, state and Federal laws as well as your judgement and commonsense when working with clients.
If you have any questions, please do not hesitate to contact me

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SUPPORT ACT COURSES

1: Tele-Behavioral Health in the Time of COVID-19 (No longer available—Incorporated into all courses!)
2: Client Engagement
3: Suicide
4: Crisis & De-Escalation
5: Withdrawal Syndromes & Withdrawal Management
6: Trauma-Informed Care
7: Overview of SUD
8: Opioids & Stimulants
9: SUD Treatment Basics
10: Screening & Assessment
11: Co-Occurring Disorders
12: Individual Therapy Skills
13: Group Therapy Skills
14: Addressing SUD Bias & Building Provider Empathy
15: SUD & Cultural Humility
16: SUD Treatment & the Family
17: Alcohol & Cannabis
18: SUD & Legal System-Involved Clients
19: SUD & LGBTQ+ Clients
20: “Novel” Substances of Use
I. Introduction: Stigma

II. Gay, Lesbian, Bisexual, Transgender and Non-Binary Populations

III. Tele-Behavioral Health Basics
I believe in using “Person-Centered language” as much as possible, thus:

- Not “Addict,” but **Person who uses drugs** or **Person with a substance use/behavioral disorder**
- Not “Addiction,” but **Substance Use Disorder (SUD)**
- Not “Clean,” but **In Recovery** or **Testing Negative**
- Not “Dirty,” but **Testing Positive**

At the same time, out of habit, I may inadvertently use some of these older words/terminology—and some of the sources I quote use older terms.

Be cognizant that some people may describe themselves as “alcoholics,” “junkies,” etc.
TWO IMPORTANT THINGS YOU MUST DO BEFORE WORKING WITH ANY CLIENT

I. **You must care!** You must like people in general regardless of their circumstances, behaviors or opinions of you.

II. **Find something to like** in the person you are working with—connect with them on a human level.
NO ONE sets out to become addicted to chemicals or behaviors.
Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual’s life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences.

Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases.

Adopted by the ASAM Board of Directors September 15, 2019
RECOVERY DEFINED

“...A lived experience of improved life quality and a sense of empowerment; that the principles of recovery focus on the central ideas of hope, choice, freedom and aspiration that are experienced rather than diagnosed and occur in real life settings rather than in the rarefied atmosphere of clinical settings. Recovery is a process rather than an end state, with the goal of being in an ongoing quest for a better life.”

(Best & Laudet, 2010 as cited in Morgan, 2019, p. 191)
STIGMA DEFINED

“Stigma is a social phenomena whereby individuals who deviate from the accepted norm are perceived by society as less desirable and are judged or punished accordingly”

(Avery & Avery, 2019, p. 94)
WHY IS THIS IMPORTANT?

Remember what we started with: People matter, regardless of what they are going through

Stigma is one of the main reasons that people with SUD do not seek treatment

Bias/Stigma ➔ Prejudice ➔ Discrimination
YOU & ME

• How do we appropriately address racial, age, cultural, sex, gender and socio-economic identities while still seeing the person we are working with as a unique individual?

• How do you practice genuine-ness?

Please keep these concepts in mind as we examine some specific groups in this course today.
BUT IF YOU REALLY KNEW ME...

THIS IS WHAT YOU SEE,
Waterline of Visibility

Value Systems
Life Experiences
Gender
Nationality
Skin Colour
Physical Ability
Ethnicity
Race
Wealth
Social Status
Culture
Religion
Age
Role/Function
Political Views
Personality Profile
Languages
Education
Talents
Perspectives
Beliefs
Skills
Work Style
Location/Division
Thinking Style
Family Status
Sexual Orientation
Sexual Identity
Sexual Orientation
Thinking Style
Family Status
Location/Division
Work Style
Perspectives
WHY IS THIS IMPORTANT?

- Most substance use disorder treatment was historically based on older, white, middle-upper class, heterosexual males
- Only recently have we begun to examine how SUD impacts women, adolescents, ethnic groups, and sexual minorities
- Even when we examine substance use disorder in the context of these differences, we need to remember that rarely does “one-size-fit-all”
  - (e.g., a person’s community and/or socio-economic level may play a larger role in their lives than their ethnic identity, sexual orientation or gender identity)
- We also need to be aware of cultural trends and our country’s historical treatment of these groups
- All of this influences treatment delivery
GAY, LESBIAN, BISEXUAL, TRANSGENDER AND NON-BINARY POPULATIONS
PLEASE BE AWARE THAT THE FOLLOWING SLIDES PRESENT BROAD VIEWS OF COMPLEX AND VARIED GROUPS: TREATMENT SHOULD ALWAYS BE INDIVIDUALIZED.
LGBTQ+: [Lesbian, Gay, Bisexual, Transgender, Questioning (and more)]; Acronym for “Optimal inclusion of individuals who may identify as being part of a sexual or gender minority group” (Marich, 2019, p. 5)
LGBTQ+ POPULATION

• This is a diverse population that is only now receiving attention in the U.S.

• There is a documented higher prevalence of substance use disorder in these communities overall; there does not seem to be a specific reason for this (NIDA, 2017)

• Sexual attraction, behavior and identity may coincide for some people but not for all (e.g. MSM vs. “gay”)

• Like other minority groups we have discussed, there is limited research regarding substance use and sub-populations of this diverse group
  • What research is conducted is largely on gay men and lesbian women, not on people who identify as bisexual or transgender

• There are few studies on LGBTQ+ persons who are also members of ethnic minorities
LGBTQ+ TERMINOLOGY

• **Androgynous**: Persons who prefer gender-neutral pronouns and may dress in a gender-neutral fashion

• **Asexual**: A lack of sexual attraction to others

• **Bisexual**: “Capacity for romantic and/or sexual attraction to more than one gender” (Marich, 2019, p. 5)

• **Cross-dressing**: Individuals who dress in other-gender clothing but do not experience a dissonance between their gender identity and their biological sex and do not wish to change their sex or gender (they often cross-dress for stress-relief, not entertainment purposes)
LGBTQ+ TERMINOLOGY

- **Fluid**: One’s attraction to people of the opposite or same sex is in flux and changes over time.
- **Gay**: Men who are attracted to other men.
- **Gender identity**: A person’s internal sense of being male or female regardless of their biological sex.
- **Intersex**: Persons born with ambiguous sexual anatomy or with the genitals of both sexes; they may report feeling neither male nor female.
- **Lesbian**: Women who are attracted to other women.
- **MSM**: Men who have sex with men, but who may not identify as gay.
LGBTQ+ TERMINOLOGY

- **Non-Binary**: “Gender identity and experience that embraces the full universe of expressions and ways of being that resonate for an individual” (Marich, 2019, p. 6)

- **Pan-Sexual**: An emerging replacement term for bisexual (poly- and omni- are also sometimes use) as a means to steer toward “many” as opposed to two (“bi”)

- **Queer**: Still seen as a pejorative term in some settings; “An umbrella term for sexual, gender, or lifestyle identity that defies heterosexual or mainstream norms” (Marich, 2019, p. 5)

- **Questioning**: A person is unsure or is exploring their gender and/or sexuality
LGBTQ+ TERMINOLOGY

- **Transgender**: An umbrella term that describes people who believe that the sex they were born into is at odds with the gender they feel themselves to be.

- **Transgenderists**: People who live and work in the other gender continuously, but do not wish to have sex reassignment/confirmation surgery.

- **Transsexuals**: Usually interested in hormone therapy or sex-reassignment/confirmation surgery.
  - **MTF**: Preoperative male-to-female
  - **FTM**: Preoperative female-to-male
LGBTQ+ TERMINOLOGY

• **Passing**: Being able to appear “heteronormative” to general society

• **Coming out**: The processes in which LGBT individuals self-identify and disclose to others their orientation and gender identity; “Some clients may need to come out in both gender expression and sexual orientation” (Anderson, 2009, p. 83)
LGBTQ+ TERMINOLOGY: HETEROSEXISM (HETERTONORMATIVE)

• More appropriate terms than “homophobia”
• Defined as a belief that heterosexuality is superior or more “natural” than homosexuality
• Like racism, classism, ageism, etc., heterosexism exists in passive and active forms and operates on individual, institutional, and societal levels
• People who are transgender can be further stigmatized by other sexual minorities
• Ethnic minorities may also be stigmatized within the larger LGBTQ+ community
LGBTQ+ TERMINOLOGY: INTERNALIZED HOMO/BI/TRANSPHOBIA

• “Most LGBT people internalize to some degree the negative messages perpetuated by society, resulting in feelings of shame regarding their sexual orientation or gender identity” (Anderson, 2009, p. 42)

• Alcohol and other drugs may aid the person by disassociating from these feelings or help them to act on (or further suppress) these feelings

• When we consider the higher rates of developmental trauma in the LGBTQ+ communities, and the correlation between SUD and trauma, we can begin to understand possible reasons for higher SUD in the LGBTQ+ communities
SHAME: Negative association with a stigmatized group

“It greatly depends on the sources of shame as to whether its possession may become a force for recovery or a factor that prolongs addiction” (Avery & Avery, 2019, p. 21)

“Consider now one example of a specific effect of looping and self-stigma: Addictive consumption in response to shame, where the shame of use turns out to be cyclical and self-perpetuating – individuals with SUDs consume in order to wipe out the shame they are feeling, and in the process they perpetuate the very condition from which they are attempting to free themselves” (Avery & Avery, 2019, p. 11)
AWARENESS FOR ASSESSMENT

• In my former clinic, our triage clinician would ask clients what they would like to be called and which pronouns they preferred as part of the initial screening.

• It is imperative that all support and administrative staff be trained in the variety of clients that can present to your clinic and to recognize and try to extinguish heteronormative actions that could push clients away from treatment.

• Be mindful of co-occurring disorders as you would with all clients.

• Also be mindful of medical needs; many LGBTQ+ clients have experienced shame and even abuse from medical providers.
AWARENESS FOR ASSESSMENT

• Intimate partner violence (often overlooked in same-sex relationships)—is your client in a safe living environment?

• Physical, mental and emotional abuse or neglect from family members (either currently happening or happened in the past) is often a source of trauma

• Suicidal ideation and/or past suicide attempts—generally higher in the LGBTQ+ communities

• HCV, STI and HIV-infection status
  • Note that recreational drug use poses serious risks when combined with the life-saving medications of highly active antiretroviral therapy (HAART) and they can interfere with the effectiveness of HAART drugs
TREATMENT

• An overall trauma-informed approach and Motivational Interviewing are almost always used in the initial stages of treatment.

• It is important that the clinician not push the client to disclose information related to their identity or sexuality, but rely on open-ended questions.

• Understand that working toward recovery may also coincide with the person beginning or continuing their coming out process.

• Once ambivalence about SUD treatment is resolved and a strong therapeutic relationship is established, consider a CBT or a psychodynamic approach to address SUD.
TREATMENT

- Group therapy, especially with group members from LGBTQ+ communities and/or with allies, can be very helpful.
- Specialized LGBTQ+ treatment communities or programs can also be helpful.
- **Rainbow 12-Step Meetings**: Are open or closed meetings for LGBTQ+ individuals and allies; other 12-Step meetings can be hit-or-miss when it comes to being open to LGBTQ+ members.
- Family of origin issues (which may or may not include family therapy) may need to be addressed once the client is engaged in treatment:
  - Family therapy is usually contraindicated if the family is violent or otherwise “toxic”
TREATMENT

• Be mindful of heterosexism in your practice or program, including documentation used in the medical record.

• Be aware of transference and counter-transference, especially the later if you are unfamiliar with working with this population or are dealing with your own gender or sexual identity.

• The concept of co-dependency, formulated by therapists working with heterosexual couples, may need to be re-thought when working with the LGBTQ+ population given the additional stress that many people in this population live with—hence their relationships, while appearing co-dependent to many, may be healthy for them (Anderson, 2009).
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<tr>
<th>WHAT CAN WE DO?</th>
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<tr>
<td><strong>Educate</strong></td>
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<td><em>Educate yourself:</em> Stay up to date on the latest information</td>
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<td><strong>Educate</strong></td>
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<td><em>Educate others:</em> Speak to community and political leaders</td>
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<tr>
<td><strong>Listen</strong></td>
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<td><em>Listen to the experts:</em> Our clients</td>
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<td><strong>Point out</strong></td>
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<td><em>Point out misinformation whenever you can to correct other people’s biases</em></td>
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<td><strong>Take Care</strong></td>
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<td><em>Take care of ourselves as clinicians and people</em></td>
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We first need to admit that most of us do not enjoy “connecting” with clients this way; “I didn’t go to school for this!”

We also need to acknowledge that not all clients have access to technology to participate in tele-behavioral health and so we have to improvise.

Therefore practitioners and clients are using phones, Skype and FaceTime to conduct sessions; and getting creative in other ways.

Clinicians do not have to use HIPAA-compliant video conferencing technology during the current National Emergency; Health & Human Services will waive any penalties for HIPAA violations related to the platform used during this emergency.
TELE-BEHAVIORAL HEALTH: CLINICIAN

• Have a space set up where you can connect with your client without being disturbed
• Your work-space should provide some privacy for your client
• Internet connectivity and/or phone signal strength should be tested prior to engaging in tele-behavioral health
• If conducting a group therapy session, educate clients on muting themselves unless they are speaking
• I recommend against using your personal phone, but sometimes this cannot be avoided
  • If using a personal device, I would set firm boundaries with clients regarding when they can and cannot contact you
You’ll likely notice that the flow of clinical sessions will be slower than in-person.

Be aware that you will likely need to speak slower than in person.

Try to express empathy with your voice, especially when not connecting via video.
TELE-BEHAVIORAL HEALTH: CLIENT

• Try to have a private space where you can connect with your counselor that is also free from interruptions and distractions

• Test out your communications system (connectivity) prior to meeting with your counselor

• Most of us (counselors especially) don’t like meeting this way, so remember this is temporary and we (like you) look forward to meeting face-to-face again
INFORMED CONSENT TO TELE-BEHAVIORAL HEALTH TREATMENT—ESSENTIAL ELEMENTS

• A statement explaining what tele-behavioral health will look like for you and the client (methods to be utilized: FaceTime, phone, etc.)

• A statement discussing the risks of tele-behavioral health (technology limitations and failures; possible/unintentional breaches of confidentiality)

• A statement agreeing that the sessions will not be recorded by either party

• A statement emphasizing that the content of the session is confidential and that a written release is required from the client to release information

• A statement noting the limits of confidentiality, including having to report suspected child abuse, vulnerable adult abuse, danger to self or others
INFORMED CONSENT TO TELE-BEHAVIORAL HEALTH TREATMENT—ESSENTIAL ELEMENTS

• A statement explaining what steps must be taken should the clinician believe that the client is a danger to themselves, a danger to others or is unable to care for themselves
  • This could include a statement that participation in tele-behavioral health may not be appropriate and a higher level of care could be required
• A statement describing how you will handle technical problems should they arise
• A statement explaining that the client must disclose their physical location during the session and an individual the clinician can contact in case of an emergency
• A statement that you are continuing to maintain treatment records during this time
DOCUMENTATION

• If you don’t write it down, it never happened
  • Record, in detail, all aspects of client interactions, including any known precipitating events, interventions, outcomes, staff members involved and all contacts with outside agencies
  • Record where the client says they are contacting you from
  • Do this as quickly as possible following the session
  • Stick to the facts; do not presuppose or assume anything
  • See documentation as a necessary means to protect yourself, the people you serve, and your organization
REFERENCES


