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2020 LGBTQ Specific Substance Use Service Survey: A Study on the Availability and  
Perceived Helpfulness of Treatment Programs

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## Abstract

Health disparities researchers have identified elevated rates of difficulties among gender and sexual minorities (GSM). In addition to a higher rate of general mental health issues, there is also a higher prevalence rate of substance misuse among GSM individuals when compared to the general population. Specific issues, such as stigma and oppression faced by GSMs, might have a direct linkage with the higher prevalence rate and might also impact treatment outcomes. To understand the specific factors that lead to substance misuse, as well as to understand the unique patterns of treatment-seeking and adherence among GSM clients, the development and dissemination of LGBTQ specific treatment programs are needed.

In 2007, Cochran, Peavy, and Robohm conducted a study of treatment programs which indicated that they provided specialized services for gay and lesbian clients; however, phone calls to these agencies revealed that over 70% of these agencies actually did *not* provide services that were different from the agencies' general services. Given the progress and development in the last decade regarding awareness of GSM rights, the current study aimed to gain a renewed understanding of the state of GSM-specific substance treatment in 2020 using a similar methodology. Results indicated that although there has been an increase in both the number and percentage of agencies that provide LGBTQ-specific services since 2007, fewer than 1 in 5 agencies who indicated offering LGBTQ-specific treatment on the National Survey of Substance Abuse Treatment Services (N-SSATS) survey actually provided such services (17.4%) in 2020. Additionally, our findings indicated a strong relationship between a positive (simulated) treatment-seeking experience and the agency staff's breadth and depth of knowledge of available services. Implications, limitations, and directions for future research for GSM clients seeking specialized services are discussed.

*Keywords: substance use, substance misuse, LGBTQ specific treatment, Gender and Sexual Minorities (GSM), initial contact*

## **Introduction**

Literature in the field of LGBTQ research has identified a series of disparities regarding mental health between Gender and Sexual Minorities (GSMs) and the general population, the majority of which identifies as cisgender and heterosexual (Marshall et al., 2011; Muehlenkamp et al., 2015; James et al., 2016; The Williams Institute, 2019). Corresponding with the higher rate of general mental health issues, there is also a higher prevalence rate of substance misuse among the GSM community (Ballon et al., 2004; Lee, 2010; Hughes et al., 2010; Towns, 2018).

Specific issues such as stigma and oppression faced by GSMs might have a direct linkage with the higher rate and might impact treatment outcomes (Lemoire & Chen, 2005). Therefore, specialized treatment programs should be developed in order to meet the unique needs of GSM clients (Lombardi & van Servellan, 2000). However, a study conducted in 2007 revealed that only around 10% of Substance Use Disorder (SUD) treatment programs reported offering specialized services for lesbian and gay clients (Cochran et al., 2007). Additionally, within the programs that reportedly offered specialized services, more than 70% of those programs' specialized programs were not distinctly different from their general services offered.

In recent years, U.S. mainstream society has become more aware and accepting toward GSM individuals (Movement Advancement Project, 2020). This trend is also reflected in the field of substance research and treatment. For example, between 2008 and 2009, the language used in the Substance Abuse and Mental Health Service Administration (SAMHSA) surveys of treatment providers changed from "Lesbian and Gay" to the more inclusive "LGBTQ" clients (SAMHSA, 2009). However, even with the attempt to become more inclusive, the nature and specificity of those "LGBTQ-specific" services remain mostly unstudied. Therefore, a renewed understanding of the discrepancy between agencies' reports and actual services provided is imperative in order

to understand and evaluate the strengths and limitations of the actual current state of substance treatment programs across the country.

In order to address the high rate of substance use and misuse among GSM individuals, it is vital to understand not only the cause of substance misuse but also GSM-specific barriers to treatment. Understanding the unique issues faced by GSM individuals when accessing treatment might result in improved treatment adherence as well as improved treatment outcomes. For example, one's initial contact with treatment programs has been shown to influence the timeliness and effectiveness of treatment entry (Dale et al.,1997). Therefore, it is essential to explore the interpersonal factors during initial contact that could affect the possibility of clients' subsequent treatment-seeking and adherence. The current study aimed to present an updated and accurate understanding of available substance treatment services to the GSM community in 2020. Moreover, the current study also focused on gaining a better understanding of GSM clients' initial-contact experience with substance use treatment service providers. This knowledge can assist treatment providers in improving substance abuse treatment for GSM clients by raising awareness about the potential limitations of the currently available treatment programs and ultimately work to close the health disparity gap between GSM individuals and the general population.

## **1. Literature review**

### **Substance Use Among Sexual and Gender Minorities**

Since the early 2010s, several reports and polls in the United States, including one National Bureau of Economic Research study and many Gallup reports, indicate a small but steady increase in individuals who identify as GSM (Gates & Newport, 2012; Coffman et al., 2013; James et al., 2016; Gates, 2017; Meyer, 2019;). One Gallup report showed that in 2017, around

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4.5% of the American population identified as GSM (Meyer, 2019). Studies dating back to the 1970s have documented a higher rate of substance use, as well as a higher risk for substance use disorders, among GSMs (Saghir et al., 1970; Meyer, 2003; King et al., 2008; Marshal et al., 2011). Recent research continues to provide evidence of elevated substance misuse risks in this population. The National Survey on Drug Use and Health (NSDUH) found that 15 percent of GSM adults had an alcohol or drug use disorder in the past year, compared to eight percent of heterosexual adults (Medley, 2016). Moreover, studies showed that GSM persons also have a higher likelihood of experiencing a substance use disorder (SUD) in their lifetime (McCabe et al., 2013), and they often enter treatment with more severe SUDs (Cochran & Cauce, 2006).

Initially, little explanation for the higher SUD rate was given that could benefit or empower GSM populations. For example, early literature attributed the higher rate of use and abuse to the "gay culture and lifestyle" (Zigrang, 1982), and therefore reinforced biases and stereotypes against the population. Many of the early studies are also critiqued for their methodological flaws, such as sampling in bars known to be frequented by GSMs. Additionally, some early research looked at substance use among GSM individuals through a trauma exposure lens and pointed out the need to address trauma as part of substance abuse treatment for GSM clients (Hughes, et al., 2010). Although these studies were conducted with good intentions, there were limitations to the methodology of these early studies. Specifically, conclusions were drawn from large-scale epidemiologic surveys on alcohol and drug abuse in which questions about sexual orientation and gender identity were not included (Hughes et al., 2016). Therefore, reliable information or representation of GSM experience with substance use treatment were not available. In the last decade, more and more studies have recognized the importance of, and put more emphasis on, understanding the relationship between substance use and gender and sexual

identity and expression. Among these studies, a 2015 national survey conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA) was reported to be the first to publish nationally representative data from the National Survey on Drug Use and Health (NSDUH) to identify patterns of substance use among people of various gender identity and sexual orientations (Medley et al., 2016). This survey found that GSM adults have higher rates of substance use (39.1%) than heterosexual adults (17.1%). However, it also indicated that members of the GSM community are more likely than heterosexuals to seek treatment for substance use disorders and mental health conditions, with the rates of 15.3% and 10.6% respectively (Medley et al., 2016).

These recent studies have revealed new and unique patterns of substance abuse and treatment-seeking while confirming the high demand for services within the GSM community. However, without fully understanding the unique experience of GSM individuals who are seeking SUD treatment, substance treatment services that tailor to and successfully meet the needs of GSM clients are lacking (Lee, 2010). Studies have already shown that failure to take sexual orientation and identity sufficiently into consideration might have a significant negative impact on the success of treatment (Hershberger & D'Augelli, 2000; Talley, 2013).

Many researchers have proposed that GSM substance abuse must be understood within the context of the stigma, prejudice, and discrimination to which GSM people are regularly exposed. Despite increasing acceptance of diversity in the United States, gender and sexual minorities still face homophobia, biphobia, or transphobia and discrimination, which may come from strangers, acquaintances, and friends and family. GSM individuals also face the constant threat of harassment, bullying, and hate crimes (Medley et al., 2016). Given the high level of stress and oppression GSM individuals endure, it is not surprising that many studies have

documented the higher rate of mental health concerns such as depression and anxiety among members of the GSM community (Semlyen, et al., 2016), as well as serious health issues such as hepatitis and HIV/AIDS (Young & Fisher-Borne, 2018). In addition to the negative repercussions on GSM individuals' physical and mental health, stigma and discrimination might also be associated with increased substance use rates. For example, a few studies have reported that GSM youths listed bullying, victimization, homophobia as some of the reasons for their drug and alcohol use (Bontempo & d'Augelli, 2002; Rosario et al., 2014). GSM individuals' ability and desire to seek substance abuse treatment might also be interfered with by the need to attend to their medical issues and psychological concerns (Romanelli & Hudson, 2017).

To avoid discrimination, some GSM individuals might choose to remain "in the closet," keeping their gender and sexual identity concealed (Pachankis, 2007). This type of concealment can not only create feelings of loneliness and anxiety (Santuzzi & Ruscher, 2002; Livingston et al., 2019), it is also related to increased levels of substance use (Hughes & Eliason, 2002; Stall et al., 2001). Additionally, the cognitive depletion (Critcher & Ferguson, 2014) and emotional inhibition (Hatzenbuehler, et al., 2009) involved in the process of concealment might also add more challenges to substance-related treatment seeking and adherence.

In all, to have optimal treatment outcomes, it is crucial to understand both the specific factors that lead to substance use, as well as the unique issues faced concerning treatment-seeking and adherence among GSM clients. These unique issues can be, and often are, inadequately captured and addressed in traditional substance treatment programs. Thus, the development and popularization of GSM-specific treatment programs are needed.



## **Understanding Substance Misuse Among GSMs Using the Minority Stress Model**

Meyer originally coined Minority Stress Theory (MST) and proposed that individuals who identify as gender or sexual minorities can be at an increased level of vulnerability in response to the issues associated with their minority status (Shilo et al., 2015). Meyer (1995) defined minority stress as the excess stress members of marginalized social groups experience because of their minority status. He posited that minority members are at a heightened risk for adverse mental health outcomes because of the social stress that these individuals experience in our society (Meyer, 1995). The distal-proximal distinction proposed by Meyer in 2003 further explained the stress processes that are specific to gender and sexual minorities. Specifically, distal minority stressors are the outside stressors that are viewed as stressful due to their external impact on the individual (Meyer, 2003). Such stressors include workplace discrimination (Barron & Hebl, 2013), housing discrimination (Ayhan et al., 2020), and biased medical (Foglia & Fredriksen-Goldsen, 2014) and mental health care. Proximal stressors are defined as subjective internalizations of adverse events and attitudes (Meyer, 2003). These stressors take the form of internalizing processes of adverse events, and GSM individuals develop self-stigma in response to negative societal attitudes (Meyer, 2003). Taken together, for GSM individuals, while proximal stressors create more mental health concerns and barriers to treatment due to processes such as internalized negative self-regard (Meyer, 2003), concealment, and anticipated rejection discrimination (Dyar et al., 2016), distal stressors further perpetuate health and mental health disparities (Ramirez & Galupo, 2019). According to Meyer (2003), this cycle would likely lead to more stress responses, such as increases in mechanisms like vigilance, concealment of identity, internalized stigma, rumination, and minority identity salience.

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As mentioned above, previous research has shown mental health disparities among GSM individuals when compared with their heterosexual counterparts. Research has also suggested that gender and sexual minorities face higher levels of day-to-day discrimination than heterosexual individuals (Mays & Cochran, 2001). As a result of their unique challenges related to discrimination and stigma (Pachankis et al., 2014), victimization (Collier et al., 2013), isolation (Beatty et al., 1999), and abuse (Goldbach et al., 2014), GSMs are prone to a range of prejudices that affect relationships, employment opportunities, and access to resources. These prejudices and biases, in turn, perpetuate the stressors and barriers faced by GSMs and potentially creates a situation in which people might use alternative strategies to alleviate their stress, including substance consumption.

As an additional indicator of minority stress, the Williams Institute found that, on average, GSM individuals make less in the workplace than their heterosexual, cisgender counterparts. Unemployment and poverty rates are particularly high among transgender people (The Williams Institute, 2019). Imagine Riley, a transgender gay woman, who faces financial difficulties and employment inequality due to her gender identity. Consequently, Riley's mental well-being has been negatively affected by the oppressive environment she endures. Because of previous experiences of discrimination while seeking help and internalized shame (a proximal stressor), Riley is reluctant to access care and, in turn, has turned to substance use as a coping strategy. The effects of distal and proximal stressors that result in substance use among GSMs have been documented extensively in many research studies (Cricher & Ferguson, 2014; Connolly et al., 2006). In addition, GSM individuals who use substances may experience compounded social pressures associated with being both a minority and a substance user

(Colcher, 1982). This double stigmatization may further exacerbate problems and prevent GSM individuals from seeking treatment for substance use difficulties.

### **Treatment Seeking Patterns for Substance Use Disorders Among GSM Individuals**

Previous literature has identified some unique trends of substance use in the GSM population. In addition to having higher rates of substance use than cisgender and heterosexual population, GSM individuals are found to be more likely than heterosexuals and the cisgender population to seek treatment for substance use and misuse, and they often enter treatment with more severe Substance Use Disorders (SUDs) and more past-year use of medical services (Cochran & Mays, 2000; McCabe et al., 2013; SAMHSA, 2016). Very little explanation has been given for this observation. However, it is well established that sexual minority individuals seek mental health treatment at greater rates than their heterosexual counterparts both in adolescence (Lucassen et al., 2011; Williams & Chapman, 2011) and adulthood (Cochran, et al., 2003; Grella et al., 2009). Some researchers have proposed that due to the higher rate and longer history of co-occurring physical and psychological issues, gender and sexual minority individuals might be primed to ask for external help and navigate through the health care system for the help they need. In addition, the compounded stress and stigma created by both one's GSM minority status and substance use might result in GSM clients' higher needs for treatment (Cochran & Cauce, 2005; Green & Feinstein, 2012).

### **Barriers to Effective Treatment for the GSM Population**

Case studies observing specialized services have demonstrated that GSM-specific programs can effectively treat substance misuse problems by addressing unique issues that are often overlooked in traditional programs (Hicks, 2000). These findings are also consistent with

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evidence from other special populations, such as women and children, for whom the benefit of specialized treatment services has been captured over the past several years (Grella, 2008).

Interviews with GSM clients and patients after treatments also indicate that GSM individuals would prefer specialized programs over standard services, if available. (Rowan et al., 2013).

Moreover, as explained by the Minority Stress Model, unique factors that lead to substance misuse among GSM individuals need to be examined and addressed in substance treatment programs. This specialized need has also been extensively documented through many studies (Stall et al., 2001; Flentje et al., 2016). Given the strong preference and need for specialized treatment, as well as the higher rates of treatment-seeking for substance misuse among GSM individuals (Grella et al., 2009), it is surprising to see that so few programs have been developed specifically for GSM patients. In 2007, a research team that looked at substance abuse programs throughout the United States and Puerto Rico found that, of the 854 programs that reported via a national survey to have specialized treatment services for GSM individuals, only 62 programs (7.3%) confirmed during telephone follow-ups that such services existed (Cochran et al., 2007). The study also revealed that the majority (70.8%) of treatment programs indicated that they offered no specific services for GSM clients (e.g., "We do not offer specific services") while a small percentage (1.9%) of agencies disclosed that they had offered specialized service in the past. Within the agencies that did provide a specialized service, around half (49.2%) named specific groups for gay men, lesbians, or both as their specialized service. About 20% of these agencies indicated that they exclusively served members of the GSM community, while another 20% stated that they had a counselor explicitly trained in GSM issues (Cochran, et al., 2007). In addition, a theme that emerged from treatment agencies' responses was

that although agencies did not offer GSM-specific programs, they also did not feel that they discriminated against GSM individuals (N= 79, 9.3%).

Multiple factors might contribute to the observed low provision rate of GSM-specific substance treatment services. Studies have found that a significant number of providers in substance abuse treatment programs endorse negative attitudes toward GSM clients (Eliason & Hughes, 2004), while others may fail to consider the unique needs of this population, utilizing more of a “one size fits all” type of approach (Rowan et al., 2013). In another study, researchers found that sexual minority issues are seldom talked about in standard treatments (Hellman et al., 1989).

Moreover, out of fear of discrimination or worry that treatment providers are insensitive or hostile (Pachankis & Goldfried, 2004), GSM individuals might be reluctant to disclose their sexual and gender identity and, therefore, not actively seek out GSM-specific treatment. The lack of room for openness about sexual and gender identity not only creates more barriers to treatment entry for GSM clients but also may contribute to misinformation regarding the need for specialized treatment among the population (Ballon et al., 2004). Moreover, the lack of understanding of these important aspects of specific clients’ lives may affect treatment adherence and recovery (Lee, 2010). Despite accumulating evidence that GSM individuals have high rates of substance treatment needs, there is comparatively little known about the most effective way to help GSM individuals who are seeking treatment. Traditional family, couples, and group therapy that is provided for the general population might potentially create unique challenges for GSM clients. For example, family therapy for substance abuse that is created within a heteronormative framework could intensify the problems a GSM client might face if their family is not supportive of their identities. The lack of guidance for the adaptation of evidence-based treatment programs

for the specific needs of GSM clients can also be a contributing factor to the low prevalence of tailored GSM-specific programs among substance treatment agencies. Researchers have stressed the importance of adapting SUD treatment to GSMs by providing special consideration of their unique stressors (Dew, 2012). One recommended framework for working with GSM clients is the use of affirmative psychotherapy (APA, 2012; APA, 2015); however, to date there is very little research effort focusing on how to adapt affirmative therapy skills and approaches into GSM-specific substance treatment programs. There also is a lack of studies focusing on understanding and evaluating the performance of SUD treatment providers within the GSM-specific treatment context using those affirmative skills. Moreover, how GSM clients perceive substance treatment programs that claim to be affirmative has been relatively understudied.

On the other hand, the last systematic analysis of specialized substance abuse treatment for GSM clients was published 14 years ago, with data collected in the two years prior (Cochran et al., 2007). Over the past 16 years, there has been monumental success for advancement of LGBTQ rights worldwide, from legalized same-sex marriage in the U.S. and in many other countries to the government repealing the military policy of "don't ask, don't tell." The number of GSM individuals living in "medium" or "high" equality states increased dramatically from 6% in 2010 to nearly half, 46%, in 2020 (Movement Advancement Project, 2020). In addition, protections for transgender individuals, such as banning health insurers from excluding transgender-related coverage and offering gender-neutral options on licenses and birth certificates, have slowly come in place in some states. Another ongoing change is that branches of the military are currently trialing standards for physical fitness that are gender neutral. At the same time, worry within the GSM community has grown over the political polarization regarding GSM issues, as well as world leaders' increased efforts to suppress GSM rights. For example, the

Trump administration reinstated a ban on transgender people serving in the military in 2018, which was reversed in the early days of the Biden administration; these actions indicate how quickly rights can be instituted and retracted. Workers still face employment discrimination based on sexual orientation and gender identity, and there is no federal guarantee that protects equal rights. Therefore, it is still relevant and vital to study barriers that impede GSM clients' treatment-seeking, entry, and adherence efforts.

### **Barriers to Treatment-Seeking Related to the Initial-Contact Experience**

For decades, researchers and treatment providers have been trying to reduce factors that prevent individuals from seeking SUD treatment in order to address the prevalent substance misuse problem in the United States (McLellan et al., 1994). The rationale for this effort is that participation in treatment has generally been associated with positive outcomes among substance abusers (Lipsky et al., 2012; Nair & Bush, 2016). However, there has been a significant gap and delay for treatment entry reported by individuals who use and misuse substances (Nelson et al., 2017). Therefore, factors that discourage treatment entry could be the key to reducing the prevalence rates of substance use disorders.

Andersen (1995), who created the dominant analytical framework in service use studies (Doran et al., 2014), looked closely at the treatment entry process and termed it “treatment linkage.” Many studies have identified system-level factors that impede treatment entry, including complicated and discriminatory eligibility and admission criteria, absence of appropriate services for groups, lack of cooperation across service organizations, and long waiting lists (Beckman & Kocel, 1982; Festinger et al., 1995; Hser et al., 1998). Additionally, studies that focused on the service-seeking experience have identified a lack of confidence in the

effectiveness of treatment, fear of stigmatization, and privacy concerns as barriers to treatment linkage from the perspective of clients (Tucker et al., 2004; Rapp et al., 2006).

Taken together, although some of the concerns reflect the flaws of our health care system, many others are barriers that can be reduced through effective communication between the treatment agency and prospective clients. Therefore, it is essential to study the effectiveness of the communication between treatment-seeking clients and the treatment agency's front-line staff. Depending on the front-line staff members' helpfulness, knowledge, and attitudes, clients may either successfully enter treatment or be deterred from further treatment seeking. Specifically, for the GSM community, there is very little research looking into what deters clients from treatment entry once they have identified the need for service and initiated contact with treatment agencies. Although studies have demonstrated the importance of creating a safe and supportive initial-contact experience concerning treatment entry and adherence (e.g., Ballon et al., 2004), little is known regarding how treatment seekers experience the initial contact encounter, as well as factors that contribute to a positive and successful initial-contact experience.

Using the Minority Stress Model, GSM individuals' treatment-seeking behavior is predicted to be affected by their initial-contact experience. Exposure to prior stressors (distal events) might cause GSM individuals to be more adept at noticing implicit discrimination and hostility, such as from front line staff members' vocal cues/tones and connotations (Maycock et al., 2009). GSM clients may also be more prone to expect rejection due to proximal stressors such as internalized homophobia or transphobia. A qualitative study asking gay and bisexual people about their treatment-seeking experience revealed that participants' perceived lack of acceptance and feelings of passivity from treatment providers were associated with increased distrust of treatment providers and reduced help-seeking behaviors (Towns, 2018). Therefore, the



consequences of negative initial-contact experiences might range from delayed treatment entry to treatment rejection. Given the potential impact of the first contact on future treatment seeking and adherence, deepening our understanding of GSM clients' initial-contact experience is crucial. This knowledge can both inform treatment providers of the needs of GSM clients and guide the development of specialized treatment programs in the future.

### **Literature on the Best Practices for GSM-Specialized Substance Treatment**

Despite the unique substance treatment needs of the GSM population, there is little consensus on the definition of best practices for GSM-specialized substance treatment. So far, very few GSM-specific services and culturally tailored interventions exist. However, the American Psychological Association (APA) has published two general guidelines for psychological practice with GSM clients, which emphasized the need for clinicians to interact with GSM clients in an affirmative manner (APA, 2013; APA, 2015). The concept of GSM affirmative practice generally refers to care that expressly validates marginalized sexual and gender identities and experiences and works to acknowledge and treat stress related to stigma and discrimination (Alessi, 2014; Chang & Singh, 2018).

In addition, for GSM clients' general health and mental health needs, researchers and clinicians have proposed ideas for appropriate and culturally sensitive care. For example, aiming to decrease the significant disparities in access to healthcare, the Cleveland clinic recommended that healthcare agencies and professionals create a welcoming environment for GSM clients, including creating electronic health record forms that allow for collection of gender identity and natal sex (i.e., biological male or female), and avoiding clinic names and signs that seem welcoming to only one gender (e.g., Men's Health Center, Women's Health Center) (McNamara & Ng, 2016).

Specifically, in the field of substance misuse treatment, some researchers have suggested utilizing a non-stigmatizing approach to GSM individuals and their use of substances (Dew, 2012; Mericle et al., 2018). For example, they have recommended utilizing a harm-reduction approach to the treatment of GSM clients' substance use problems, as well as individualizing treatment planning to address the specific needs of the person. In addition, other researchers have suggested treatment providers offer services that are inclusive for GSM individuals, and to provide services in a manner that is affirming of GSM clients and responsive to their unique health care needs (Senreich, 2011; Flentje et al., 2016). For example, creating an affirmative treatment environment might include having brochures, magazines or literature that is relevant to GSM individuals in public-facing lobbies and waiting areas (SAMHSA, 2012).

From the existing literature, we've learned that how a GSM client is treated during the initial-contact interaction is thought to affect their attitudes toward the treatment-providing agency, and in turn, affect their decision to follow up and to utilize that service. Given this, for the current study, we hypothesized that:

1. GSM-specific substance treatment programs will be offered more frequently, and by more treatment agencies, in 2020 than they were in the similar study published in 2007. We based our first hypothesis on the steady increase in the reported numbers of individuals who identify as GSM, as well as the overall more open social and political climate toward the GSM community in the United States.

2. The availability of GSM-specific treatment will be associated with the population density in that region. We made this prediction with the rationale that the more populated an area

is, the more likely that treatment agencies in that area are capable and willing to offer specialized treatment for subgroups of the population.

3. Substance treatment agencies that are more competent regarding GSM-specific treatment will be perceived as more helpful during initial-contact by our research assistants who are disguised as potential clients. We will use a rated swiftness and informativeness score from each substance treatment agency as an index of the agency's GSM-treatment helpfulness. We theorized that agencies that put more effort into developing and maintaining GSM-specific programs would train their receptionists to be more responsive and more informative in answering a potential GSM client's questions over the phone. We also theorized that those agencies would create a more welcoming and positive experience for their GSM clients, and thus should be rated as more helpful. The operationalization of swiftness and informativeness is discussed in the methods section.

4. Both the informativeness and positive attitudes of the treatment agency staff will be associated with the likelihood of (simulated) GSM clients considering treatment for self or for others in the future. Moreover, we predict that positive staff attitudes will have a stronger association with willingness to consider treatment for self or others in the future than providers' informativeness. We based our prediction on existing literature that higher helpfulness and better attitudes from treatment staff are associated with more successful treatment entry (Towns, 2018).

## **2. Method**

The primary goal of the current study was to gain a better understanding of 1) the scope and prevalence of LGBTQ-specific substance treatment services offered currently, and 2) the nature of potential GSM clients' experiences when they initiate contact with treatment agencies. To be able to compare our study results with data collected by the previous research team for the 2007

report, we utilized a similar phone inquiry methodology. In addition, we evaluated callers' subjective evaluation of, and affective reactions to, the interaction they had with each agency. Therefore, callers who made contact effort with the substance use treatment agency were asked to fill out a perceived helpfulness scale for every interaction.

## **2.1 Participants**

### **Participating Agencies**

Participating substance use treatment programs for the current study were selected from the 2018 National Survey of Substance Abuse Treatment (N-SSATS) database (SAMHSA, 2018). N-SSATS is an annual survey of all known public and private substance abuse treatment facilities in the United States, and it is the same survey that was used to identify programs in the Cochran et al. (2007) study. N-SSATS survey collects three types of information from facilities: characteristics of individual facilities, client count information, and general information, such as licensure, certification, and accreditation. Specifically, for facility characteristics, the N-SSATS survey collects information regarding the scope of services offered, location, languages spoken by staff, payment options, and other key factors that might influence treatment selection. In 2018, the survey contained 37 questions and was posted in its entirety online. The resultant SAMHSA treatment facility locator database is available online to the general public and is searchable by the types of services provided; this is an effort to increase treatment linkage by providing prospective treatment seekers with information they need to make an informed treatment choice. The original purpose of this survey was to assess the scope of services provided across the United States and to generate the National Directory of Drug and Alcohol Abuse Treatment Programs. Because the survey results are from SAMHSA, the general public regard it as the most reliable source of information and thus utilize it as a platform to find

treatment providers. Our use of this database was an attempt to replicate the experience of potential clients seeking information about agencies that provide specialized services for GSM individuals.

### **Raters for the Initial-Contact Experience**

A team of seven research assistants was recruited and trained for contacting substance abuse treatment agencies and rating their interaction with each agency. The primary objective was for the research assistants to simulate the initial-contact experience of potential GSM treatment-seeking clients by contacting the specific treatment providing agency via phone call to gather information; a secondary purpose was to evaluate the interaction.

To establish the intra- and inter-rater reliability of the perceived helpfulness scale, all seven research assistants attended four 60-minute training sessions prior to the start of data collection. The purpose of the training sessions was for the research assistants to become proficient in conducting the phone interview, scoring the perceived helpfulness scale, and reviewing documentation procedures. Specifically, for the perceived helpfulness scale (Appendix 2), a score of 1 is described as “poor” or “strongly disagree,” and a score of 9 is described as “excellent” or “strongly agree.” Because multiple aspects are likely to influence a given research assistant's scoring, raters might vary in the extent to which different aspects are deemed to be important in determining the score. Therefore, during the first two training sessions, raters discussed and reached consensus on what each numerical value means on the scale, and what differentiates the scores. During the last two training sessions, the raters were paired up to practice rating mock phone-interactions using the perceived helpfulness scale. After each mock interview, the two raters and the researcher shared their ratings as a group and reached a score by

consensus. The purpose of this training was to minimize personal variations that might not be relevant to the constructs intended to be assessed in the scale.

## **2.2 Procedure**

The current study had a twofold procedure. First, objective information was gathered from all treatment agencies who indicated that they provide specialized services for GSM clients via phone inquiries. For each agency, an information sheet (Appendix 1) was completed by the research assistant after the phone inquiry. A standardized script was used by the research assistants. After each phone inquiry, research assistants transcribed the responses that they received during each call verbatim. During the phone inquiry, research assistants self-identified as someone seeking GSM-specific substance treatment for a loved one. Contacting efforts for each agency were discontinued after three attempts, assuming that potential treatment seeking clients in an analogous situation would be unlikely to persist if there was no response or if there were insufficient answers from an agency after three attempts. During the phone inquiry, research assistants asked a series of questions to gather information from each agency, including the type of program, provider credentials, size of the program, specific clientele accepted, and soonest availability (Appendix 1). Additionally, to capture the nuances of the calling experience, research assistants also recorded the number of call attempts, the time and duration of the call, and the number of line transfers (if any).

After each phone inquiry, research assistants then filled out a perceived helpfulness scale (Appendix 2). Due to the lack of similar study designs, there is no pre-existing perceived helpfulness survey for people who are seeking information about treatment. However, there have been many open source customer satisfaction questionnaires available online that ask about clients' experiences and perceptions. The perceived helpfulness scale that was used for the

current study contains eight Likert-scale questions and one open-ended question that were adapted from multiple consumer satisfaction questionnaires (Tessier, 2016; Cussen, 2017; Sharma, 2019). The questions were designed to gauge callers' overall calling experience, which included, for instance, how knowledgeable the respondent was and whether the caller was comfortable in seeking help from the agency.

### **2.3 Measures**

SAMHSA reports that the N-SSATS database is updated weekly with verified changes to existing listings, as well as monthly to incorporate new facilities (SAMHSA, 2018). We accessed the N-SSATS database on March 15<sup>th</sup>, 2020 and downloaded our full agency contact list at that time. Among the total 14,161 data entries, we eliminated redundant data points and identified 3,099 out of 14,068 agencies that self-identified as providers of substance use treatment agencies who reported offering specialized services for "lesbian, gay, bisexual, transgender (LGBT) clients" (SAMHSA, 2018).

Within the 3,099 agencies reporting to offer GSM-specific treatment services, 746 individual sites were branches of larger organizations. For those sites, we assumed that the sub-branch sites would either have similar offerings or that they would refer clients to another location within the same organization where the specialized program is offered. Under this assumption, the branch sites were taken out of the provider list, leaving only one main site from each large organization. After this elimination, we determined that there were 2,353 independent agencies who reported to SAMHSA that they offered specialized treatment for GSM clients in March 2020. After identifying these programs, we downloaded their contact and demographic information (address and zip code) and began our data collection efforts. Descriptive analyses were conducted to examine the nature of the sample, including geographic data, the number of

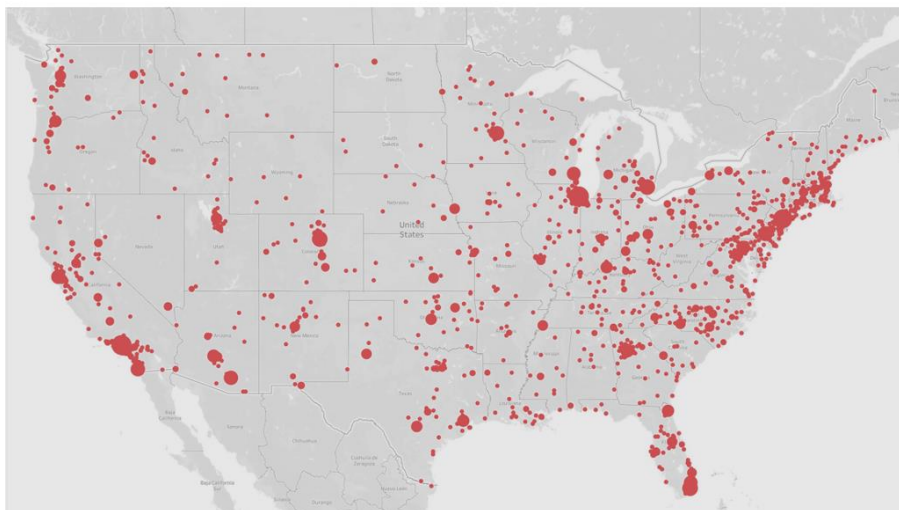
facilities confirming specialized treatment, types, and frequency of treatment provided, and rates of interview completion. The identified number represents 16.6% of agencies that completed the N-SSATS survey.

### 3. Results

**Hypothesis 1: GSM-specific substance treatment programs will be offered more frequently, and by more treatment agencies, in 2020 than they were in 2007.**

The substance treatment agencies list containing 2,353 agencies was downloaded from the 2018 N-SSATS database, and the current study was conducted between June 2020 and January 2021. Graph 1 shows the locations of all 2,353 agencies who self-reported having LGBTQ specialized treatment services. Due to the time delay, among the total of 2,353 agencies, 40 agencies (1.7%) were no longer in business when contacted by research assistants. In addition, due to the COVID-19 pandemic, 29 agencies (1.2%) indicated that they were currently and temporarily closed for business. In addition to these agencies which were closed for business, permanently or temporarily, 388 agencies (16.5%) in our study were unable to answer our phone inquiry. Among those 388 agencies, most agencies (N=320, 82.5% out of the unreachable agencies) simply did not answer our phone calls. A minority of them did answer the phone inquiry but provided information that resulted in a lack of data for this hypothesis: some agencies indicated that they are not substance treatment centers and thus were not suitable for the study (N=57; 14.7%); in some instances, the person on the call refused to give information unless our caller had a treatment referral or had gone through assessment (N=11; 2.8%). Additionally, due to researcher error with data storage, collected data on 85 agencies were lost (3.6%). Together, these 542 agencies (23.0% of the study total) were not considered in further analyses, resulting in a final sample of 1,811 agencies.





*Graph 1: Distribution of substance treatment agencies who self-reported to have LGBTQ+ specialized treatment services in the 2018 N-SSATS survey*

Responses gathered from the phone inquiry are summarized in Table 1. Data were analyzed for themes and categories using a general inductive approach (Thomas, 2006; Creswell, 2007). Using such an approach, raw data were organized and cleaned with the following steps: 1) only responses where the agency staff did not explicitly indicate that they do *not* have LGBTQ specific service were included into the analysis for the categories; 2) all responses were read closely by the researcher and two research assistants in order to gain familiarity with content and themes; 3) ten preliminary categories were created based on the observed themes; 4) the researcher and two research assistants evaluated the categories and coded the responses individually in order to test for inter-rater agreement, and 5) revision and refinement of the categories were discussed based on the preliminary categories among the three coders, who reached consensus for each response.

To test for reliability of coding across raters, we used the method outlined by Miles and Huberman (1994) for computing interrater reliability in aggregate. Reliability between coders for this sample was .985, suggesting extremely high agreement (McAlister et al., 2017). Following the last step from Miles and Huberman (1994), we revised and refined the categorizations of

responses that had discrepancies in ratings and finally reached a consensus with all response categorizations. See Appendix 3 for the finalized category codebook.

**Table 1: Agency Responses Regarding LGBTQ-Specific Services**

Category	Frequency	
	N	Percentage
<b>Offer LGBTQ Specific Service</b>	<b>315</b>	<b>17.4</b>
<b>Does Not Offer LGBTQ Specific Service</b>	<b>1,496</b>	<b>82.6</b>
> No current offering (offered service in the past or plan to do so in the future)	6	0.3
> Do not discriminate	80	4.4
> Have/had GSM Clients	64	3.5
>No LGBTQ Service Offered	1,273	70.4
>Do Not Accept GSM clients	73	4.0
<b>Total</b>	<b>1,811</b>	

Among the 1,811 agencies who self-reported to the N-SSATS survey that they provide LGBTQ specialized services, our phone inquiry indicated that most of these agencies (82.6%) do not have such services available. This result was similar to the findings from the 2007 study, although the overall percentage of agencies indicating have no specific services for LGBTQ individuals has decreased from 92.7% (Cochran et al., 2007) to 82.6%. In other words, there is an upward trend of substance use treatment agencies confirming that they offer LGBTQ-specific treatment services, from 62 agencies (7.3%) in 2007 to 315 agencies (17.4%) in 2020.

In the current study, within the “No LGBTQ Service Offered” category, 71 (4.0%) agencies explicitly indicated that they do not accept GSM clients. The reasons provided for their explicit rejection are summarized in Table 2. Apart from the explicit rejection of LGBTQ identified clients, the majority of the agency staff responded that no specialized programs for LGBTQ clients existed at that agency (e.g., “no, we do not have that service here”; N=1,273;

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70.3%). In addition, 64 agencies (3.5%) indicated that although they did not currently have specialized services for LGBTQ clients, they currently have or once have had LGBTQ-identified clients receiving treatment at their agencies. Another 80 agencies (4.4%) reported that despite not offering a LGBTQ-specialized service, they also did not discriminate (e.g., “we have zero tolerance for discrimination based on gender identity and sexuality here”). Finally, within the “No LGBTQ Service” category, 6 agencies (0.3%) expressed that whereas they did not currently offer such specialized services, they either had done so in the past (e.g., “we used to have a program but the coordinator for that program left”), or that they were in the process of creating such service (e.g., “we are actually planning to have an LGBTQ support group in the coming weeks”).

**Table 2: Reasons provided for not accepting LGBTQ clients**

Reason for rejection	Example	#
No reason provided	“We don’t deal with that here”	8
Religious Reason/affiliation	“We are faith-based and there’s no room to discuss that”	6
Partial acceptance to sexual minorities but does not accept transgender/non-binary identified	“People are housed and put into groups by their sex assigned at birth. That’s it.”	54
Partial acceptance to sexual minorities and only allows transgender who are post-gender-confirmation-surgery	“Accept transwomen, as long as they’ve done the surgeries”	3
	<b>Total</b>	<b>71</b>

Further inspections of responses from the 315 agencies who disclosed having specific services for LGBTQ clients indicated that more than one third of these agencies (N = 135; 42.8% of agencies offering services) offered specific support and therapy groups, housing accommodations, or community outreach for the LGBTQ community. Seventy-three agencies

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(23.2% of agencies offering services) indicated that they offer individualized treatment planning for LGBTQ clients. Examples given by the treatment agency's staff included, "treatment depends on what the client needs and wants"; and "individualized treatment plan that can address client's primary and co-occurring concerns." Seventy-two agencies (22.9% of agencies offering services) shared that they provide LGBTQ training for their counselors and staff. Examples of trainings provided for treatment agency's staff include sensitivity training, cultural competency courses, and training in LGBTQ patient-centered care. In addition, twenty-three agencies (7.3% of agencies offering services) expressed that they offer a sub-program for LGBTQ clients within their agency, and another twelve agencies (3.8% of agencies offering services) indicated that their whole program was dedicated exclusively to the LGBTQ community. In sum, our data did support the hypothesis that GSM-specific substance treatment programs were by more treatment agencies, in 2020 than they were in 2007. See Table 3 for the service summary.

**Table 3: LGBTQ Specific Services Reported to be Offered by Agencies in 2020**

Category	Example	Frequency	
		N	Percentage
Entire Agency/program dedicated for LGBTQ community	An agency specific for gay, bi, and nonbinary men	12	3.8
Sub-program for LGBTQ individuals within agency	LGBTQ Track; Zebra Coalition	23	7.3
Specific service for LGBTQ individuals	Housing accommodations for LGBTQ; support group; community outreach	135	42.8
Individualized treatment for LGBTQ clients	Treatment planning that was tailored to the client's situation	73	23.2
LGBTQ training for provider and staff/ certified LGBTQ provider	Mandatory training in LGBTQ patient-centered care for all providers	72	22.9
	<b>Total</b>	<b>315</b>	

**Hypothesis 2: The availability of GSM-specific treatment is associated with the population density in that region.**

To test the hypothesis that more densely populated areas will have more LGBTQ-specific treatment programs, we used population per Zip Code as an index of population density. The population by zip code data were taken from the 2016 5-Year Community Survey conducted by the Census Bureau. We first compiled a list of Zip Codes with population density for each Zip code, along with the number of substance use treatment agencies who self-reported providing LGBTQ specific services in the N-SSATS. A Pearson's correlation coefficient was performed, and we found a positive correlation between the number of agencies offering LGBTQ specific service within a specific ZIP Code and the population density of that ZIP Code ( $r=0.073$ ,  $n=1,811$ ,  $p<.001$ ). Given the effect size, our observed correlation was positive but weak.

Therefore, in a similar analysis, agencies were coded as either offering or not offering LGBTQ specific services; we conducted an Independent-Samples t-test examining whether population density was related to the availability of LGBTQ services. The result indicated that Zip Codes that contain agencies who self-reported to have LGBTQ specific substance treatment services, on average, have significantly higher population density than Zip Codes containing treatment agencies who did not report to have LGBTQ specific service,  $t(6696) = 10.58$ ,  $p <.001$ , with an average population density difference of over 900 individuals per square mile ( $M=903.62$ ,  $SD=85.41$ ). Therefore, our data did support the hypothesis that the availability of GSM-specific treatment is positively correlated with the population density in that region.

**Hypothesis 3: Substance treatment agencies that can promptly provide relevant information regarding LGBTQ-specific treatment will be perceived as more helpful during initial-contact exposure.**

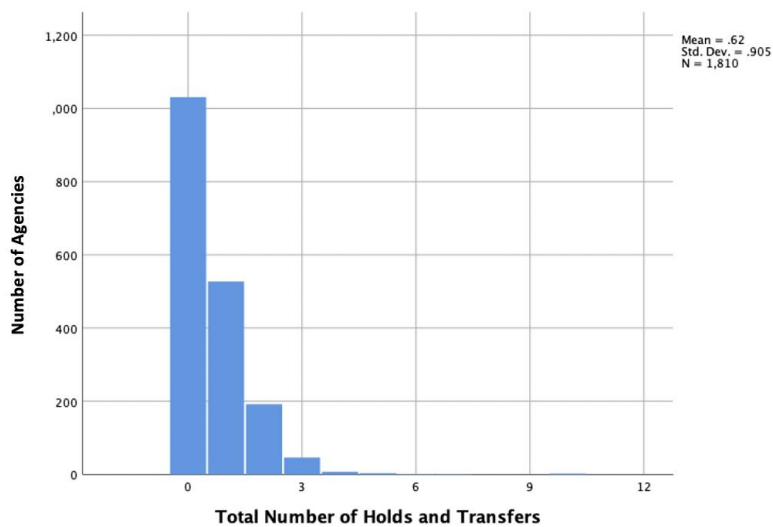
### **Informativeness and Helpfulness**

When the current study was first designed, the index “Informativeness” was operationalized as the percentage of completion of the information sheet for each treatment agency. It was rationalized that Informativeness would be related to the amount of information provided by the agency staff. However, while conducting the interviews, the research assistants reflected that many factors other than the respondent's ability to provide information affected the percentage completion of the measure/questionnaire used. For instance, one research assistant reported being rushed off of the phone call by the agency's respondent; another reported that some questions did not apply to specific agencies. Therefore, we re-operationalized informativeness as whether the respondent from each treatment agency could provide a direct and relevant response to the LGBTQ-specific service question posed to them. The responses were coded as binary, with 0 representing that the provider could not provide any information regarding the LGBTQ specific service (e.g., "I am not sure, let me check"), and a value of 1 represented that the respondent could give a concrete answer (e.g., "yes, there are" or "no, we do not have such services"). The 1156 agencies who provided a clear answer to our question were rated significantly higher on helpfulness by participants ( $M=44.4$ ,  $SD=14.9$ ),  $t(1810) = 14.4$ ,  $p<.01$ , compared to the 655 agencies who were less informative ( $M=34.4$ ,  $SD=12.9$ ).

### **Swiftness and Helpfulness**

The number of line transfers (e.g., the respondent transfers the caller to another person at the agency to answer the call) and holds were recorded for each inquiry. We initially planned to

add all transfers and holds together for each agency to create a swiftness score. However, such compiled scores revealed that most agencies had no more than three transfer and hold combinations, while a few outliers were present, with up to 6 transfers or holds (see graph 2). To avoid violating the assumptions of dependent variable normality and of equal variances, we decided to compile the swiftness list into another binary code, with 1 indicating "one or more holds or transfers" and 0 indicating "no hold or transfer." There was no significant effect for swiftness on helpfulness,  $t(1810)=-.155$ ,  $p=.877$ , with the scores of the no transfer/hold group ( $M = 40.82$ ,  $SD = 14.66$ ) not being significantly higher than scores for the transfer/hold group ( $M = 40.70$ ,  $SD = 15.43$ ).



Graph 2: Frequency Distribution of the Total Number of Holds and Transfer Per Call

**Hypothesis 4: Agency staff's positive and non-discriminatory attitudes and their ability to elucidate their agency's specific services are key factors that impact potential clients' decisions regarding treatment-seeking at a particular agency.**

In the post-contact survey, we asked the research assistants (i.e., simulated clients) to fill out a perceived helpfulness scale and to answer a series of questions on the overall experience of the interaction (see Appendix 2 for the full scale). Using ratings from the post-contact survey, we

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computed scores for each agency's perceived informativeness and helpfulness from the simulated client's perspective, as well as the simulated client's willingness to access services from this agency for self or for others. Specifically,

- Informativeness was compiled by averaging the score for Questions 5: "My questions were answered during the interaction," and 7: "This interaction helped me learn about information and resources regarding GSM-specific substance abuse treatment at this agency."
- Perceived attitude toward callers was compiled by averaging the score for Questions 2: "The person over the phone was warm, affirming and understanding," and 3 (reverse-scored): "The respondent's attitude made me feel uncomfortable, triggered, and/or judged."
- The caller's willingness to access services was compiled by averaging Questions 6: "This interaction helped me feel more comfortable in seeking help from this agency," and 8: "Based on this interaction with the agency, how likely would you recommend their GSM-specific program to your friends and families who are in need and are seeking treatment?"

Two sets of Pearson's correlation coefficients were analyzed to examine the relationship between the raters' willingness to access services from an agency and that agency's informativeness score and helpfulness score. Results indicated a significant positive relationship between the participants' willingness to access services and their rating on the agency's informativeness,  $r(1810) = .77$ ,  $p < .01$ , and helpfulness,  $r(1810) = .86$ ,  $p < .01$ . Further, because the two correlation coefficients were obtained from the same sample, we were able to compare the two correlations using Fisher's r-to-z transformation (Lee & Preacher, 2013), and Steiger's



(1980) Equations 3 and 10 to compute the asymptotic covariance of the estimates,  $z(1811)=10.37, p<.01$ . Like our prediction, both correlations are positive and significant. Contrary to our predictions, the Willingness-Informativeness relationship was more robust than the Willingness-Attitude relationship, indicating participants' self-rated willingness to access services has a strong and positive linear relationship with how informative participants perceived the agency to be. At the same time, participants willingness to access services is highly and positively correlated with agency staff positive attitudes.

## 5. Discussion

The current study was conducted to understand the changes and developments regarding substance use treatment for the GSM community that have occurred since 2007. It also provided a snapshot summary regarding specialized LGBTQ substance treatment services available in the United States in 2020. The study's goals were to determine what substance use treatment agencies understood and advertised as specialized treatment for GSM clients and to evaluate how substance treatment agencies are treating potential GSM clients during their initial phone inquiry. Results indicated an increase in both the number and percentage of agencies that are confirmed to provide LGBTQ specific treatment services. However, still in our current sample, fewer than 1 in 5 agencies who indicated on the N-SSATS that they provided LGBTQ specific treatment services *actually* could identify a specific service offered during telephone contact (17.4%). This actual availability showed a trend similar to that from the 2007 data, where only a minority of (7.3% from 2007 and 17.4% in 2020) agencies offered LGBTQ services that they claimed to have (Cochran et al., 2007). Additionally, the post-interview survey with the research assistants (i.e., simulated clients) indicated that agency staff's openness and ability to elucidate

the specifics of services they have, whether it is LGBTQ related or not, are the key determinants of GSM clients' willingness to access the service for self or others in the future.

### **Implications for GSM Clients Seeking Services**

As previous literature has demonstrated, seeking treatment for substance misuse is difficult, especially for GSM individuals who already face a disproportionately high level of discrimination and prejudice. Therefore, knowing whether treatment agencies that purport to offer LGBTQ specific services are able to clearly expound upon their services, and if these agencies can create a positive treatment-seeking experience for prospective clients, can highlight areas for improvement in clinical practice and care for GSM clients. Based on the findings from Hypotheses 1 and 2, we uncovered a similarly dissatisfying pattern to the one observed in the 2007 study. Despite the appearance of doubled treatment availability from 2007 to the present day, there is still a scarcity of specialized substance services to meet the needs of the GSM community. The problem of over- and misrepresentation of LGBTQ specific services still exists in many agencies' responses to the N-SSATS survey. However, our data still represented that hundreds more LGBTQ specific substance treatment service exist in comparison to 2007.

In the 2007 data, the researchers found that the 62 agencies who confirmed to have LGBT-specific services were located across 23 states, with 31 (50%) located within just two states (New York and California) (Cochran et al., 2007). Further investigation of the data from our current study revealed that such centrality converging around two key states had largely disappeared. In 2020, the agencies that confirmed to offer LGBTQ specific services over the phone were spread over 46 states, with 81 agencies (24.71% of agencies offering services) located in California and New York. In addition, it was observed that those agencies with confirmed LGBTQ-specific services were mainly concentrated along the East Coast (ME to FL)

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(N=102, 32.4%) and in the Southwest regions (CA, NV, NM, AZ) (N= 82, 26.2%). This finding, taken with the significant difference of population density between agencies with LGBTQ-specific services and agencies without, captured a broader but still centralized pattern of service availability and reflected a lack of specific services for GSMs in rural areas. This finding corresponded to the lack of resources as a barrier to accessing substance use treatment services for the GSM community in rural areas that had been identified in previous research (Israel et al., 2016).

Our data suggested that although some agencies' (n=80) responses fell under the category "we do not discriminate" to our question regarding specialized services for GSM individuals, the percentage of such responses went down significantly when compared to the 2007 data. Within those agencies, the majority of them (67%) emphasized having an inclusive and affirming environment in addition to their anti-discrimination policy. This observation might suggest that more agencies now viewing non-discrimination as the lowest bar to meet and in order to attract potential clients. It also may represent that longer interactions between agency representatives and research assistants in the current study, in comparison to 2007, enabled more elaborate responses by agency staff. It also, perhaps, signals a subtle but vital shift of attitudes regarding the provision of treatment for GSM clients.

Another new trend observed was that 135 treatment agencies reported individualized treatment as their specialized service for GSM clients. In the 2007 study, not one agency brought up "individualized treatment" as their specialized service. In 2020, many agencies across different states and regions answered with this response, however. There are several ways to interpret this trend. A more generous interpretation would be that these agencies are fully aware of and sensitive to the issues LGBTQ individuals face during treatment-seeking and are willing

and capable of addressing those specific barriers on a case-by-case basis. A more critical interpretation would be that it is a new way of expressing that these agencies do not discriminate and a new way of covering for not providing specialized treatment for the LGBTQ community they as they have claimed. The extension of such an interpretation would be an even more limited scope of actual LGBTQ-specific services being provided than the number reported currently. It could also be that individualized treatment services, regardless of a client's gender identity or sexual orientation, are more common in present day than they were during the era of the previous study.

From Hypothesis 3, we observed a pattern in which simulated clients valued the quality and specificity of information provided by the agency staff more than the speed of the conversation. This preference was reflected by informativeness being the determinant of higher levels of willingness to access services in the future. This is not surprising, given that agency staff's ability to provide relevant and specific information often signifies a higher level of understanding of LGBTQ issues. This corresponded to what the GSM health disparity literature has already shown: one major barrier to help-seeking for GSMs is the perceived lack of understanding and sensitivity regarding LGBTQ issues from treatment providers (Calton et al., 2016). Our data demonstrated that if treatment staff showcase such understanding, it is more likely that clients would consider seeking substance use treatment for self and others from that agency.

In addition, Hypothesis 4 indicated that both agency staff's positive and non-discriminatory attitudes and their ability to elucidate their agency's specific services are key factors that impact potential clients' decisions regarding treatment-seeking at a particular agency. Specifically, our data suggested that when agency staff demonstrated a willingness to understand

clients' concerns and help, our simulated treatment-seekers rated their likelihood of accessing services much higher, regardless of whether that agency has LGBTQ-specific services to offer. Similarly, agency staff members' abilities to clearly describe the type and detail of services they have, whether LGBTQ-specific or not, were related to treatment seekers' overall perception of, and the likelihood of accessing, that agency. Moreover, it also signifies the importance of training for *all* staff members at a treatment agency. The agency staff members who answer phone calls are the first point of contact for potential clients. Whether these individuals can create an open, inclusive, and knowledgeable first impression affects clients' willingness to access treatment and potentially impacts future treatment effectiveness and outcomes for GSM clients. Indeed, our findings attested the importance of reducing perceived stigma and discrimination from treatment agencies in order to increase treatment seeking behavior (McNair & Bush, 2016). One study showed that GSM individuals who feel comfortable being "out" to their treatment providers are more likely to exhibit positive health behaviors (e.g., seeking preventive care) and are more comfortable discussing sensitive issues (White, 1998). Another study revealed that providers signaling openness and acceptance could help promote a safe environment and enhance clients' comfort level with self-disclosure (Rankow, 1995).

Taken together with existing literature in this area, the current study reinforces the already observed need for specialized substance treatment services for the GSM population, particularly in rural areas. In addition, it provided feedback from simulated clients' perspectives regarding the specific directions and areas of improvement for increasing treatment accessibility. Our findings indicated a strong relationship between the positive treatment-seeking experience and the agency staff's breadth and depth of knowledge of available services. It also demonstrated a strong need to offer cultural competency training to all agency staff (particularly phone-

answering staff such as the receptionists) so that LGBTQ identified clients could access services more easily and comfortably.

In addition, the current study highlights the urgency for a more standardized definition of "LGBTQ-specific service." Although the language of the N-SSATS survey was relatively straightforward ("For which client categories does this facility at this location offer an abuse treatment program or group specifically tailored for clients in that category?"), it might be possible that many treatment agencies were unclear as to what "tailoring programs" means, and hence created the observed discrepancy between self-report and actual availability. Therefore, it might be useful for SAMHSA to more strictly operationalize the terms "specialized" and "tailored." To that point, another takeaway from the data is that future studies and surveys should include a set of more targeted and detailed questions regarding substance treatment agencies' services and accommodations for GSM clients to gather more comprehensive and accurate data.

### **Limitations**

Although the current study tried to provide significant contributions to the literature on substance misuse issues within GSM communities, we only began to scratch the surface in many respects. For example, we only had seven individuals placing calls to treatment agencies, including some research assistants who did not identify as LGBTQ and/or as individuals seeking substance use treatment. This limited pool for feedback can hardly encompass the diverse attitudes and expectations among GSM or individuals with SUDs we expect to see in real life. The actual calling experiences of transgender clients might be vastly different from those of gay, or bisexual, or gender fluid clients. For example, previous studies have documented that transgender people reported more difficulties accessing care and lower rates of insurance coverage compared to LGB and cisgender individuals (de Haan et al., 2015). Therefore, unique

difficulties that each subgroup may face under the overarching umbrella term "LGBTQ" were not captured in the current study. A study that more directly solicits feedback from members of the GSM community might be more suitable for future exploration.

Moreover, given the limited time and resources, we did not have a control group in which callers were asking general treatment-seeking questions and then rating their experience with the agency. It could be the case that some sites are generally more helpful than the others, regardless of whether the caller is calling regarding a specialized program or service.

In addition, we simulated the initial-contact experience of potential GSM clients who are at least curious about substance treatment programs. However, this meant that we were focusing on a very selected group of clients who might have some shared features that are not known or captured by the study. For instance, clients who are willing to make the initial contact might be from a higher socio-economic background, or they may have more social and familial support for treatment-seeking.

Lastly, due to the impacts of the Covid-19 pandemic, many substance treatment agencies were either closed or had shortened hours. Therefore, nearly twenty percent of agencies were unreachable during our data collection phase. It is unknown how this lack of information might skew our results. A renewed, post-pandemic data collection effort might help fill in the gap.

## **Directions for Future Research**

### **More comprehensive and client-centered data**

As mentioned earlier, the discrepancy observed between the reported existence of an LGBTQ-specific service and its actual availability might occur due to the lack of standardization of its definition. It might also reflect a broader issue within the field of GSM substance use treatment research, which is the lack of data to form a comprehensive understanding of the

problems, barriers, and concerns GSM clients face when seeking treatment. By extension, there is also a lack of consensus on practical solutions treatment agencies could provide to address those barriers and concerns. A study that examined millions of articles in the National Library of Medicine showed less than 0.1% of articles were related to LGBTQ issues (Boehmer, 2002). Moreover, the majority of those GSM-related studies were disease-specific, focusing only on sexually transmitted diseases (primarily HIV/AIDS). This disease-focused approach in the field of health disparity research cannot describe the full extent of GSM people's health experiences, especially in the domains of substance use and treatment-seeking. Therefore, much more research effort is needed in the field. In addition, future research efforts should be centered around GSM clients' treatment-seeking experiences. A more client-centered approach would allow researchers to close the gap in our knowledge between what is being provided and what is truly needed.

### **More in-depth understanding of LGBTQ training**

Many studies have documented the benefits of healthcare providers receiving training regarding GSM clients (Sekoni et al., 2017; Dubin et al., 2018; Morris et al., 2019). For example, a systematic review suggested that LGBTQ+ training for healthcare students and professionals leads to short-term improvement in knowledge, attitudes, and practice with regards to LGBTQ+ specific healthcare (Sekoni et al., 2017).

However, little is known regarding the training provided for substance treatment providers and staff in actual practice. Our data revealed a spectrum of responses that fell under the category of "LGBTQ+ training." From "sensitivity training" to "training on cultural competency" to "LGBT classes providers have to take," the answers gathered in the current study were mostly vague and provided very little insight into what is truly offered for the benefit of



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GSM clients. In consideration of ecological validity, we did not ask follow-up questions that might have seemed too research-oriented and thus raised respondents' suspicions. For that reason, our data raised some questions regarding the scope and level of training treatment providers and agency staff members receive. It is worth exploring the content, depth, length, and credibility of these "LGBTQ+ training" experiences to investigate whether such reportedly LGBTQ-specific services can indeed facilitate healing and recovery for this targeted population. It is also worth exploring whether post-training health professionals are more equipped to meet the needs of GSM clients from both client and provider perspectives. Future research efforts should focus on exploring the potential benefits, drawbacks, and barriers to implementing such training for substance treatment providers and staff, with the goal to find a more precise and unified conceptual model for LGBTQ+ training.

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Appendix

**Appendix 1: Treatment agency information sheet**  
**Information sheet**

Site number:	
Number of call attempts:	
Time and Duration of the call	Date: _____ Time: _____ AM/PM Duration: _____ mins
How many transfers:	
Offered follow up and/or request contact info?	<ul style="list-style-type: none"> <li>• Yes, specify _____</li> <li>• No</li> </ul>
Brief intro to the program (verbatim)	
Currently recruiting/ taking on new clients? (availability)	<ul style="list-style-type: none"> <li>• Yes</li> <li>• No, waitlist? Y, N how long? _____</li> </ul>
Who is organizing those programs? What credentials do they have?	
Program offered:	<ul style="list-style-type: none"> <li>• individual therapy</li> <li>• group therapy Specific group • Yes _____ • No</li> <li>• other, specify _____</li> </ul>

**Appendix 2: Treatment agency information sheet**

**Perceived helpfulness Scale**

Site number: \_\_\_\_\_

1. Overall, on a scale from 1-9, how would you rate your experience?

1	2	3	4	5	6	7	8	9
Poor (problems so bad the call was extremely hard)				Average (have some problems that affected the call)				Excellent (perfect, clear, no problems)

- 1- Poor (problems so bad the call was extremely hard)
- 3- Unsatisfactory (had several problems, really affected the call)
- 5- Average (have some problems that affected the call)
- 7- Satisfactory (minor problems, hardly notice them)
- 9- Excellent (perfect, clear, no problems)

2. The person over the phone was warm, affirming, and understanding.

1	2	3	4	5	6	7	8	9
Strongly disagree				Neutral				Strongly agree

What makes you think so? Please explain:

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3. The respondent's attitude made me feel uncomfortable, triggered, and/or judged.

1	2	3	4	5	6	7	8	9
Strongly disagree				Neutral				Strongly agree

What makes you think so? Please explain:

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2020 LGBTQ Specific Substance Use Service Survey

4. My call was handled at an appropriate speed.

1	2	3	4	5	6	7	8	9
Strongly disagree				Neutral				Strongly agree

What makes you think so? Please explain:

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5. My questions were answered during the interaction.

1	2	3	4	5	6	7	8	9
Strongly disagree				Neutral				Strongly agree

What makes you think so? Please explain:

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6. This interaction helped me feel more comfortable in seeking help from this agency.

1	2	3	4	5	6	7	8	9
Strongly disagree				Neutral				Strongly agree

What makes you think so? Please explain:

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2020 LGBTQ Specific Substance Use Service Survey

7. This interaction helped me learn about information and resources regarding GSM-specific substance abuse treatment at this agency.

1	2	3	4	5	6	7	8	9
Strongly disagree				Neutral				Strongly agree

What makes you think so? Please explain:

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8. Based on this interaction with the agency, how likely would you recommend their GSM-specific program to your GSM friends and families who are in need and are seeking treatment?

1	2	3	4	5	6	7	8	9
Not at all (0%)				50%				100%

What makes you think so? Please explain:

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9. Based on your interaction with this clinic/agency, how can they improve the quality of service and improve your experience with them? (Please circle all that apply)

- more client-centered      more accepting      less judgmental      more supportive
- more knowledgeable      more dependable      more flexible      more patience
- better communication skills      clearer language      better time management
- more honesty      more friendly      pay more attention      less automated
- more available      more specific      more engaged      other

If circled "other", please specify:

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**Appendix 3: Finalized Category Codebook**

<b>Category</b>	<b>Description and Coding Criteria</b>	<b>Code</b>
>Entire Agency/program dedicated for LGBTQ community	describe the agency itself as serving only LGBTQ community (or specific letters within the community)	1
>Sub-program for LGBTQ within agency	Within the agency, have a separate program just for LGBTQ	2
> Specific service for LGBTQ	Housing accommodations for LGBTQ ; support group; community outreach	3
>Individualized therapy for LGBTQ clients	tailored; individualized	4
>LGBTQ training for provider and staff/ certified LGBTQ provider	sensitivity training; cultural issues training	5
>Offered service in the past or plan to in the future	any mentioning of specialized program that they used to have, or in the active process of creating such program	6
>LGBTQ affirmative environment	gender neutral bathrooms, medical record with inclusive language	7
> Non-discrimination policy	anti-discrimination policies, any mentioning of similar policy or expectations	8
> LGBTQ identifying provider	we have providers who are within the community	9
> Accepting of LGBTQ clients	Providers have/had LGBTQ clients currently/ in the past	0