LGBT Communities and Substance Use - What Health Has To Do With It!

A Report On Consultations With LGBT Communities

February 2003

Drafted by Devon MacFarlane
Submitted on behalf of LGBT Communities and the Substance Use Working Group

lgbt health association of b. c.

ACKNOWLEDGEMENTS:

The consultations could not have been undertaken without the assistance and support of many individuals, community groups, and organizations. Their organizing, facilitating, hosting, and advertising of the consultations ensured the involvement of a very broad cross-section of our diverse communities. Nor could they have taken place without the willingness of LGBT people and straight allies to participate and share their knowledge and insights during the community forum, the focus groups and/or interviews.

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Aiyyana Maracle opened and welcomed people to the Community Forum. Moderators, presenters, and facilitators include: Jensen Didulo and Sadie Kuehn were the moderators; presentations were made by Louise Chivers, Gil Lerat and others; Benjamin Owens, Dean Diamond, Dean Dubick, Paul Harris, Victoria Henry, Colin Steel and others facilitated workshops.

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Finally, thank you to the Vancouver Coastal Health Authority for its commitment and support of this initiative on many levels, including staff time and financial resources.

GLOSSARY AND ACRONYMS[1]

ACRONYMS

V/RHB: Vancouver/Richmond Health Board
VCHA: Vancouver Coastal Health Authority
VCMHS: Vancouver Community Mental Health Services (a division of the Vancouver Coastal Health Authority)

DTES: Downtown Eastside

AA: Alcoholics Anonymous
NA: Narcotics Anonymous

TERMS RELATING TO SUBSTANCE USE

Four Pillars or Four Pillar Approach: an approach to substance misuse which encompasses prevention, treatment, harm reduction, and enforcement.

Harm reduction: An approach to substance use issues which focuses on strategies that reduce both the personal and social harm done. This approach is client-centred, working with clients where they, and what they themselves want and need. It acknowledges and accepts that quitting drugs may not be realistic or desirable for everyone; that there are many ways to deal with problems; and that no one approach will work for everyone.

Substance Use: In this document, "substance use" is used to include substance misuse and abuse, and is used to include alcohol, licit and illicit drugs, inhalants, etc. We recognize that while many people do not have concerns with their drug and alcohol use, they may have concerns such as access to information about particular substances, using safely and responsibly, and making informed decisions.

Wet: Programming or services that are accepting of people who are intoxicated or actively using substances – e.g. Needle exchanges, safe injection sites, housing where people may use substances on site.

Damp: Programming or services for people who are aiming to moderate their substance use – e.g. Heroin maintenance; housing where people may use substances off-site, but not in the building.

Dry: Programming or services (including housing) designed for people who are abstinent or are seeking abstinence.

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[1] This glossary draws upon glossaries in ***Creating Visibility: Providing Lesbian-Sensitive and Lesbian-Specific Alcoholism Recovery Services***; ***Your Every Day Health Guide: A Lesbian, Gay, Bisexual and Transgender Community Resource*** and others.

TERMS RELATING TO CULTURE AND ETHNICITY:

Aboriginal: An Aboriginal person may be First Nation, Metis or Inuit. First Nations includes Status Indian, as defined by the Indian Act, and non-Status Indian.

TERMS RELATING TO SEXUAL ORIENTATION AND GENDER IDENTITY

Sexual Orientation

LGBT: acronym for lesbian, gay, bisexual and transgendered.

Queer: a term originally used as a homophobic insult. It has been reclaimed and is used as a term of pride denoting a gay man, lesbian, bisexual, transsexual, or transgendered person.

LGBT communities or **queer communities** is used to identify the fact that there are a diverse range of communities of LGBT people – that there is not a singular homogenous LGBT community.

LGBT-sensitive is used to describe programs, services, and individuals that have made a commitment to serving the needs of LGBT people and communities. That commitment is rooted in knowledge and awareness of the needs of this population.

LGBT-specific: is used to describe supports, programs or activities geared primarily or exclusively to LGBT people.

Bisexual or Bi: is used to describe anyone romantically and sexually attracted to both males and females.

Gay, gay man, fag: terms that men who are sexually and/or emotionally involved primarily with other men use to describe their sexual orientation.

Lesbian, dyke: terms that women who are sexually and/or emotionally involved primarily with other women to use to describe their sexual orientation.

Pansexual or Pan: is used to describe anyone romantically and sexually attracted to people of all genders.

Two Spirited: refers to people of Aboriginal heritage who are lesbian, gay, bisexual, transgendered or queer.

Gender identity is the sense of being male or female that is usually in accord with, but sometimes opposed to, physical anatomy.

Transgender or **TG** or **Trans**: refers to individuals who do not fit or who challenge conventional gender categories of male/female. This term is often used as an umbrella to cover other terms such as transsexual; bigender; third gender; drag queen; drag king; intersex; two-spirited; transvestite or crossdressers.

Transsexual or **TS**: refers to individuals who do not identify with the gender they were assigned at birth and want or have had hormonal treatment and sex reassignment surgery. Some transsexual people do not identify with the terms "transgender."

Trans Woman, Male-to-Female, or **MtF:** transsexual or transgendered persons who were assigned male at birth, but consider themselves female all or part of the time.

Trans Man, Female to Male or **FtM:** transsexual or transgendered persons who were assigned female at birth but consider themselves male all or part of the time.

Transphobia – a fear or hatred of people who are transgendered, transsexual or challenge conventional gender categories of male/female.

Homophobia – describes a fear/hatred of same-sex relationships, of gays and lesbians, and/or of one's own feelings for individuals of the same gender.

Heterosexism is the presumption that heterosexuality is the norm or standard, or is considered the "natural" of superior preference.

Gay bashing refers to physically or verbally assaulting someone on the basis of their perceived sexual orientation or gender identity.

Gay-Straight Alliances are student clubs formed in high schools. In BC, they require the support of school administration and the involvement of at least one teacher.

"Out," "coming out," or "out of the closet" is the more or less public act of declaring oneself queer, lesbian, gay, bi, or trans. It is important to remember that a person may be out in selected circumstances, such as to friends, but not family, co-workers or neighbours.

"Closeted" or "in the closet" is a term used to describe someone who has not disclosed their sexual orientation or gender identity to others, and perhaps has not admitted it to themselves.

"Rainbow" or "Rainbow flag" is a popular international symbol celebrating the diversity of LGBT communities.

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1.0 INTRODUCTION

Drug and alcohol use and misuse are priority health issues in the lesbian, gay, bisexual and transgender (LGBT) communities of Vancouver and Richmond. Yet, these identified priorities have met with the reality that there are few resources dedicated to supporting LGBT people who are concerned about substance misuse or who are pursuing abstinence.[i] Until recently, no detailed needs assessments or research had been conducted into what LGBT substance users[2] perceive their needs to be, how best to address them, and/or how best to support and increase the capacity of individuals and communities regarding substance use issues.

In 2000, the Lesbian, Gay, Bisexual, and Transgender Population Health Advisory Committee (LGBT PHAC)[3] invited a diverse group of informed individuals from LGBT communities to a meeting to discuss whether they agreed that substance use and its impact in LGBT communities was an area needing study and, if so, what questions needed to be asked and what methodology should be used to glean the needed data. The participants at that initial meeting decided to form a Substance Use Working Group. The Working group is a partnership between the LGBT PHAC, as a part of the V/RHB; the LGBT Health Association; The Centre: A Community Centre Serving and Supporting Lesbian, Gay, Transgender, Bisexual People and Their Allies; and community members. The membership in the working group consisted of people who use(d) substances, people who seek and who have achieved abstinence; members of the community at large; service providers, and people with experience in community development and community-based research. Two of the members sat on the LGBT PHAC, one was a staff person with the LGBT PHAC, and the other members were interested individuals and representatives from other organizations. The mandate of the Working Group was to design and conduct a series of consultations, as a detailed, systematic and rigorous evaluative research project, to ascertain our communities' needs and concerns. Particular efforts were made during the project to ensure that as many parts of LGBT communities as possible were included in this undertaking. As a result many Aboriginal people, people of colour, people with mental, physical and sensory disabilities, sex trade workers, transgendered people and youth members of the community participated in the project.

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[2] By "LGBT substance users" we mean lesbian, gay, bisexual and transgendered persons who use alcohol, illicit drugs, and other substances or who are abstinent or are seeking abstinence from substance use. We recognize that many people who use substances do not have concerns with their use. Nevertheless, some of these people want more information about substances, their effects, and how best to use in a responsible and healthy way.

[3] The Lesbian, Gay, Bisexual, and Transgender Population Health Advisory Committee (LGBT PHAC) was connected to the Vancouver Coastal Health Authority through the former Vancouver Richmond Health Board (V/RHB). The V/RHB was merged with other health authorities to create the Vancouver Coastal Health Authority. The LGBT PHAC was one of the V/RHB's 15 public committees. The LGBT PHAC and the other public committees advised and assisted the V/RHB with a number of governance functions, including health plans and strategies and resource allocation. The LGBT PHAC and the other public committees of the V/RHB were dissolved in April 2002.

This report is the outcome of research, gathered through community consultations, which consisted of:

- A community forum (March 2001), to begin discussions, to get input from the community about substance use, misuse and abuse; to raise awareness, and to offer opportunities to educate both LGBT communities and straight communities about the issues.
- Twenty-three focus groups for community members, service providers, and allies, supplemented by seven interviews, to obtain in-depth information about the needs, wants, expectations, as well as gaps in services, and ensure that information gathered through the process is representative of the diversity of the LGBT communities.
- Through the review of other research undertaken of the Vancouver/Richmond LGBT communities by members of the working group to ascertain the diversity of the community. And by reviewing which cultural communities were involved in its focus groups, it was able to ascertain some of the interlinking issues impacting on drug use, misuse and abuse (for instance, whether gender plays a role in substance use and access to appropriate services).

Goals

The goals of the consultations were to:

Develop community capacity:

- Identify what could by accomplished through the use of a community development approach or model;
- Identify what supports, programs and services people want, need and suggest;
- Ascertain whether LGBT substance users feel listened to;
- Determine whether LGBT substance users experience social isolation

Develop more responsive and effective services:

- Find out from lesbian, gay, bisexual and transgendered people what supports and services they need and what would improve existing services;
- Find out from service providers working with LGBT people what their perspectives are on the needs of LGBT people, and what supports they themselves need to work effectively with the queer communities;
- Present recommendations to the Vancouver Coastal Health Authority, governmental bodies, community groups and members of the public, to LGBT and substance user organizations throughout Canada and internationally.

Timeliness

This report comes at a time where discussions about and changes to addiction services are already occurring on a number of fronts in Vancouver. The Vancouver Coastal Health Authority is redesigning addiction services, both for adults and for youth, for the whole of Vancouver. The federal and provincial governments, the City of Vancouver, and the Vancouver Coastal Health Authority are implementing the ***Vancouver Agreement***, a five-year, three-party agreement among the federal, provincial and municipal governments to look at substance use and abuse. The Agreement is aimed at improving the social and economic conditions in all Vancouver communities. The first community focused on is the Downtown Eastside. The Vancouver Agreement uses the model of a four-pillar approach:

- prevention,
- treatment,
- harm reduction, and
- enforcement

Responsibility for providing and coordinating addiction services in Vancouver, Richmond, and the North Shore lies with the Vancouver Coastal Health Authority (VCHA). The VCHA was formed in December of 2001 from the Vancouver/Richmond Health Board (V/RHB), the North Shore Health Region, and the Coast Garibaldi Community Health Services Society, Sunshine Coast Community Health Council, Sea to Sky Community Health Council, and Powell River Community Health Council.

A Framework for Action: A Four Pillar Approach to Drug Problems in Vancouver identifies that, although many policies and strategies addressing drug problems are federal and provincial responsibilities, local communities play a key role in shaping and implementing these strategies. **Community involvement** will ensure that:

- Specific communities are included
- It is locally relevant
- It is immediate and targeted to particular problems and populations.[ii]

2.0 METHODOLOGY

Our needs assessment consisted of an initial community forum, focus groups, and committee meetings. Data analysis was iterative.

2.1 COMMUNITY FORUM

The community forum consisted of a panel discussion, two workshop sessions, and a plenary discussion with reporting back of key issues raised in the workshops. The 41 people in attendance included people who are currently using; people in recovery; addictions counsellors and other service providers; and people involved in policy development. Participants included allies as well as LGBT people. Demographics information was not collected.

The panelists spoke to what resources are available for LGBT people; trends in substance use; and process addictions. Five workshops were offered:

- Hepatitis C, HIV/AIDS and Substance Use;
- Understanding Substance Use and Addictions;
- Mental Health and Substance Use;
- Substance Use and Institutionalization; and
- Youth and Substance Use.

All of the workshops, with the exception of Youth and Substance Use, were 1.5 hours long. The workshop on Youth and Substance Use was 3 hours long, limited to people age 25 and under, and youth-facilitated.

In the workshops, groups considered the following questions:

- What are some of the issues relating to substance use and the workshop topic?
- What are some of your own experiences with these issues?
- What are some useful actions that could be taken to support individuals in these situations? Who should do this?
- What recommendations would you make?

Facilitators recorded discussion points on flipcharts, which were compiled for later use.

2.2 FOCUS GROUPS

Focus groups served as the primary method for data collection. Focus groups were facilitated as supportive group discussion to allow the development of ideas through exchange. Interactive and collaborative in nature, the groups yielded detailed and nuanced understandings of the communities' concerns. They also broke down isolation from multiple marginalizations (due to being a sexual minority, the stigma of substance use, and further marginalizations based on gender, gender identity, race, culture, socioeconomic status, dis/ability, and mental illness).

The LGBT Substance Use Working Group chose to have a broad range of focus groups that could address many of the diversities of LGBT communities. The working group was aware that due to multiple marginalizations and the areas of discussion, people might not be as forthcoming about their particular needs and issues in groups that were not peer based. The working group believed that having very targeted focus groups and offering five focus groups in languages other than English would reach segments of the LGBT population that usually do not participate in consultations. Groups were held in different parts of Vancouver and Richmond, to reduce barriers due to transportation, preference or discomfort in attending a focus group in or outside one's neighbourhood.

Focus groups were offered primarily in English. Groups were also held in American Sign Language; Cantonese; Spanish; Vietnamese; and South Asian languages (Hindi, Urdu, Punjabi). By addressing language needs and cultural issues, it was possible to gather information that helped to develop a better understanding of how cultural issues, sexual orientation, gender identity, and issues around substance use intersect in different cultures, and learn about culturally specific concerns for programs and services. Information from the Cantonese speaking focus group was supplemented by an interview with a Chinese service provider working with the queer Asian community. Information from the Vietnamese focus group was supplemented with a more informal discussion with the facilitator. Both of these took place to gain a more in-depth understanding of cultural issues for these communities.

Facilitators were recruited from stakeholder communities, which were defined as queer, lesbian, gay, bisexual and/or transgendered and with personal experience of current or past substance use. Facilitators had a broad range of experiences of substance use, including social and recreational use, addiction to street drugs, recovery and abstinence. In the majority of the specifically targeted focus groups, the facilitators were also members of the target population. Facilitators were recruited through word of mouth, people who had attended the community forum, a call for facilitators widely distributed via email, and from members of the Substance Use Working Group. Facilitators attended orientation and training sessions which addressed the purpose of the project, discussion of the questions, confidentiality, and focus group facilitation skills. Among the facilitators were trained researchers in social and behavioural sciences.

2.2.1 DATA COLLECTION METHODOLOGY

At all spoken-word sessions, detailed field notes were taken. The note taker for all but one of the English-language focus groups was the project coordinator. Note takers who were bilingual or multilingual were recruited for the groups in Cantonese, Spanish, Vietnamese, and South Asian languages. A professional ASL interpreter was hired for the group held in ASL for the note taker to be able to record the discussions. In each of the focus groups, participants were asked to complete a

ballot giving them the option of agreeing or disagreeing to have the focus group audio recorded. Two focus groups, one for the Vietnamese community and one for lesbian, bi and trans women living in the Downtown Eastside, chose not to be tape-recorded. The measures regarding confidentiality were explained. Only the project coordinator had access to the tapes from all of the focus groups. The other note takers were responsible for transcribing the tapes of their focus groups.

In addition to the field notes, tapes from the focus groups were used to prepare abbreviated transcripts. Notes were verified and supplemented by details from reviewing the tape recordings. These abbreviated transcripts were analyzed thematically. Following that, the notes taken at the community forums were added to the master document.

The major themes identified included:

- Accessing appropriate and effective supports and services related to substance use and addictions
- The need for community information and education relating to substance use and addictions
- Accessing appropriate supports and services relating to determinants of health

Section 4.0 Prevention, addresses all three themes, while section 5.0 Treatment and 6.0 Harm Reduction focus on accessing appropriate and effective supports and services relating to substance use and addictions.

2.2.2 RECRUITMENT

Focus group participants were recruited through a variety of methods, including the community forum on substance use; postering in neighbourhoods with large LGBT populations (West End and Commercial Drive); snowball sampling; notices in community papers (Xtra West, Georgia Straight; Vancouver Courier) and on queer radio shows (Queer FM and Fruit Salad). Notices were distributed and posted at community agencies, addictions and other health services. Notices were distributed via email to LGBT list servers, to individual contacts and organizations. Facilitators also assisted in recruiting participants, and were key in recruiting participants in the language-based focus groups.

Materials were translated into Spanish and Cantonese to increase the ease of reaching the Latino and Chinese communities. After discussions with members of the South Asian communities, it was realized that translating materials into Hindu, Urdu and Punjabi would not be feasible, as different components of the population use different scripts for the same language. For a number of reasons, it was not possible to get a recruitment notice translated into Vietnamese.

A strategy that was successfully used to recruit participants was to hold focus groups

in, or at the same time and in the same building as, drop-in groups. The coordinator of the Richmond Youth Drop-in asked the drop-in group if they would be interested in taking part in a focus group, and they agreed. A second youth focus group and the Two-Spirit focus group were held in the same building and at the same time as the Boys R Us drop-in. This was a successful way of recruiting young men involved the sex trade. The facilitator of the Vietnamese group invited a diverse group of friends who use drugs to take part in a focus group, which they conducted in his home over dinner. The facilitator and note-taker for the Latino group held a focus group in conjunction with a safer-sex workshop and recruited from their social and community networks.

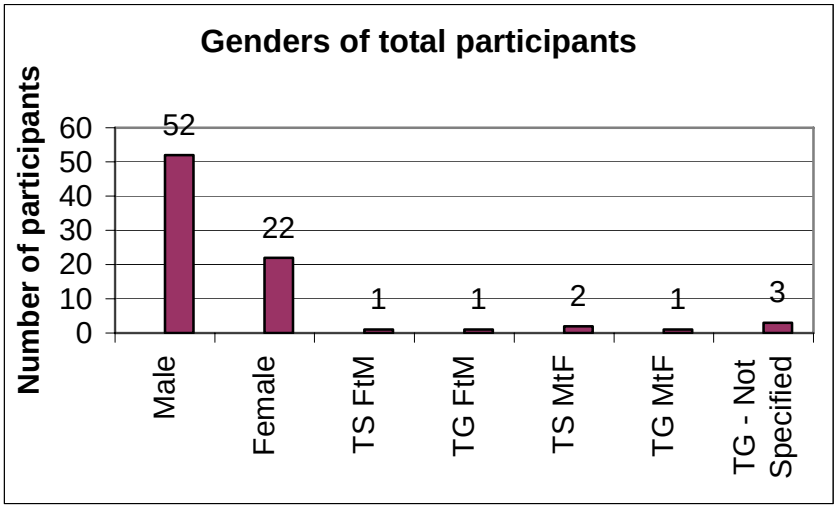
Barriers that were faced in recruiting participants were the amount of time required to conduct thorough outreach to multiply marginalized populations, further augmented by the inherent barrier of asking people to come and speak about a stigmatized topic. Even when facilitators attempted to recruit participants from their social and using networks, where levels of trust and comfort were already established, many reported it to be very difficult. Aside from the Richmond Youth Group, recruiting participants from Richmond was a challenge, due to the lack of an organized and visible LGBT community in that city. One of the challenges of organizing the focus groups that a higher proportion of people than was expected would register for groups and then not attend.

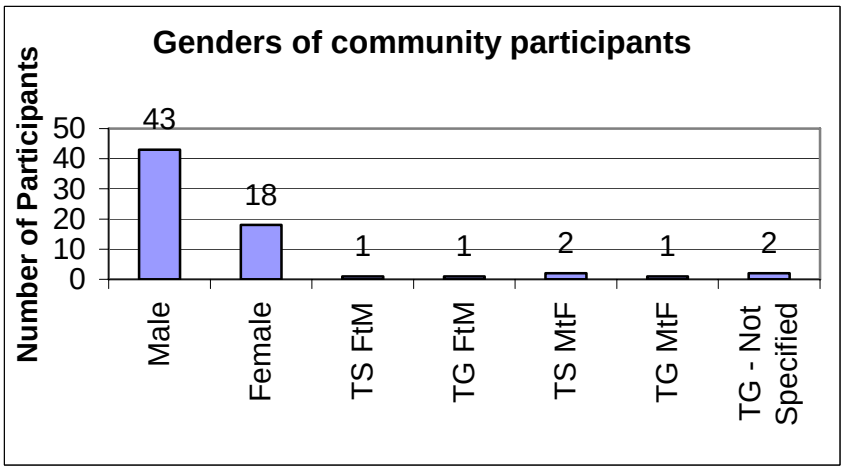
2.2 DEMOGRAPHICS

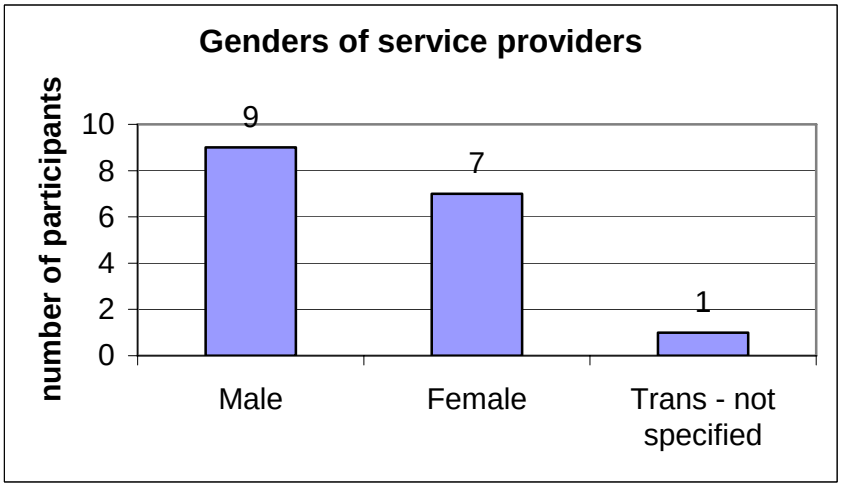
Eighty-two people participated in the focus groups. Sixty-five of them were participants in community focus groups, and 17 were in service provider focus groups. Participants were asked to self-identify their race or cultural background, their first language, their gender, and their sexual orientation.

2.2.1 GENDER

Participants whose gender identification is “man” or “woman” and who also self-identify as transgender or transsexual, or attended a trans focus group, were sorted throughout the demographic analysis as trans, in order to attempt to have a better understanding of the trans people that we saw. Approximately 63% of the participants were male, 26% female, and 10% transsexual or transgendered.

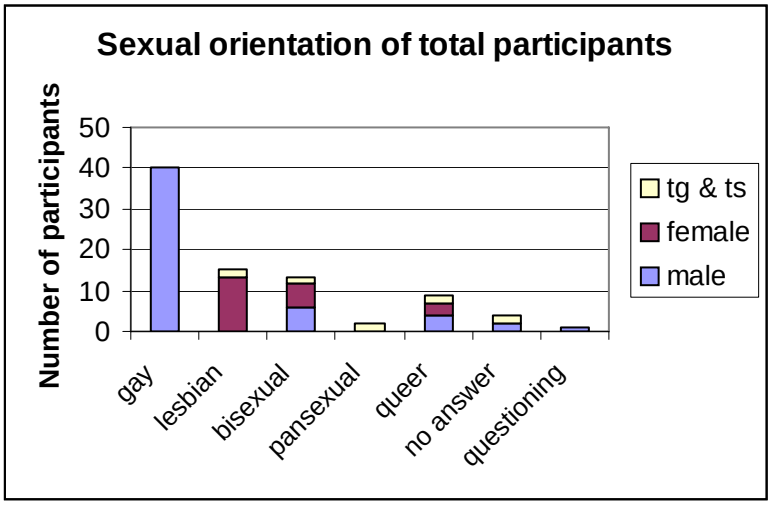

Genders of total participants
Number of participants
60
50
40
30
20
10
0
52
22
1
1
2
1
3
Male
Female
TS FtM
TG FtM
TS MtF
TG MtF
TG - Not Specified

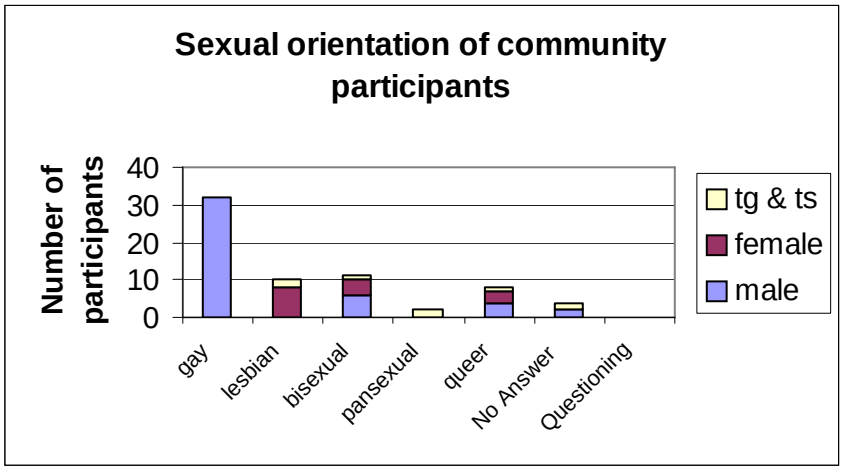

Genders of community participants
Number of Participants
50
40
30
20
10
0
43
18
1
1
2
1
2
Male
Female
TS FtM
TG FtM
TS MtF
TG MtF
TG - Not Specified

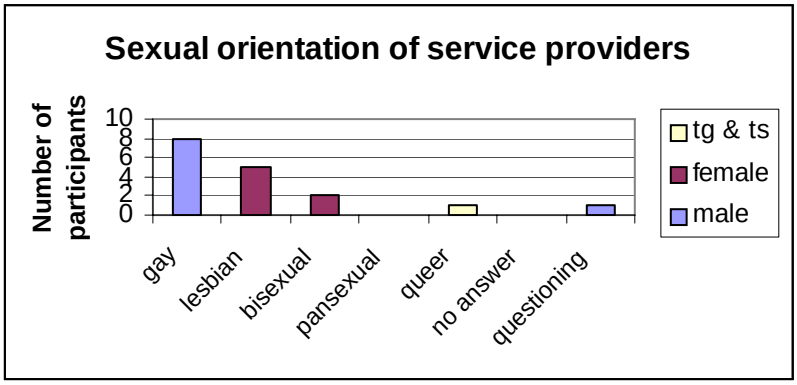

Genders of service providers
number of participants
10
8
6
4
2
0
9
7
1
Male
Female
Trans - not specified

2.2.2 SEXUAL ORIENTATION

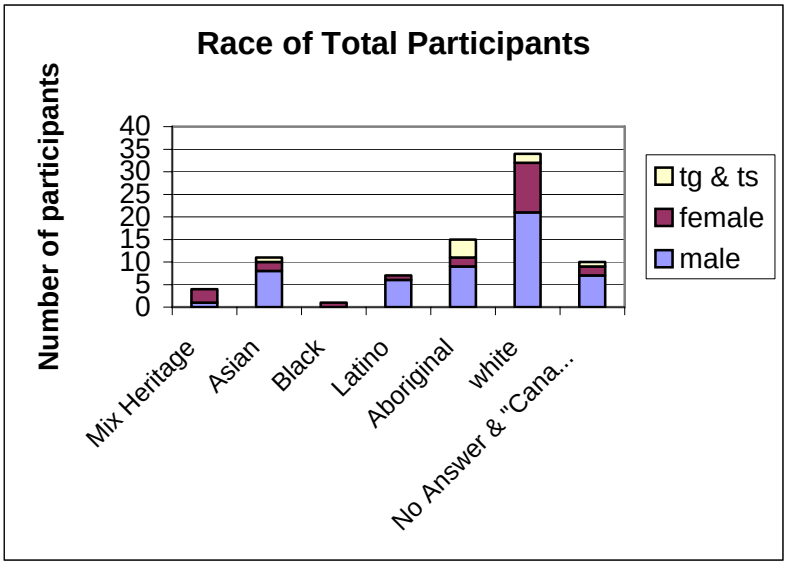
Participants self-described their sexual orientation in a variety of ways. Approximately 49% of participants self-identified as gay men; 15% as lesbians; 15% as bi or pansexual; 11% as queer; 5% gave no answer and one person identified as questioning.



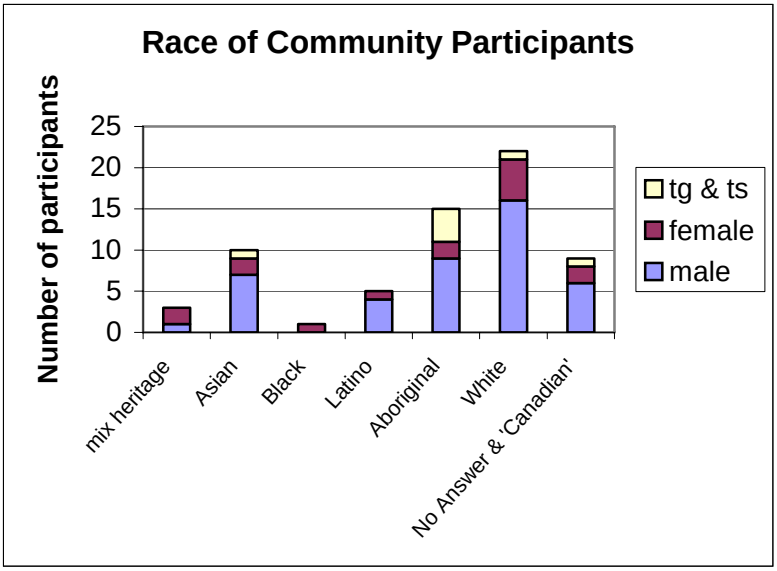


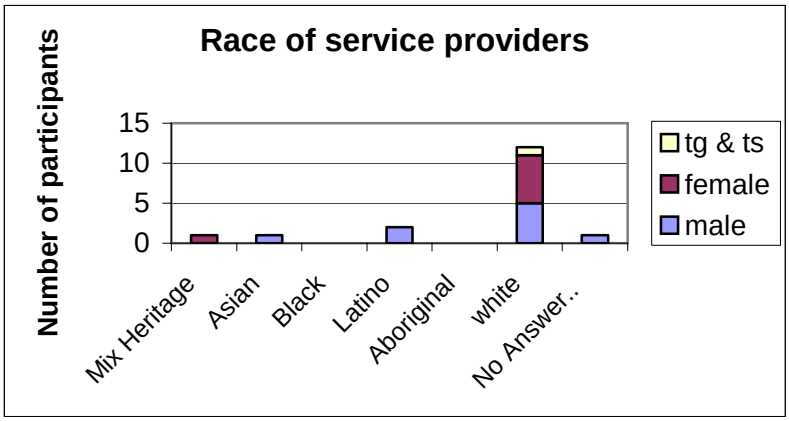


2.2.3 RACIAL AND CULTURAL AFFILIATION



Participants in the focus groups came from diverse cultural backgrounds: 42% of the women self-identified as people of colour; 46 % of men as people of colour; and 62 % of trans people self-identified as people of colour.

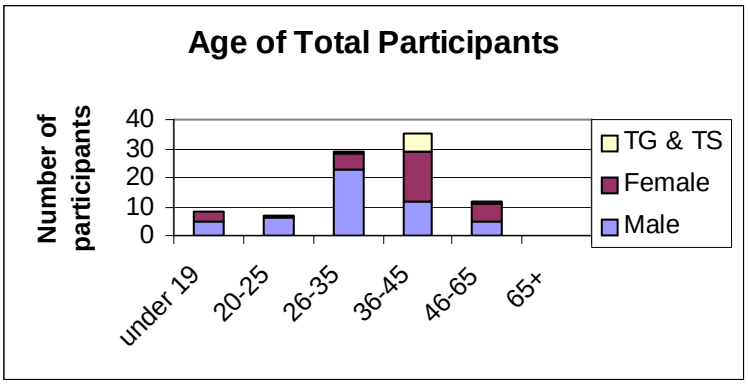


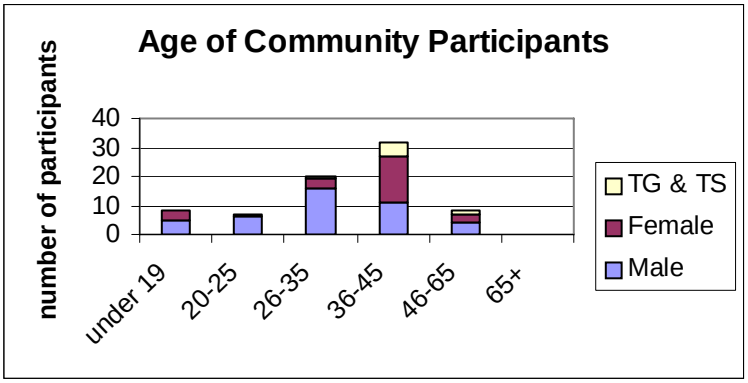


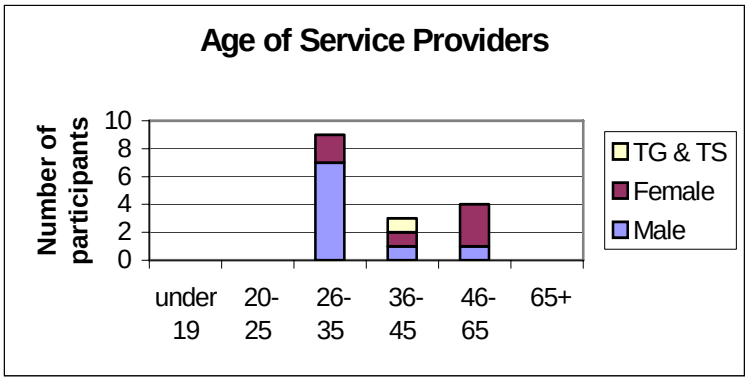
The service provider participants were significantly less culturally diverse than the community participants.

2.2.4 AGE

The focus groups drew 15 people, or 19% of the participants, who were age 25 or under. Over a third (34%) of the participants were between the ages 26 and 35; 33 % were between ages 36 and 45; and 14% were between 46 and 65. None of the participants were over age 65.

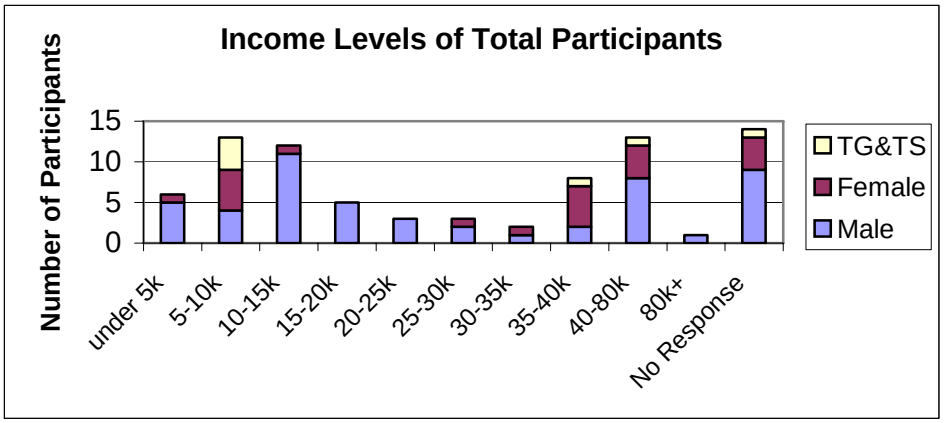


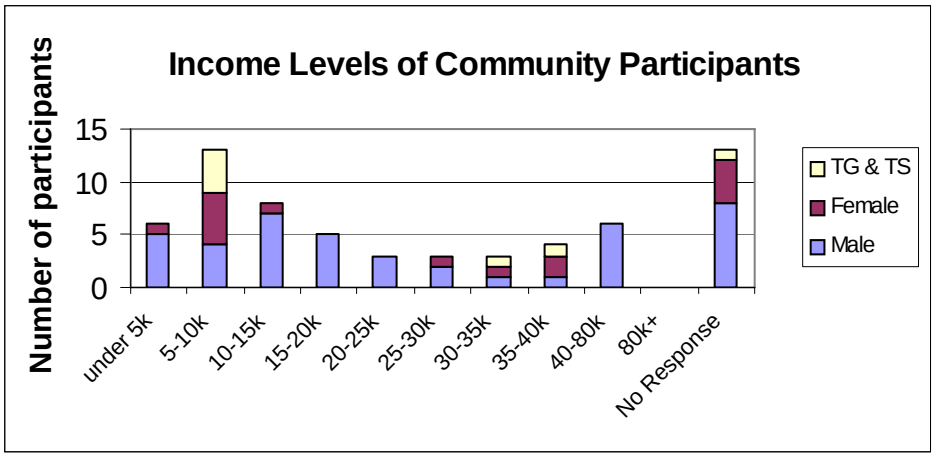




2.2.5 INCOME

Participants had a range of income levels: 29% of community participants reported incomes of $10,000 or under per year; a further 21% reported incomes between $10,000 and $20,000 per year. Overall, the distribution was as follows:





2.2.6 DIVERSITY OF SAMPLE

The focus groups were successful in recruiting men of colour and young men. There was moderate success in recruiting transgender and transsexual people, as they comprise 10% of the community participants. Groups that were under-represented include women of colour; trans people of African, Asian and Latino descent; African-Canadian men; young women; young trans people; and community participants who have middle to upper income levels. There was a complete gap in recruiting participants over the age of 65. In the focus groups that were language based, only four women participated. Three of the women were participants in the ASL group, and the other in the Spanish-speaking group. This may be due in part to the facilitators of the language-based group all being men, and that many if not all of the participants were part of their social networks. Further research may be needed into the needs of immigrant and visible minority queer women and trans people.

2.2.7 FOCUS GROUP COMPOSITION

Focus group sizes ranged from two to nine participants, with an average group size of four. Eight people took part in more than one focus group. Notes, tapes and transcripts were reviewed in order to ensure these people were not over-represented. Participation in more than one group was allowed as participants discussed different issues and nuances of issues in different peer-groups. A total of 23 focus groups were held. In five cases, the focus groups were run as interviews when a sole participant attended. Facilitators were given the opportunity to contribute their experiences, thoughts and ideas to the research by taking part in a focus group specifically for the facilitators. In two additional instances where none of the confirmed participants attended, the project coordinator/note taker interviewed the facilitator, resulting in a total of seven supplementary interviews being held. The interviews were conducted following the format and questions used in the focus groups.

A core series of focus groups had been planned, and then additional groups were held based upon demand, opportunity, and addressing under-representation from particular population groups.

Groups that were conducted as interviews are as follows:

- Disabilities
- People who have been institutionalized
- Transgendered / Transsexual (three separate interviews)
- South Asian community member
- Chinese Service Provider

Table 1:

Focus Groups (grouped by population)	Number of focus groups	Number of Participants
Mixed LGBT	3	7
Lesbian, Bi and Trans Women	2	6
Gay, Bi and Trans Men	2	6
Mental Health	2	9
Two-Spirit	1	5
People of Colour	1	2
Youth	2	15
Sex Workers	1	2
Facilitators	1	2
Service Providers	4	17
American Sign Language	1	3
Cantonese	1	2
Spanish	1	5
Vietnamese	1	5

In order to reduce barriers to attending the focus groups, childcare and transportation costs were reimbursed and snacks were provided, and groups were held in physically accessible locations well served by public transit. Focus groups were held in the daytime, in the evening and on weekends in different neighbourhoods in Vancouver - Commercial Drive, the Downtown Eastside, Mount Pleasant and the West End. Focus groups were held a variety of locations: community health centres (REACH; Pender, Raven Song and Three Bridges); spaces in non-profit organizations (Pacifica Treatment Centre; Portland Hotel; Richmond Caring Center), in the home of a facilitator and of an interview subject.

2.3 DIVERSITY AND HEALTH STATUS OF THE LGBT POPULATIONS

In every section of the population, in every community, race, age, class, gender, colour, range of abilities and disabilities, there are lesbian, gay, bisexual and transgendered people. Although the population is extremely diverse, it shares common expression of being vilified, persecuted, verbally and physically attacked, ignored and rejected because of being perceived as 'deviant' due to sexual orientation or gender identity. "LGBT people are subjected to institutional and systemic abuse, discrimination, denial and the with-holding of privileges heterosexuals take for granted. This is due to their non-conformist form of behaviour, identity, relationship, and community.[iii]

A Community Report on the Health Concerns of the Lesbian, Gay, Bisexual and Transgendered Communities documents the effects of systemic and individual oppression through heterosexism, homophobia and transphobia and their impact on LGBT people and communities through higher incidences of disease and lower health status, and through creating significant barriers to adequate health care, which also contribute to higher rates of disease and lower health status. In addition to substance use, lower health status manifests itself through stress, incidence of disease, poverty, domestic violence, physical, emotional, sexual and spiritual abuse, hate crimes, stress related suicide and depression.[iv]

The ***LGBT Health Care Access Project Final Research Report***, based on research conducted locally, notes that "negative treatment can affect LGBT individuals anywhere and any time, threatening both their physical and mental health. Disrespect, abuse, mistreatment, sub-standard services, inappropriate comments and behaviours violate basic human rights and dignity. People's rights to proper health care are universal, and should be respected at all times for all individuals."[v]

In the focus groups and interviews, participants articulated barriers, issues and challenges which affect their health and well-being. These included use of substances before age 12, violence (childhood sexual assaults, childhood abuse, gay-bashing, etc) mental illness, poor mental health, poor self esteem, internalized homophobia and shame, social isolation, lack of family and social supports, challenges in connecting with queer communities, being subjected to systemic

homophobia and transphobia, racism, poverty, inadequacy of welfare and disability rates to meet basic needs, and barriers due to physical disability and Deafness. Participants described issues for specific groups:

Deaf and Hard of Hearing

- Homophobia and transphobia within the Deaf community
- Loss of friendship networks within the Deaf communities after coming out
- Difficulties in obtaining privacy and confidentiality within Deaf communities with coming out or with seeking support relating to substance use

> I was married and I got divorced. My husband and I split. And Deaf people heard that I was a lesbian and they were gone so fast. I had no friends. I was left totally alone. And I tried to... I had a suicide attempt. I was depressed - coming out was very difficult. *"Alice," Deaf lesbian.*

- Barriers to accessing LGBT hearing communities; including lack of interpretation services; lack of TTD/TTY machines in LGBT-specific and LGBT-sensitive agencies; lack of access to information about LGBT community events
- High rates of substance use in Deaf communities
- 80% unemployment rates

Disabilities:

- Multiple marginalizations due to having a disability, being queer, having issues with substance use; as well as further marginalizations on the basis of race, culture, mental illness; poverty; access to education
- Mental health problems are more common among people who are socially isolated and have little support. Mental health concerns include high rates of depression; suicidal tendencies; trauma; anxiety disorders; obsessive-compulsive disorders; and agoraphobia
- Risks of and vulnerabilities to violence and other abuse associated with receiving physical care and/or home-maker services compounded by homophobia or transphobia of care providers and other persons in the health system; and high rates of severe abuse experienced by people who have been disabled since childhood
- Inadequate information about whether or not disclosing substance use will impact access to service and supports such as home making, personal care, disability benefits and welfare, resulting in fear and lack of disclosure when people are in need of support relating to substance use
- Over-prescription of medications for physical or mental illnesses
- Lack of access to information on adverse reactions between prescribed and illicit substances, with associated increased risks of lethal interactions and overdoses
- Lack of access to prevention and harm-reduction information and supports
- Lack of support and promotion of decision making about one's own care, and access to information relevant to decision making

- Lack of physical access to community spaces and events, including LGBT communities and ethno-cultural communities
- Lack of acceptance or support in some cultural communities, due to having a disability and/or being queer
- Inadequate outreach to people with disabilities from LGBT communities
- Timely access to transportation
- Poverty and low employment rates
- Social isolation contributing to substance use; over-medication; poor mental health, poor self-esteem

Ethno-cultural Communities:

- Barriers due to language and culture, racism and discrimination, in accessing supports in queer communities, health and addiction services, and society at large
- Very few supports and resources dedicated to queers from different cultures
- Inadequate access to service providers who are culturally and linguistically competent and who are sensitive to the specific needs and concerns of LGBT people
- Lack of cultural diversity of service providers in many agencies, including those serving LGBT communities and those which address determinants of health
- Denial among some members of cultural communities that people from their cultures use substances and have addictions
- Cultural views on substance use and addictions can create barriers to accessing information and seeking support
- Social isolation, especially for people who move to Canada alone, and do not have friends and family living here.
- First-generation LGBT people face stresses due to differences between family culture and expectations and dominant culture.
- The process of applying for immigration or refugee status is very energy intensive. In this time, immigrants and refugees are at risk for poor mental and physical health, and they do not have adequate supports for this
- Immigrants and refugees face barriers to employment, and welfare rates are inadequate. These factors increase the risks for some immigrants and refugees to use substances and/or get involved in the drug trade

> One [Asian] guy went to a group for gay men who are HIV positive, and it was good, he liked the group, and he thought that people would stay behind and get to be friends. He was surprised that after the group everyone just left... From his perspective, you only talk about personal stuff that's that personal, you can only do that with friends, so he expected friendship from the people who were there, but that wasn't necessary for the people in the group coming from a western mentality…. So it was a big cultural shock from him, as he was expecting really deep friendships. *"Ming," Chinese Service Provider*

Mental Health Consumers

- People with mental illness often experience stigma from society at large and marginalization within LGBT communities – other LGBT people often are not welcoming of queers with mental illnesses
- Treatment programs often do not ask about or address dual-diagnosis issues
- Stereotyping can result in issues not being identified and addressed (e.g. older gay men often missed for body image and eating disorders)
- Doctors often over-prescribe medications, or are unwilling to prescribe non-addictive, non-euphoric antidepressants
- In the 1970s and earlier, some LGBT people were subjected to psychiatric treatments, including shock therapy, in attempts to 'cure' them of their sexual orientation or gender identity
- In mental health group homes, there may be very little understanding of drug and alcohol issues, which may result in residents not being permitted to leave to attend support group meetings
- There can be significant rates of and problems associated with substance use in institutions. Many beds in institutions have been closed in BC, without adequate resources being transferred to community settings

Transgendered People

- Many programs and services relating to health and to substance use are sex-segregated. Trans people who are in transition or who do not feel that "male" or "female" accurately expresses their gender experience barriers to accessing these services. Very few inpatient or residential services have single rooms and single-stall washrooms to accommodate transgendered people
- Lack of service provider knowledge and sensitivity to trans issues
- High levels of internalized stigma and shame, poor self-esteem, poor mental health
- High rates of HIV infection and violent experiences among transgendered sex trade workers
- Lack of family support
- Abuse in childhood
- Lack of trust of service providers
- Lack of safe space for transgendered sex trade workers
- Perception that disclosing history of substance abuse or childhood sexual abuse to staff at the Gender Clinic will prevent access to sex reassignment surgeries
- Cumulative barriers and marginalizations which result in barriers to completing high school or GED and limit options to employment
- Currently the BC Human Rights Code does not prohibit discrimination on the basis of gender identity

Two Spirited people:

- Racism in LGBT communities, among service providers, and in mainstream society
- Homophobia within some First Nations communities, largely a result of colonization, which may result in Two Spirited people being excluded from their communities and from taking part in ceremonies
- While some Aboriginal agencies are supportive of Two Spirited people, others are not. Two Spirited people may be cautious about using some First Nations resources as a result of this
- Lack of awareness and sensitivity to First Nations issues in many organizations that are not Aboriginal-specific
- Disconnection from Aboriginal communities and heritage; due to a variety of circumstances, including Aboriginal children being fostered in non-Aboriginal families; impacts of residential schools and other reasons
- Bureaucracies not understanding that this disconnect happens, and that some Aboriginal people are not comfortable accessing Aboriginal services
- High rates of HIV among Two Spirited people

2.3.1 Rates, Risks and Protective Factors for LGBT People

There is a commonly held belief that, due to a number of complex factors, levels of substance use are higher in the LGBT communities than on average. ***Healthy People 2010: Companion Document for Lesbian, Gay, Bisexual and Transgender (LGBT) Health*** summarizes research on rates of substance use in LGBT populations in the United States. Research has focused primarily on lesbians and gay men, and few studies have specifically been designed to include bisexual and transgendered persons. However, it appears that substance misuse and abuse in the LGBT communities is at least as serious a problem as it is for the general population in the USA. Recent data indicates that there appears to be a decline in the usage of substances, especially alcohol, amongst lesbians and gay men over the past 20 years. ***Healthy People 2010*** refers to studies which cite that, in 1992, it still appeared that there was more heavy drinking amongst lesbians and gay men than in the general population, and this behaviour persisted later in life than on average. Lesbians were shown to drink more heavily than both straight women and straight men.[vi] As well, lesbians and gay men are less likely to abstain from alcohol and drug use. Lower rates of abstention show up more consistently in studies than higher rates of "heavy drinking". Furthermore, amongst youth and some older groups of lesbians and gay men, heavy drug use and drinking, is prevalent.[vii]

Hughes and Eliason summarize research relating to protective factors for LGBT people. They note that researchers theorize that given the stigma associated with a non-heterosexual identity and behaviour, substances may be used by queer people to lower inhibitions associated with same-sex sexual activity. Furthermore, substance use appears to be linked to sexual activity in very different ways for gay and bisexual men than for lesbian and bisexual women.

While few studies have explicitly explored protective factors for lesbians and gay men, and very little is known specifically about bisexual and transgendered people, several factors that are commonly protective in the general population appear to not be as protective among lesbians and gays.

For the majority of the general population, rates of substance use are highest in early adulthood and decrease with age. However, it appears that for lesbians and gay men, older age may be less of a protective factor than it is amongst heterosexuals.

Generally, women are less likely than men to become dependent on substances. However, being female is less of a protective factor for lesbians than it is for heterosexual women.

While in general, white women and men are more likely to report use of almost all substances than their non-white counterparts, it appears that among lesbians and gay men of colour, their patterns of substance use are more similar to those of white lesbians and gay men than to their racial/ethnic heterosexual counterparts.

The combination of employment and other social roles is believed to be a protective factor among heterosexuals. Employment choices, opportunities and stresses differ for lesbians and gay men compared to heterosexuals, resulting in increased risks. However, social roles, and levels of social and legal support and recognition differ significantly for lesbians and gay men. Protective factors that may benefit lesbians and gay men include that in same-sex relationships, responsibilities tend to be more equitably distributed than in heterosexual relationships; and lesbians and gay men often perceive their communities as sources of support.

Risks of depression appear to be higher amongst lesbian and bisexual women, particularly for queer women of colour. Significant stress generally occurs among members of stigmatized and marginalized minority groups. LGBT people, particularly lesbians, have high rates (73% and 80% of lesbians in two separate studies) of using mental health services such as therapy or counselling, which may help to reduce the correlation between stress, depression and substance use.

Lesbians and gay men are at least as likely as heterosexuals to experience violence in intimate relationships. There are greater barriers to seeking help. The isolation and stigmatization may increase substance use; and substance use may increase vulnerability to further violence.

Lesbians are as least as likely as heterosexual women to have experienced childhood sexual abuse. Gay and bisexual men also appear to have high rates of childhood sexual victimization. Childhood sexual abuse is linked with substance use.

Lesbians and gay men may be more strongly influenced by peer and partner drinking levels than heterosexuals. Peer groups, particularly those who socialize in bar settings, can create social norms for substance use.[viii]

3.0 Substance Use in Local LGBT Communities

Common beliefs among participants include that LGBT people have higher rates of substance use and addiction that on average. Substance use seems to be an integral part of queer lifestyles. Also, there is a strong link between engaging in sexual activities and drinking or doing drugs. A few people spoke about being very uncomfortable with their sexuality or gender identity. They connected their drug or alcohol use to this discomfort. Many spoke about how their addictions were affected by life experiences of homophobia or transphobia.

For many of the male participants, sex and drugs seem to be interconnected. Particular concerns expressed by individual participants include:

- Lack of functional models of queer intimacy: anonymous sex and queer public sex supports unhealthy and problematic substance use, where people "need to get drunk to go out and get laid, or do more than get drunk, and if they don't get laid, at least they get drunk. This follows with a sense of loss." *("Nick", gay man)*
- Needs for role modeling and social marketing of the message that sex is better without drugs.
- Need for increased non-shaming dialogue about how combining sex and drug use can affect practicing safer sex.

> We as a gay culture, drug and alcohol abuse is in our environment. We go to the bars to be social. We go to dances after midnight. We take ecstasy and cocaine. Sex is associated around certain drugs. Substance use is almost promoted in LGBT communities, and there isn't something out there to promote the opposite. There's nothing set up to gear people away from that so-called lifestyle of drug & alcohol abuse and parties. *"Neil," gay man in early recovery*

Focus group participants stated it is very difficult to socialize in the queer community in spaces that are not alcohol and drug saturated. In many focus groups, participants expressed the desire for there to be greater awareness about substance use, misuse and addiction in queer communities. This would involve developing a greater understanding that marginalization due to sexual orientation and gender identity - and vulnerability due to homophobia and transphobia - increases risks and vulnerabilities to addictions. It could also involve an examination of what using and non-using people can do to promote and support alcohol and drug free spaces, events and activities in ways that are non- judgmental, reduce stigma, and do not assign blame. Participants felt that there is not a good understanding of substance use and addiction in society at large, and there needs to be "a broadening of our understanding that there's a continuum of behaviours and activities around using substances, and addiction is the far end, and there's also different varieties of misuse, and having people be able to get the difference," *("Alexa," service provider).* Participants articulated the need for education about the risks of drug use, and how to increase safety. They said that a fair number of people are using without knowing exactly what it is that they're using, how it may impact their bodies, and the risks they are taking.

Participants felt that some people are not comfortable talking about drug use from a user's perspective in queer communities. Furthermore, they believe that a number of queer people who use drugs intravenously seem to be closeted about the injection drug use in queer communities, and closeted about being queer in the IDU communities.

3.1 Barriers to Accessing Queer Supports

Community members and service providers spoke about the importance of being able to make connections with other LGBT people, to break down social isolation and loneliness, and to have a sense of community where one's sexual orientation or gender identity is seen as ordinary and matter of course. These are broad community issues, however participants in the Disabilities, Deaf, Cultural and Transgender groups did identify specific barriers to accessing LGBT communities.

Many participants spoke about the challenges of accessing the queer community, including not knowing about, and not knowing how to find out about, queer community resources. Participants spoke about the need for greater awareness within the LGBT communities about racism, cultural issues, Deafness and disabilities, and issues facing transgendered people.

Newcomers to Canada and People of Colour

Newcomers are not familiar with the cultural environment, and may come from countries where same-sex sexual behaviour is not culturally acceptable, and/or is illegal and is punished. Furthermore, laws and enforcement regarding substance use may also significantly differ. Participants in multicultural groups recommended information about the LGBT communities be included in settlement supports, processes and resources, along with information about services and supports relating to substance use. .

People of colour spoke about experiencing racism within broader LGBT communities. Services for broad LGBT communities often do not have staff complements that are similar to the cultural diversity of the geographic area they are serving. Participants articulated that they do not feel connected to organizations where they do not see people from similar ethno-cultural or racial backgrounds. While some groups exist for LGBT people from a range of cultural backgrounds, most groups are composed exclusively of volunteers. The needs are so great that many of the volunteers are at risk of burnout.

Recommendation #1:

Include information about LGBT communities and about substance use in settlement supports, services and resources for immigrants and refugees.

Increase supports for LGBT immigrants and refugees that meet their needs in dealing with culture shock, acclimatizing and connecting with LGBT communities in Canada. ***See page 67 for discussion***

- Include information about LGBT communities and about substance use in Newcomers' guides; teaching modules in Language Instruction for Newcomers to Canada classes.
- Ensure that settlement and integration workers are familiar with LGBT communities and with resources relating to substance use.

Deaf People and People with Disabilities

The Deaf participants spoke about the challenges they face trying to get information about current groups that happen in the queer communities. Currently, information about LGBT resources is disseminated through The Centre, through Xtra West, a newspaper for the gay and lesbian community in Vancouver, and the Gay and Lesbian Business Directory. Xtra West provides a listings service where community groups can get a mailbox, leave messages with information about the groups, and have them listed in the newspaper for free. The listings are often the only way to get in touch with many community groups. The Gay and Lesbian Business Directory is available in print and online, and it has listings of some community groups. However the space for listings is extremely limited: groups can have their name, contact information and a one or two line description. Many community groups give their contact information as their Xtra West mailbox. Deaf people cannot access these phone listings, as relay operators cannot or will not help them to do this. Organizations that have listings in the Red Book rarely mention if they offer LGBT-sensitive services. The Centre does not have a TTD/TTY line. Deaf people can contact The Centre through a relay operator, and The Centre has quite a bit of community information, but may not have the details available in the Xtra West listings, and using relay operators presents challenges in and of itself.

Deaf participants also spoke about barriers to taking part in community workshops and activities. Interpretation is costly and is not provided at the majority of support groups and workshops offered to the LGBT communities. Deaf participants reported that rates of unemployment are extremely high in the Deaf community – approximately 80%. As a result, most Deaf people cannot afford to hire interpreters to access programs and activities in the queer communities. This results in queer Deaf people having a near-complete lack of access to existing resources in the LGBT communities.

People who have disabilities find that often there is no acknowledgement that they are sexual beings and that they have a sexual preference. Given this and the levels of social isolation and lack of access to information that many people with disabilities face, this creates a barrier to making connections with LGBT communities. Within LGBT communities, there is very limited support for people who have disabilities. Supports do exist for people with disabilities related to HIV/AIDS.

Many resources, including those that serve LGBT communities and cultural communities are not physically accessible and do not adhere to the 1998 BC Building Code. Among them are The Centre, A Community Centre Serving and Supporting Lesbian, Gay, Transgender, Bisexual People and Their Allies. The Center has made efforts to hold a significant portion of their programs and services off-site at wheelchair-accessible locations, but many things are only available on site.

Little outreach and little in the way of support is currently directed to LGBT people with disabilities. Suggestions for how to address these issues include:

- Develop a friendly visitor program for homebound queers with disabilities
- Increase coverage of LGBT issues and supports in newsletters for people with disabilities
- Increase outreach to queers with disabilities to inform them of newsletters that address queer and/or disability and/or substance use issues, and to inform them how to get on the mailing list
- Increase the capabilities of existing phone support lines to provide services to queers with disabilities
    - Provide training for Pride Line volunteers and Crisis Line volunteers on issues for people with disabilities; recruit people with disabilities to be Prideline volunteers
- Develop other mechanisms for increasing phone support for queers with disabilities

Recommendation #2:

Increase access to LGBT information and supports for both Deaf and Disabled queers.

See page 67 for discussion.

4.0 PREVENTION

A Framework for Action: A Four Pillar Approach to Drug Problems in Vancouver describes three main approaches in prevention. *Primary prevention* attempts to prevent substance use altogether or delay the onset of substance use. *Secondary prevention* refers to interventions aimed at early stages of substance use before serious problems develop. *Tertiary prevention* focuses on interventions that prevent serious harm to individuals who have become addicted to drugs. All of these approaches are part of a harm-reduction model. Furthermore, prevention/harm reduction programs are not simply responses to substance use, they are principally proactive initiatives that are implemented before substance use takes place. "Prevention efforts should seek to promote a sense of meaning and purpose in life, enhance abilities to practice healthy ways to manager anger, trauma, hurt, boredom, alienation, curiosity, etc. and strengthen connectedness at the individual, family and community level (Steinmann, 2001). Successful prevention programs foster healthy development of self-esteem and reduce isolation from constructive peer and social supports."[ix]

Participants strongly felt the need for prevention efforts focused on LGBT communities that cross all age groups. Experiences of marginalization increase risk for substance use and vulnerabilities to substance misuse and addiction, and LGBT people experience marginalization and isolation from a very young age. Proactive prevention efforts that build community capacity and individual self esteem, confidence, social connections and resiliency are needed in the LGBT community, to counteract not only social isolation and traumas experienced by individuals but also the cumulative and damaging effects of individual and systemic homophobia, transphobia and heterosexism that is so prevalent in our society. Issues within prevention that emerged included community education campaigns; LGBT youth-focused interventions in schools; community based support for queer youth; trauma supports for queer youth; increasing peer, social and community supports for the adult population basic needs and life skills; drop-in spaces; and an LGBT drug and alcohol centre.

4.1 COMMUNITY INFORMATION AND EDUCATION RELATING TO SUBSTANCE USE AND ADDICTIONS

Social marketing and education campaigns are needed as critical components of prevention, treatment and harm-reduction efforts. Two thirds of the participants (63%) identified needs for information and education, with the following themes:

- Increase understanding of what substance use and addiction are and address stigma
- Convey harm reduction information
- Spread information about the full range of existing supports and services, and specifically those that are welcoming to the queer community
- Address discrimination faced by LGBT people.

Participants had specific suggestions for how education campaigns might reach the mainstream and Chinese communities, the LGBT communities, people with disabilities, LGBT drug users and drug users from other populations.

> People would be eager to share 'pleasure enhancing tips', compared to 'harm reduction' - 'pleasure enhancement' is much more positive." *"Scott," gay man involved in party scene*

It is crucial to reach people who use substances, ranging from club-drugs to drugs that are injected, with harm reduction information. Participants mentioned wanting to have reliable, neutral and non-judgmental information presented in appealing ways. People in several different focus groups mentioned Dancesafe.org as a website that provided this, however people felt that information needed to be available in a wide variety of environments, formats, and media. Participants in the Gay, Bi and Trans Men's group stressed that reframing harm reduction messages as "pleasure enhancement" messages would be more successful in gaining currency and attention.

One participant who has a disability and is involved in activism on disability issues noted some unique concerns and issues relating to information and education. The participant identified that some people with disabilities who are dependent on other people for assistance may be at risk for unsafe use, due to lack of information and increased vulnerability. There is a lack of knowledge about basic harm reduction and prevention information, such not sharing needles. It is difficult for people with disabilities who are homebound to access information, and to learn about what resources and supports exist that are accessible. Doctors' offices and rehab centres were suggested as the best places to make information available to people with disabilities. A concern for people who are prescribed a variety of medications is that information is not readily available about reactions can happen between prescription and illicit drugs. For people with cognitive impairment and/or learning disabilities, information needs to be presented in an appropriate way that addresses basic information about what drugs are and what they can look like; what drugs do; and what equipment, such as needles, are used with some drugs.

There are challenges to addressing both concerns relating to substance use and concerns relating to sexual orientation in each of the ethno-cultural communities that were targeted in the focus groups. Some examples of this are given by the Chinese Service Provider.

> …Most of our language is about substance *ab*use, and to put it in a more neutral way, to highlight individual choice, that's difficult, because a lot of the language is moralistic. "*Ming,*" *Chinese Service Provider*

Some challenges in Chinese communities include that there is not language to discuss *substance use* in a non-judgmental and non-shaming manner. The cultural view of people using substances is that the person is morally depraved and has a weakness in their personality. The cultural view does not lead to seeing or understanding factors which influence addiction, increasing the difficulty in acknowledging problematic drug or alcohol use. The cultural values of maintaining privacy result in barriers to discussing issues that are seen to be personal, such as substance use and sexual orientation, with family

members and with service providers. This is compounded by a lack of knowledge in the Chinese community about existing services, and how to find culturally appropriate services. In the Chinese communities, queer people also face stigma, and may face rejection from their family and cultural community if they come out. People who are LGBT and/or are using may not pick up information relating to sexual orientation or addictions, for fear of being seen and stigmatized.

The Vietnamese focus group participants felt that it would be beneficial to have more education for the community at large, in each of the Asian communities, about sexual orientation and gender identity, as they felt they encountered substantial discrimination from other Asian people. Within the Vietnamese community, LGBT people are called a homophobic slur, "pédé", from the French word "pederast," meaning pedophile. Community education that increases the levels of awareness, addresses stereotypes, and reduces prejudice and discrimination would help people be able to come out, reduce shame, and develop and maintain better self-esteem.

Recommendations about information campaigns from various interviews and focus groups were synthesized into the following:

General community:

- Develop multi media campaigns with information about the continuum of substance use; how to tell if you may be developing problems with substance use; what signs to watch for; and how to get help.
    - Advertise on public transit and in a wide range of newspapers, and on television.

Targeting the queer community:

- Support the development of a political analysis about drug use and harm reduction, looking at the complexities of the issues, and how that impacts queer users, their partners, and other members of the queer communities.
    - Suggestions for accomplishing this include having a regular column in LGBT community newspapers and forming a discussion group.

Targeting substance users (including queers):

- Development of a series of small cards or accordion-style cards that are aesthetically appealing and have information on a variety of topics. Suggested topics include:
        - General health: CPR, what to do if someone has overdosed; safe drug use; and needle handling and disposal;
        - Accessing general services: Basic information about what services exist and where to get help, such as Access 1 and other access points.
        - Specific populations: what is welcoming to LGBT communities; what is available for Aboriginal populations, for Two-Spirited people, etc.
    - Distribute cards through a variety of means and locations, including:

equipment bags distributed through the needle exchange; drop-ins; bars and baths; community centres; community health centres; community agencies.
    - Ensure capability to update information and do new runs over the course of a number of years.

- Develop a social marketing campaign with "pleasure enhancement" tips targeting queer users. Develop club cards; run ads in Xtra West and other community papers; put posters in bars and other public places.

- Develop zines, or build on newsletters, targeting street-involved people.
    - In addition to the information developed above, zines and newsletters could include "bad date" sheets for female, male and trans sex trade workers; personal notices (e.g. so and so call home); and stories about people's experiences.

- Develop peer education campaigns targeting queers: educate people about issues and train them to lead discussions around substance use in a variety of settings to increase awareness and produce attitudinal shifts.

- Increase awareness about and develop an easily accessible, anonymous means for people who are on medications to find out about possible bad reactions between prescribed medications and illicit drugs.

Targeting Ethno-Cultural Communities:

- Outreach to newcomers to Canada, through vehicles such as the Newcomer's Guides, ESL classes, settlement services, etc.
- Develop an information package, translated into several languages, with general information about accessing health within the VCHA, general health issues and what services exist. Include sections on issues that are stigmatized: substance use and addiction; sexual orientation; sexual health, sexually transmitted diseases, HIV prevention and treatment; breast cancer, prostate cancer.
- Education initiatives addressing LGBT issues as well as substance use tailored to various ethno-cultural communities.
    - E.g.: Opportunities and strategies that were suggested to bring information to the Chinese communities include:
        - Chinese seniors appear to be more open to hearing about substance use information and may be willing to bring information in written formats into the home.
        - Most people in the Chinese community learn about safe sex through what they read in newspapers. This strategy could be built upon by developing an advertising campaign about substance use, addiction and related issues. An advertising campaign targeting the Chinese community would be most successful if it takes a factual, non-pathologizing approach, with information presented in an impersonal manner, to work with cultural

concepts of saving face and what is appropriate to discuss with people you don't know. Such a campaign should include:

- Information about the continuum of substance use: non-use, experimentation, social use, problem use, addiction, recovery, etc;
- What services exist, and how one accesses them
- Neutral information on risks and risk management
- How to tell if someone may be having a problem

Targeting People with Disabilities

- Develop education campaigns, targeting people with disabilities, which address basic information needs.
  - Include education that is appropriate for and targets people who have learning disabilities and cognitive impairments.
- Ensure that information gets to locations that people with disabilities generally access (e.g. doctors' offices; rehabilitation centres).
  - Include phone numbers to call for support and information about access points to services if people want to make changes.

Recommendation # 3

Develop social marketing and education campaigns targeting LGBT communities; LGBT substance users; ethno-cultural communities; people with disabilities and VCHA residents at large.
See page 68 for discussion.

4.2 Accessing Appropriate Supports And Services Relating To Determinants Of Health

The Broad Determinants of Health include a wide range of factors that affect health. Factors that were brought up in the consultations include education; housing and shelter; inadequacy of welfare rates; access to life skills, and social factors such social isolation and lack of individuals' connections to communities and the larger population.

4.2.1 School-Based Prevention

Service providers, youth and adult participants felt that interventions amongst youth are very important in helping develop positive self-esteem and resiliency, and to find alternatives to substance use. Schools present important opportunities to make interventions. However, the participants in the Richmond

> A lot of people talk about using alcohol and drugs to deal with their sexuality when they're quite young. So teaching children in school at quite a young age that it's ok to be gay is a really good idea, and teaching heterosexual kids that it's ok for these kids to be gay, and that it's ok to be different, that it's ok to be different in our society. *"Matt" dually diagnosed gay man.*

youth focus group, most of whom were in high school, articulated that for many youth who are, or are perceived to be, lesbian, gay, bisexual, transgendered or questioning, schools are places where they face name-calling, physical violence and bullying. They have very few positive role models within the school system, and are not able to easily identify queer or queer-sensitive resource people. They seldom have opportunities to learn about LGBT history and issues, as it is not mandatory components in curricula. The development of gay-straight alliance student clubs are often not supported by school administrators. While some progress has been made in addressing individual instances of homophobia, often administrators deny that there are problems for LGBT youth, do not take concerted and proactive actions around homophobia and heterosexism from students and staff, and do not support student's requests in these areas.

The decision by the BC Human Rights Tribunal in the case of Jubran v. Board of Trustees, School District No. 44 established the right of a student, whether queer or not, to have a safe school environment in which to learn, and the responsibility of school administrators to provide a safe environment[4].

Making schools environments where LGBT and questioning youth are nurtured, rather than ignored or harmed, would contribute to the development of better self-image and self-esteem, which would improve their mental health, their resilience, and reduce their vulnerability to substance use.

Recommendation #4:

That the Ministry of Education provide leadership, and that school boards and individual schools take action on their legal obligation by ensuring safe school environments for LGBT and questioning youth.
That the VCHA ensures staff working in schools (school nurses, alcohol and drug workers, in-school support teams etc) are able to effectively work with LGBT youth.
That members of the LGBT communities and allies take proactive action in advocating for safe environments for LGBT youth, peer education programs, and Gay-Straight Alliances.
See page 68 for discussion.

[4] On Jan 02, 03, the BC Supreme Court overturned this ruling, stating that Jubran was not entitled to protection under BC's human rights code because Jubran is not gay and his attackers claim they did not see him as gay. The ruling also overturns the tribunal's finding that school boards are responsible for taking proactive steps to eliminate homophobia and ensure schools are discrimination – free. (Robin Perelle, ***Xtra! West,*** Jan 23, 2003, p.7) It is expected that an appeal will be filed in the Supreme Court of Canada.

4.2.2 COMMUNITY-BASED SUPPORTS FOR YOUTH

Service providers, youth from both focus groups, and the youth workshop at the first forum all identified peer supports and role modeling for LGBT youth as a need and a gap that is not being adequately met. One service provider identified that "most minority groups have youth groups. They make a difference. We don't have that. There are not many queer youth groups, and the schools don't want them, churches don't want them, and so on. GSA's [Gay Straight Alliance student clubs] don't tend to get much support." *("Ellen," mental health worker)*. While there is some programming for LGBT and questioning youth in Vancouver and Richmond, it is nowhere near adequate.

None of the LGBT youth groups in Vancouver or Richmond have staff whose primary function is providing alcohol and drug services. However, one service provider reported that they see on average 300 youth each year, almost all of whom have some experience with alcohol or drugs, and many of whom are looking for information and/or other support and services related to substance use.

Deaf Youth

Participants in the Deaf focus group and the Disability interview expressed grave concern about risks and social isolation faced by queer and questioning Deaf youth and youth with other disabilities, compounded by the lack of ability to access existing queer youth resources.

> Our youth are really suffering. They have no way to understand… most Deaf peoples' English is basically very [limited]. They may not know what all these groups are, what YouthCo could mean. They don't know [where they could go]…. If they get the confidence to go and ask, it may be doubly nerve-wracking because they don't have the language to ask. It's the first time, they're coming out and if there's a communication barrier, they're going to lock themselves right back in that closet because there's no way for them to access the service. It's doubly scary. *"Ed," Deaf gay man*

Participants in the Deaf group identified that queer Deaf adults could do outreach into schools for Deaf children and youth. The outreach would be to provide visibility and role models, to inform them about BC Rainbow Alliance for the Deaf, and to do some education about sexual orientation and gender identity.

Youth with Disabilities

Concerns were expressed about youth with physical disabilities: "If they could get out more, be able to be positive about who they are and around people of similar experiences, then they have a chance of becoming healthier adults, because there is less chance of isolation, and less isolation breeds a greater ability to think creatively, grow, become strong individuals who can do anything" *("Regan," a person with disabilities).* GAB Youth Services offers weekly drop-ins and other programming, however much of the programming is based out of The Centre, which is not physically accessible.

Two-Spirited Youth
Two-Spirited youth indicated that they would like to see programming specifically for them. Included in this, they would like to have access to elders, other role models and mentors for support. For a time through Urban Native Youth Association, there had been a counsellor for Two-Spirited youth but that position no longer exists, and participants believe there is a need for it to be reinstated.

Developing Alternatives to Substance Use
Youth in the Richmond focus group and the youth workshop at the community forum spoke about the need to have social alternatives to the bar scene. Youth activities help to increase a sense of connection to community, build self-esteem and reduce vulnerabilities to harm. Connections between service providers and youth established through such means create opportunities for support, education, early intervention and referrals.

> Lots of kids do drugs or have sex, there's not much else to do. If there were more youth programs, with cool things or fun things to do, kids would probably sober up, because they want to have fun.
> *"Nicole," bisexual youth living in Richmond*

Youth in Richmond felt that it is a very different experience to get involved in community activities than it is in Vancouver. Youth in the Richmond focus group spoke about an almost complete lack groups, programs and activities that are LGBT focused. The only LGBT-specific group they are aware of in Richmond is the weekly drop-in for queer youth. There also is a lack of activities for the broader population of youth in Richmond that are not faith-based. Due to historic and current attitudes opposing homosexuality that are supported by many Christian faiths, church-based activities and groups are generally avoided by queer youth. Furthermore, youth in Richmond identified a number of barriers to getting involved with existing programs, including financial inaccessibility and lack of knowledge about how to get involved in existing and ongoing activities.

Youth identified that lack of activities and opportunities to develop and explore other interests contributes to substance use. Youth thought that taking part in programs and activities would lead to developing skills, exploring potential careers, and gaining experience to put on resumes to help in entering the workforce.

Activities queer youth would be interested in include:

- Community events
- Youth art and media programs such as painting murals, putting on film festivals, exploration of film, television, radio, and internet
- Outdoor activities and sports

Recommendation #5:

To dedicate funding for expansion of existing services and develop additional activity-based programs for queer and questioning youth, and to remove all barriers to full participation in programs.
See page 69 for discussion.

4.2.3 TRAUMA INTERVENTION AND SUPPORT FOR YOUTH

The National Institute for Drug Abuse states that an emerging body of research has documented a very strong association between post-traumatic stress disorder and problems with drug and alcohol use. In most cases, substance use begins after exposure to trauma and the development of post-traumatic stress disorder. Children who witnessed or are exposed to a traumatic event and are diagnosed with post-traumatic stress disorder have a greater likelihood of developing drug and alcohol use disorders later in life. NIDA further states it is critical that there be early intervention with children and youth who have experienced trauma.[x]

> "*Aileen*" I was down on Hastings Street shooting up at the age of 14. It wasn't safe to be at home, and I know that that's the situation for so many queer teenagers. And I think, probably for all queer people, housing for youth is the most important thing…
> "*Doug*": It would be wonderful to have supportive housing, a big one, not with security guards but attendants at night. The reality is that if a gay youth downtown wants a bed for the night he's got to suck somebody's cock.
> "*Aileen*" And if you're going to do that, you've got to be stoned first.
> *Adult participants who had been street and/or sex-trade involved as youth.*

A number of youth and adult participants disclosed experiences of childhood sexual abuse, of being placed in foster homes and of leaving home early in their youth due to lack of safety. For queer youth, a component of effective, sensitive trauma intervention could include providing supportive housing for queer youth.

Recommendation #6:

Work with partners in identifying current housing and trauma intervention options for LGBT and questioning youth.
See page 69 for discussion.

4.2.4 BASIC NEEDS

Participants in a number of focus group discussed access to basic needs: emergency shelter, long-term housing, food and clothing. Nearly half (47%) of the service providers and 17% of the community participants raised issues related to the need for safe, affordable, accessible and appropriate housing.

> Without adequate housing what gives a person motivation to brush their teeth or their hair or worry about whether they're going to infect their arm again. But something as simple as a safe bed and a safe place to get clean can make all the difference. "*Kurt*" *transsexual man who had been a street kid*

Service providers in two focus groups identified the need for emergency shelter, transition housing and long-term housing that was "Safe to queer folks, where you can go there and not have to hide the fact that you're a fag or dyke and is also safe for transgendered people with these issues" ("*Rachel*," *service provider).* Service providers from the Downtown Eastside identified the need for wet, damp and dry housing which is safe for LGBT people. This would involve staff and resident

education about what constitutes discrimination, what the rules are, and what the consequences are for violating rules.

Participants in three focus groups (two service provider groups and the second mental health focus group) particularly identified that queer youth need to be targeted for safe and affordable housing initiatives. This would play an important role in prevention and early intervention efforts.

For people with disabilities, finding housing can be complicated by the necessity of having housing that is physically accessible. "Housing is really difficult because you can't let anyone know that you're queer when you move in because lots of places aren't queer-sensitive, so you can't be open, and if you're with a partner that would make it very difficult. It's not that easy and there's not a lot of accessible places," (*"Regan," a person with disabilities).*

> People on welfare don't get enough money to eat properly, and to get extra money for dietary allowances to eat properly required determination to maneuver through the system, especially as they're slashing programs…. Telling people that they're not worth making nutritional supplements and dietary health needs available to, that would seem to be a pretty negative self-esteem message from society to these people. *"Nick" IV drug user*

Some portable housing subsidies have been developed for people who are living with HIV or AIDS. Similar subsidies could be developed for people who have substance use issues if they do not need to live in a supportive housing setting.

Participants in two focus groups identified the inadequacy of welfare rates to cover basic living expenses, that eating properly is necessary to prevent illness or maintain health, and that many people who use or have used substances have serious health issues. Such systemic barriers to being able to meet basic needs and look after one's health affects people's self-esteem.

Recommendation #7:

Develop capacity to equitably serve LGBT people in existing supports and supports under development that address housing and other basic needs.

See page 70 for discussion.

4.2.5 LIFE SKILLS

Participants in six of the focus groups and interviews indicated they feel it is important to have access to supports focusing on life skills, health-supporting habits that people could use to replace their drug use, and skills to maintain their sobriety and move further in their personal development.

These participants identified a wide variety of life skills they would like to gain and services and supports they would like to have access to:

Assessment

- Needs assessments and evaluations of what skills and gaps in skills individuals have

Mental And Emotional Health And Well-being

- Anger management
- Confidence building and quality of life
- How to reach and maintain stability
- How to take healthy risks and make decisions
- Exploring alternatives to drug use
- Coping with and recovering from trauma
- Self-care

Education and Employment Skills

- Returning to school
- Support in developing employment skills and first stages of entering the workforce, career development and other employment services
- Vocational training
- Leadership training

Advocacy, financial and legal support

- Advocacy and self-advocacy in maneuvering through systems and bureaucracies
- Finding and interviewing doctors and other health care providers
- Legal support
- Money management support (e.g. getting out of debt and dealing with creditors)

Programs addressing these issues could be offered in a variety of settings where life skills support and training is offered, and in LGBT communities. Currently, a Life Skills Centre is under development through the Vancouver Coastal Health Authority. Opportunities may exist to ensure that LGBT people can safely access and be equitably served within the Life Skills Centre programs.

Recommendation #8:

> **Develop capacity to equitably serve LGBT people in existing Life Skills programs, and programs under development.**
> **Develop Life Skills programs targeting LGBT people.**
> ***See page 70 for discussion.***

4.2.6 COMMUNITY-BASED SUPPORTS FOR ADULTS

Family and Friends

Many community participants spoke about families and friends relating to support. In the Latino and Vietnamese focus groups and the interview with the Chinese service provider, they spoke about their cultural communities not being supportive of LGBT people. Participants in the Vietnamese focus group said that support from friends is extremely important due to the lack of support from the Vietnamese community and the mainstream community, and that families are not always supportive. The Chinese service provider said that families are accepting of their sons' and daughters' sexual orientation, as long as it is not directly spoken about and they are not pushed to publicly make a statement about it.

Some people also mentioned the limits of turning to friends for supports. Friends have their own lives and own problems and either may not want to or may not be available to be a peer support when needed. People mentioned that they can talk with some friends about some issues, but often they cannot talk about their entire experience and concerns with any one person. Friends can provide support, but cannot take the place of therapy.

One parent, who is HIV positive, stated that she knows of only two programs in Canada for HIV-infected or affected children. There are no local regular support groups for kids to let them know they are not alone, and this is badly needed.

Social supports

Participants in many groups noted the challenges of meeting people, and stated concerns about feeling socially isolated and lonely. They perceive there to be a lack of places to go to socialize, that are fun, and that are atmospheres where people are not drinking and doing drugs. Participants also articulated the need for support programs, social and discussion groups that either do not currently exist in the queer community or that need to be expanded. These supports would serve to increase resiliency, improve well-being and healthy living, and increase interpersonal connections and connections to the queer community. Particular ideas that were identified include:

- Develop a range of fun activities where people can meet and socialize, such as:
    - Ongoing drug and alcohol-free space that is fun, has music and dancing, that's available to go to in the evenings and on weekends
    - Day trips and outdoor activities that are designed to build interpersonal connections, to help with stepping outside of the day-to-day environment, providing activities that are healing
    - Offer regular, low cost or free movie or video nights for the queer community, designed in such a way that there is a greater social

component than going to the movies with a friend

- Develop a range of supports and activities that focus on healthy living and well-being, such as:
    - Retreats that focus on healthy living, that also build interpersonal connections and help with stepping outside of the day-to-day environment
    - Groups discussing queer men's sexual health; including a group for queer men on staying negative
    - HIV/AIDS support groups for trans people
    - Exploring internalized homophobia, directed at people who have been out for some time
    - Body image for queer men and for queer women (gender specific groups that are welcoming of trans people)
    - Groups that address compulsive disorders
- Develop a range of social, discussion or support groups, such as:
    - Groups for queer people of colour
    - More supports for queers with disabilities.

Recommendation #9:

Develop a range of social supports serving LGBT communities that are not directly focused on drug use.
See page 70 for discussion.

4.3 ACCESSING APPROPRIATE AND EFFECTIVE SUPPORTS AND SERVICES RELATING TO SUBSTANCE USE AND ADDICTIONS – COMMUNITY

Community participants and service providers do not know of supports relating to substance use specifically for the LGBT communities other than gay and lesbian AA and NA meetings. Participants also discussed the strengths and limitations of 12 step groups, and of getting support from family and friends. Some participants mentioned VANDU as a drug user's organization where they found some support. Over one third (34%) would like to see a range of LGBT-specific supports developed. Overall, there was general concurrence that there is a grave lack of supports, and that supports are needed in a variety of models, both for people who are considering making changes, who are seeking moderation and for people seeking abstinence.

4.3.1 12 STEP GROUPS

There seems to be a reliance on AA and NA meetings as the primary support for LGBT people. Some people spoke about 12-step groups saving their lives, but there was also recognition that there are limitations to the 12-step model, and there are many people for whom the 12-step model does not fit, or does not work. While there are daily gay AA meetings in Vancouver, many of which are in physically

inaccessible locations, there aren't any in Richmond. Nor, at the time of the focus groups, were there any Trans-focused 12 step groups, although a Trans NA meeting has recently been developed. Queer youth face additional safety issues in going to queer all-ages 12 step meetings, including being hit on by older participants.

> The whole spirit of anonymity [in AA groups] is devastating in our community because actually it's something else to come out about. But the program teaches you'd better be anonymous because if you're not, you're not humble. But you know what, I'm damn proud that I got clean and sober again, and I have done the work…. I think that for queer people, we get so lost and ashamed of being queer, that if you do actually manage to throw the monkey off your back you're still left standing with ok now how do I be who I am in this world, how do I do that. *"Rebecca," queer mom*

4.3.2 ALTERNATIVES TO 12-STEP GROUPS

Participants articulated the need for groups in the queer community where people can come in and question - without being judged - whether or not they are having problems with their use, whether or not they want to change the way they use, and the role of substance use in their lives and in the queer communities. Formats they suggested for groups included queer 16 step or non-step meetings; groups that have both social and discussion components; facilitated groups; unstructured drop-in groups; and community art-therapy based groups.

In the youth workshop at the community forum, youth who have used substances indicated that they would like to have programming and activities for them specifically, as they did not want to hang out with substance-naïve youth.

Participants mentioned a need for:

- A queer youth's drug user group
- A queer women's drug user group
- A queer men's drug user group
- A support group for partners, families, and friends of queers using substances
- A grief and loss group for queer users
- A discussion group focusing on a political analysis about drug use and harm reduction; the role of substance use in global economics; and developing an understanding of user politics
- Drug and alcohol free space at the Pride Parade and Festival, as well as throughout Pride Week, as part of social supports for queer folks

Recommendation #10:

Develop a range of social supports related to drug use for LGBT communities.

See page 71 for discussion.

4.3.3 Peer Supports, Role Modeling, and Mentoring for Adults

Many people spoke about the needs for queer peer supports, role models and mentors to help them enact changes - to living more healthily and/or to current patterns of drug use. Resources need to be put in place to help develop and maintain this. Participants offered a number of ideas about how this could be accomplished:

Peer support

- Set up a buddy program that is not based in the 12-step movement and is linked to other drug and alcohol groups for queers
- Build the strength of existing peer networks through providing education and support
- Develop information campaign about peer-based resources. Identify the hours that these resources can be accessed.

Mentoring and leadership

- Set up mentoring programs relating to healthy living, to addictions and compulsive disorders for queer people, where volunteers are taught to act as mentors
    - This could be based on the model used by the Consumer Initiative Fund with Community Mental Health Services, a part of the VCHA. In this program, funding is provided for projects run by people with mental illness for other people with mental illnesses. Other people who are recovering from mental illnesses are trained to act as the mentors for the projects. The program has been found to build self-esteem, capacity, connections, and make a difference in the community. An important part of this program is that honouraria are provided for mentors and project leaders.
- Leadership training focusing on people who are marginalized on several fronts and face barriers from within their overlapping communities.

Role Modeling

- Develop an awards campaign as part of a larger awareness campaign about substance use in the queer community.
    - Awards would focus on support, mentorship and people making positive changes in their lives regarding substance use. The awards and awareness campaign would also pay attention to the relationship between substance use, homophobia, and all the other oppressions and types of marginalizations.
- Develop a Biographies project, showcasing and publicizing the successes of some queer people who have made changes around their substance use.
- Individuals acting as role models
    - Individuals who are comfortable coming out as lesbian, gay, bisexual

and/or transgender create opportunities to act as role models, raise awareness and educate on a peer level

Recommendation #11

Develop a range of peer support, role modeling and mentorship programs in the queer communities.
See page 71 for discussion.

5.0 TREATMENT:

Issues identified in discussions about treatment services include: availability and accessibility to care; continuum of care; gaps and barriers; a discussion of current services, and the need for LGBT-sensitive and LGBT-specific programs and services for youth and for adults.

5.1 AVAILABILITY OF ACCESS TO APPROPRIATE SUPPORTS AND SERVICES

> I think that when we're looking at services that are accessible to the LGBT population, we're also looking at services that are accessible - accessible to people with disabilities, who are queer, who are First Nations, who have children, who are addicted to substances… Because those are sometimes all one person.
> *"Gina," Counsellor in the DTES*

Both service providers and community participants identified that existing alcohol and drug services are inadequate to meet the needs of this community, and that drug and alcohol services as a whole are severely under-funded. The lack of a comprehensive continuum of care means that many people fall through gaps. Furthermore, service providers and community participants both identified that there are almost no supports for queer people around substance use that are queer specific, minimal services that are queer-sensitive, and almost no services that are prepared and equipped to work with trans people. There is also a perception that few addiction services are able to meet the needs of different cultural communities, people with disabilities, and /or mental health consumers. It is very difficult for people who have complex needs get appropriate services.

5.2 CONTINUUM OF CARE

Service providers spoke about the need for a comprehensive continuum of care that would offer a range of approaches and services, while also promoting non-discrimination and the right to receiving respectful treatment throughout the system. Across the continuum, a systemic approach needs to be taken to ensure that LGBT people can equitably access services that are accessible to people who are using substances as well as those who have achieved sobriety.

A comprehensive continuum of services would include basic supports such as food, clothing, emergency shelter, and wet, damp and dry housing, and encompass a range of prevention, harm reduction and treatment options. Treatment options would include various types of detox services, graduated levels of treatment, one to one workers, long - term treatment, and after care.

5.3 GAPS AND BARRIERS

5.3.1 HOMOPHOBIA AND TRANSPHOBIA

Substance use for LGBT people is often enmeshed in issues relating to sexual orientation, gender identity, and/or making connections with queer people and communities. It is not possible for LGBT people to successfully address alcohol and drug issues without dealing with issues relating to sexual orientation and gender identity. LGBT people are not able to bring forward the whole of their experiences when they are in environments that are non-supportive and where they experience homophobia or transphobia.

Community participants express that it is very important to have a place and have services where they can go and feel safe and be open about who they are at a time when they are vulnerable. Both community participants and service providers identify homophobia or transphobia, or the perception that people will experience homophobia or transphobia, as reasons why people don't try to access services; leave treatment; don't come out to service providers or during group programs. When people do not come out in treatment, they are not able to address their issues and fully benefit from services.

Community participants and service providers identify that LGBT clients are reluctant to access residential treatment for fear of homophobia, transphobia, and violence. Service providers state that residential facilities are often not equipped to handle homophobia and transphobia from staff and participants, much less address issues related to sexual orientation and gender identity. Furthermore, service providers identified that LGBT people are reluctant to access Faith-based residential services as they "can pose real barriers to people being out or people being comfortable in accessing those services, as LGBT people have been and continue to be marginalized by religious institutions." This effectively reduces or eliminates access for LGBT people to a significant portion of residential beds.

Working in LGBT-specific groups can make it possible to address issues of homophobia and transphobia in ways that are not possible in groups that are a mix of LGBT and heterosexual clients. LGBT-specific groups also serve to break down social isolation and increase levels of peer support. Currently, no LGBT-specific therapy or treatment groups addressing substance use exist in the VCHA.

5.3.2 Lack of Agency Commitment

Service providers identified that that whether a program is safe and welcoming to queers currently depends on whether there are individuals at that program who make that a priority, rather than an ongoing agency commitment rooted in policy and practice. Service providers state that systemic measures need to be undertaken to ensure that LGBT people have equitable access to services that are capable of meeting their needs. The level of agency commitment has an impact on increasing service provider competency in working with queer clients.

5.3.3 Lack of Service Provider Competency in LGBT Issues

Over half the service providers (59%) and 23% of community participants identified concerns with service providers' lack of knowledge and ability to work effectively with LGBT clients. This is compounded by experiences with or concerns about racism, classism, physical accessibility and cultural and language issues affecting quality of service. Some participants expressed that it is not appropriate for clients to have to educate service providers on these issues.

The DTES service providers raise the issue that many service providers, including queers, do not have an understanding of how class, race and poverty affect people. This may result in some people who access these services being shamed about other aspects of who they are.

Participants have experiences of being treated as "the problem," "the illness" or "the addiction" rather than being treated respectfully, with caring and compassion, and being seen as real people. Often, participants have been able to talk about some facets of their experience but not others, and experience discrimination about different issues at different places.

5.3.4 Lack of Information

A common experience for community participants is to struggle to get access to services for substance use and addiction. People do not know where to find the information about where to go, what the entry points are, and what services were available, and don't know how to find alcohol and drug services that are queer-sensitive. A service provider said that *if* a queer person happens across a queer service provider, chances are good that that person would be directed to other places that are welcoming and safe. But a lot of people fall through the cracks.

5.3.5 Culturally Appropriate Services

Aside from some services for Aboriginal people and an IDU outreach program run by ASIA (Asian Society for the Intervention of AIDS), participants were not aware of any drug and alcohol programs or services targeting ethno-cultural groups. Many mainstream services are not designed in culturally sensitive ways, and participants indicated they may feel like they don't fit in, if they're from a minority cultural group. There are different cultural expectations about what level and types of interactions occur with people who are close friends, acquaintances and strangers. Language, cultural barriers for newcomers to Canada, and lack of service provider competencies in working cross-culturally pose challenges in service delivery. Refugees may be unwilling to seek addiction services for fear that that may affect their claim.

5.3.6 Financial Barriers

Participants found financial barriers to accessing existing services, like not being able to pay for childcare and bus passes, to be able to attend funded programs. Financial Aid Workers are not always willing or able to help people meet these needs. A total of 17% of participants spoke specifically about the difficulties in accessing free or low-cost counselling and therapy, and the need for more free or low-cost therapy. A significant number of other participants, not included in the numbers above, mentioned having accessed counselling or therapy that was free or low cost.

5.3.7 Mental Health

There isn't a comprehensive range of services for people with mental illnesses. The Community Mental Health Teams have a limited mandate, and many people are left without access to free or low-cost counselling. Mental health service providers often lack knowledge of addictions issues, and addiction service providers often lack knowledge of mental health issues.

5.3.8 People with Disabilities

Services are required that are accessible to physically disabled and Deaf youth and adults. In the Deaf focus group, participants relate that queer Deaf youth are at high risk of substance use and social isolation. Due to lack of interpretation and other means of providing accessible services, Deaf people of all ages cannot access the majority of LGBT communities, and face homophobia within the Deaf community. Deaf queer people encounter a lack of awareness and education in LGBT communities about the Deafness and the Deaf community, often resulting in prejudice and rejection.

5.3.9 PROCESS ADDICTIONS

With regards to other addictions, 6% of the participants disclosed they experience(d) disordered eating, while 21% of the (non-trans) men and 25% of the transgendered people disclosed on the cover sheets that they had concerns about sex addiction. Community participants raised the issue that there are gaps in services for people who are dealing with process addictions such as sex addiction, eating disorders, and other obsessive-compulsive disorders. Service providers are not sufficiently knowledgeable about these issues and know of no supports or services specifically for queer people who have eating disorders.

5.3.10 TRANSGENDERED PEOPLE

Trans people and service providers spoke about a number of issues for Male to Female (MtF) and Female to Male (FtM) transsexual and transgendered people. A very small number of trans-sensitive service providers and agencies exist, however the health and addictions systems as a whole do not know how to accommodate trans people. The system, along with the larger society, functions in gender binaries of "male" and "female" and does not know what to do with people who have moved or are moving from one gender to the other, or do not fit in either category. There is significant transphobia in society, and trans people often come to expect discrimination.

> They [trans sex trade workers] don't know of any services that exist, and the people that provide them certainly have never focused on that particular small segment of the population. It might be a small segment of the population, but not only is it high risk, but high levels of them that are HIV positive, safe sex isn't exactly something that happens all the time. *"Sarah," a TS woman who volunteered at High Risk Society*

Trans people spoke of problems in accessing residential services, from detox through recovery houses. Services for women tend to not be very welcoming of trans people, services for men can be physically unsafe, and there are few co-ed services that will accept trans people. Some agencies refuse to take trans people.

A significant number of trans women work in the sex trade and have unique needs that are not being met. High Risk Society, a drop-in for trans sex trade workers, was able to meet some needs until it shut down in 1998.

5.3.11 TRAUMA

The current model for treatment does not work for people who have severe and complex experiences of trauma, often stemming from experiences of abuse and neglect from their early childhood onwards.

> There's no kind of recognition of how hurt people are by the time they get to that point [treatment], for whatever reason, and part of the reason they get hurt is because they're queer, or because they're confused about their sexuality, or they're confused about their sexuality because their uncle sexually abused them or whatever. They get to that place, and there's that one model, and that model says ok, we're going to deal with everything in 4 weeks, and then we're going to wrap it all up. Ok, so we know that people with complex post-traumatic stress take two to five years to get to safety and containment, so they're not going to make it in 4 weeks. Or 8 or 12 weeks. That is a long-term project, and we have to look at it as a long-term project. *"Gina," counsellor in the DTES*

5.3.12 YOUTH

A clear consensus of participants and service providers perceived there to be very high rates of substance use amongst LGBT youth. A service provider working with youth stated that almost all the clients they see (on average 300 per year) use substances. There are additional challenges for LGBT youth seeking treatment such as the inadequacy of existing facilities for youth in general, and the difficulty of finding a service that is both able to serve youth well and is sensitive to the needs of LGBT people. Youth often need to hide their sexual orientation or gender identity in order to have any kind of safety while they access treatment services, which means they can't speak openly about their issues or focus on recovery because they're focusing on keeping themselves safe from homophobia and violence.

Service providers state that there is an inadequate amount of residential services that are youth and queer-sensitive. Only one facility was identified as being both appropriate for youth and queer-sensitive. This facility has six beds, serves the entire province, is limited to people under 19, and has a long waitlist. There are no queer and youth sensitive services for people over 19. Due to lack of queer-sensitive and safe services, youth often need to go into the closet in order to access treatment services.

Participants in a focus group of young male sex-trade workers stated they want to work with service providers who are queer, who come from personal experience of substance use, who come from diverse cultural backgrounds, and who are closer to them in age. Two-spirited participants particularly want to see Two-Spirited counsellors. Participants in the youth workshop at the community forum said that it is important to have services specific to queer youth, as queer youth have different issues. In order to serve youth effectively, services need to have a harm-reduction approach rather than requiring abstinence.

5.4 ADDRESSING GAPS AND BARRIERS

Focus group participants provided some insight into what steps they felt would help to address gaps and barriers: agency commitments to providing appropriate care for LGBT people; service provider knowledge and competency in a number of areas; and creating a welcoming environment.

5.4.1 AGENCY COMMITMENT

Service providers identified that agencies need to take leadership and responsibility to acknowledge that LGBT people are currently not well served, and to develop and implement policies and strategies to address homophobia and other forms of discrimination that are expressed by staff and by clients. Measures suggested as part of agency culture shifts include:

- Develop and implement diversity and employment equity policies
    - Awareness campaigns aimed at staff and clients about the rights of clients to equitable and non-discriminatory services. These could include posters about agency diversity policies being developed and displayed in visible locations in agencies
    - Development of social marketing campaign focused on basic lesbian, gay, bi and trans awareness, targeting service providers, as part of a culture shift
    - Ensure there is ethno-cultural diversity amongst staff and competency to work cross-culturally with clients

- Develop, enhance, and evaluate programs
    - Develop baseline expectations about how staff behave towards clients
    - Involve clients in all aspects of program development and evaluation
    - Ensure that the staff complement in addiction services includes people who have a variety of second languages used in the VCHA, including ASL
    - Ensure that programming in facilities addresses racism and cultural differences
    - Train staff in issues relating to substance use in LGBT communities

These measures would improve clients' experiences in care as well as increase the efficiency of service delivery. Service providers working with clients who are at risk of experiencing discrimination and prejudice could count on clients being treated well, rather than constantly being vigilant and constantly having to problem solve and search for services where clients won't be subjected to discrimination.

Recommendation #12

That agencies take responsibility for ensuring equitable access to appropriate service for LGBT people.
See page 71 for discussion.

5.4.2 SERVICE PROVIDER EDUCATION

In some of the groups, participants outlined some of the skills and knowledge that they felt it was important for service providers to have:

- Appropriately and sensitively ask questions about sexual behaviours and gender identity
- Understand the impacts of homophobia, transphobia and heterosexism
- Provide an environment where the treatment is not based on a male, heterocentric, white, middle to upper-class model
- Provide effective intervention when homophobia or transphobia arises from other clients and staff
- Understand the role that substance use plays in queer communities
- Understand from a clinical perspective the special needs that LGBT people have in addictions treatment

Meeting the educational needs of service providers is complicated by the fact that general sexuality issues, much less sexual orientation and gender identity, are frequently not addressed in service provider training programs in colleges and universities. Many service providers in the work force completed their formal education many years ago, and so have had no education on working with LGBT clients. Resources and training for service providers on LGBT substance use issues are currently not easily accessible.

In addition to education to develop competency in working with LGBT clients, participants in some groups noted the necessity for service providers working in addictions to receive standardized education about substance use and addictions. Participants in one focus group felt that it is important for service providers to understand the history, both legal and cultural, of drug use, prohibition and addiction.

Furthermore, participants noted that service providers need to have awareness about mental health, cross addictions and compulsive behaviours, and other issues that can be related to substance use. It is important for service providers to be able to work sensitively and effectively with people who have experienced trauma, especially life-long trauma. Service providers also need to be knowledgeable and sensitive enough about issues for different cultural populations, for people with disabilities, for immigrants and refugees, that they are able to work effectively with people from diverse backgrounds. Many service providers and community members commented on the importance of addressing classism and racism, stating that they cannot be overlooked within the community or when providing health services because they affect the health of individuals.

Participants stated they wanted to work with service providers who treated them respectfully, who approached their care in a holistic and non-judgmental manner, where they do not experience discrimination on any front. People wanted to be

involved in decision making about their own care, and to be given full information in a timely way about what options are available to them. Providing services in safe environments with caring and respect enable people to open up, explore their issues, make disclosures and heal.

5.4.3 Service Provider Networking

Many service providers mention that networking is essential in order for them to be able to work effectively. In order to be able to refer LGBT people to appropriate services they spend many hours developing networks and connections with other queer service providers and agencies to find out whether the staff are queer-sensitive, able to be supportive and are equipped to deal with homophobia and transphobia.

Developing more formal networking opportunities for LGBT service providers would improve opportunities for referrals, information exchange, mutual support, and partnership building.

Recommendation #13:

That the VCHA designate a staff member to coordinate networking opportunities for LGBT people providing alcohol and drug services.
See page 71 for discussion.

5.4.4 Welcoming Environment

> If we don't have things that SHOW that we're friendly, then it makes it a lot more difficult for people to walk in and get the help that they need. *"Jane" alcohol and drug worker in the DTES*

An important component of sensitive and culturally appropriate care is for people to be able to see reflections of their communities, including representations of queers, of people with disabilities, of people from many cultures. It is important for queer people to know when they go into a service if it is queer-sensitive, and if it is sensitive to other issues and oppressions as well. Some suggestions that were given for how to do this include: rainbow stickers on the front door; diversity statements with messages that a site is a hate-free zone and that LGBT people are welcome and that people of colour are welcome; making LGBT newspapers and magazines available in the waiting room; having posters up with LGBT people on them.

Participants stated that they would want to have service providers drawn from similar peer groups, and they would prefer to see LGBT service providers who have personal experience with substance misuse and addictions.

Participants went on to stress the importance of creating and maintaining welcoming, safe environments that provide clients with emotional and physically safety, and afford them respect, dignity and privacy. They also stated that agencies need to

ensure they are able to accommodate transgendered people and reduce the potential for violence against LGBT people. One means of accomplishing this is to ensure that all facilities have single-occupancy washrooms, and that residential facilities have private rooms.

5.4.4 Culturally Appropriate Services

Barriers could be reduced through ensuring there is cultural diversity amongst staff and competency to work cross-culturally with clients. Although some people seeking services may speak English as a second language with some degree of fluency, it is often easier to express complex thoughts and emotions in one's first language. Ensuring that staff complements include people who are fluent in a variety of languages used in Vancouver, including ASL, will reduce linguistic barriers. Ensuring that programs are sensitive to and address racism and cultural differences increases the effectiveness of these programs.

Recommendation #14:

That agencies ensure their staff have taken part in comprehensive education to develop competency in serving LGBT populations.

See page 72 for discussion.

5.5 Discussions Of Current Treatment Systems.

Participants discussed strengths, concerns and suggestions relating to the range of programs and services that currently exist. Some points were raised in a number of groups, and others were very specific.

5.5.1 Outreach Programs

Strengths:

The Street Nurses and outreach program are able to reach trans women who are involved in the sex trade. Having counsellors who know the trans women and know the streets reduces barriers to accessing services.

Having a queer alcohol and drug prevention worker doing outreach to queer youth groups helps to increase information and reduce barriers to accessing other alcohol and drug services.

Concerns:

Participants in the Boys R Us focus group stated that there are not enough street outreach workers and that they experience homophobia from some of the current workers, which speaks to a need for staff training.

A participant in the sex trade workers' focus group identified that outreach efforts don't seem to be directed at sex trade workers who are working in the bars, which is a common environment for males in the sex trade to work out of.

Suggestions:
A couple of participants who were in both the Boys R Us and the Two Spirit focus groups would like to see service providers do more outreach. This would involve:

- Home visits to help address paranoia resulting from substance use and make it easier to take the first steps in seeking help
- Service providers developing a better understanding of their clients and their circumstances
- Service providers taking clients to visit agencies and meet staff before making a commitment to go to a program, to reduce barriers to access

One South Asian participant suggested that members of different ethno-cultural communities should be hired to do outreach to cultural communities and ensure that organizations are accessible and sensitive to their clients' needs.

5.5.2 DETOX

Strengths:
Community participants and service providers want and value having options in ways to detox, and being able to detox in a manner which best meets individuals' needs and life circumstances. One service provider mentioned that the Seniors Well Aware Program connects people to provide mutual support in home detoxing, and has been successful with older gay men.

Concerns:
One participant raised the need for adequate support for people dealing with complex health issues while in detox, and that they have not received this support.

Several service providers and participants identified that residential detox does not know how to accommodate transgendered youth or adults. Trans women have been forced to dress as men, or have been put in the men's section. This is neither safe nor respectful, makes it likely they will leave, and increases their distrust of the addiction services and the health system.

Youth participants, service providers, and those in the youth workshop at the community forum all state that queer youth commonly have bad experiences in youth detox. A youth service provider says that it is challenging to get someone into youth detox quickly. A participant in the Boys R Us youth group said there was inadequate support after having gone through detox to help people maintain progress they've made.
Two participants who are in a long-term relationship have concerns about the lack of flexibility of policies and procedures that separate people who use together while in

residential detox. They were concerned about experiencing homophobia in the detox, and felt it was important to be together to maintain their ability to provide support to each other, especially as they had limited sources of support outside of their relationship.

Participants said that it has been very difficult to get into detoxes. The focus groups took place shortly after Access 1 was put in place. Access 1 coordinates bed availability and waitlists for all adult detox beds in Vancouver. None of the participants mentioned having called Access 1 to get into detox.

Suggestions:

- Development of youth home-based detox program; ensuring competency exists to adequately serve LGBT youth
- One service provider suggested adding a "night-tox" - a non-residential, safe place for people to go, or contact at night for support while going through Daytox or home detox
- Some service providers would like home detox and daytox to be expanded and build on the component that SWAP offers of connecting participants
- Several participants would like to see an LGBT-specific detox or wing of a detox
- Ensure that there is some flexibility in policies, to best meet the needs of clients
- Ensure that detoxes have single-occupancy washrooms and shower facilities; and that residential detoxes have some private rooms in order to accommodate trans people and reduce potential for violence against LGBT people

5.5.3 Outpatient Individual And Group Counselling And Therapy

Strengths:
Given time, individual counselling is able to get at root causes of substance misuse. Service providers and community participants often felt that queer counsellors are best able to meet the needs of LGBT people.

Individual counselling from a holistic approach, not strictly focusing on alcohol and drug use, can help to develop a sense of safety and get at issues that people don't usually raise, such as same-sex domestic violence.

Group therapy works well for some participants, and helps to reduce sense of isolation, helps to develop peer bonding, and can help build self-esteem through receiving positive feedback from other group members.

Concerns:
Group therapy does not always provide safety for participants to raise their issues. Currently there are no LGBT-specific therapy groups offered.

Seventeen percent of the participants raised the need for increased availability of free or low-cost individual counselling of sufficient duration to address the root causes of people's substance misuse. Currently, there are long waitlists to get into existing free or low-cost counselling, and such counselling generally has a limit on the number of sessions people can have.

One participant stated that if one's primary addiction isn't to alcohol or drugs, but to sex addiction or other compulsive disorders, it's almost impossible to find free or low-cost services.

Suggestions:

- Develop LGBT therapy groups
- Increase amount of free or low-cost counselling and therapy

5.5.4 Residential Treatment and Supported Recovery Houses - Adult

Strengths

Service providers noted facilities using a bio-psychosocial-spiritual model in treatment, rather than a disease model, seem to be better able to support people using methadone and people who have mental illnesses.

Including workshops on issues such as sexual health, dual-diagnosis, racism, and homophobia helps to increase levels of education, open dialogue and to reduce stigma and discrimination.

Community participants identified the following as strengths in treatment:

- Group therapy; drama therapy
- Diversity of having participants from all walks of life, as long as there wasn't homophobia
- Addressing and emphasizing nutritional needs as a cornerstone of recovery
- Environments where issues such as childhood sexual abuse and sex addiction can be addressed in safe ways
- Environments where LGBT people are supported by knowledgeable staff
- Physical activity
- Having staff from a wide variety of cultures and ethnicities

Concerns:

Participants spoke about a strong reluctance for queer people to go to residential treatment due to fear of, or previous experiences of, homophobia, transphobia and physical violence. It is difficult for people with disabilities, people with mental illnesses, and transgendered people to access residential treatment.

LGBT people who go to treatment centres often edit their lives because they don't feel safe, comfortable or understood, to the extent that they don't address many of

their problems. Sex and sexuality are often not sufficiently addressed.

Service providers in the DTES raised concerns that the current model for residential treatment may do more harm than good for people who have severe and complex experiences of trauma. Currently, clients in a short-term (4-12 week) treatment program are asked to delve into their painful experiences. Many clients who have had traumatic experiences have not reached safety and containment about these issues. This can result in participants reaching their "last straw" and losing their ability to maintain defence mechanisms and coping abilities (decompensating), leaving treatment, using again, and likely overdosing. Furthermore, the DTES service providers stated that "staff at treatment programs often do not have an understanding of class issues".

Some treatment centres are reluctant to take people who need to be on medications for mental illnesses, and some recovery houses refuse to take them. People in residential treatment often get messages from other people in the facility that they shouldn't be taking any pills because they are addicts.

Community members were concerned about having to wait to get into treatment programs.

Suggestions:
Community participants had the following suggestions for residential treatment programs

- Take a holistic approach
- Develop a treatment centre specifically for people who have mental illnesses
- Provide complementary therapies, such as massage and acupuncture
- Ensure that staff have knowledge about specific substances and their effects, such as crystal meth
- Ensure that adequate life-skills programming exists both in residential facilities and in post-residential services, to support people in breaking patterns, and addressing potential scenarios

5.5.5 Residential Treatment And Supported Recovery Houses – Youth

Concerns:

- There are an inadequate number of residential treatment space that are LGBT and youth sensitive
- Long waitlists are not conducive to getting people into treatment when they need it
- The youth workshop participants at the community forum identified that young queer men are not safe in gender-

> I have had a lot of experiences calling treatment programs and saying this is the situation, there's a young queer person, is it going to be safe for them to be out in this home? The response I get on the *good* days is, "well I don't have a problem with it, but I can't guarantee what all the guys in the house are going to be like, and I can't be everywhere at once, so I *guess* it would be ok." *"Eva," youth worker*

specific residential services where there are also heterosexual boys
- Dividing participants in treatment programs on the basis of biological gender can create a lack of safety for trans youth

Suggestions:
- Provide funding to expand existing queer and youth sensitive residential treatment programs and create new programs that have the capacity to serve this population
- Funders could encourage or require other youth-based alcohol and drug programs to develop competency to serve LGBT youth

5.5.6 COURT-ORDERED TREATMENT

Concerns:
Participants in the community forum identified that people who are in treatment because they were ordered by a court to attend may be there primarily to avoid being incarcerated rather than having a desire to address their substance use. They may be bumped up the waitlist past people who are prepared to address their substance use. Having a mixed population changes the dynamic in a facility, and the forum participants felt it often impedes people who are in treatment voluntarily.

One focus group participant who was ordered by the court to undergo treatment programs says the end result was making her feel resistant to the programs, rather than being willing to benefit from them. Furthermore, the Ministry of Child and Family Development has threatened to seize her children if she doesn't comply with court-ordered treatment, and she feels the more they threaten, the more she retaliates against those threats.

Suggestions:
- Develop separate facilities for people who are in treatment by court order
- Explore creative alternatives to court ordering which would reduce resistance to addressing fundamental issues

5.5.7 AFTERCARE FOLLOWING TREATMENT

Concern:
There is a lack of adequate support following detox and treatment. Currently people are referred to AA/NA for support following treatment. While 12 step groups can meet some needs, on a variety of levels it does not meet needs of a substantial portion of the population. Professional support is needed to ensure that people have the best chance possible to be able to maintain and build on the progress they have made.

Services are needed specifically for youth, as they are not comfortable accessing services for adults. Queer youth who go to mixed-age 12 step groups are often hit on by older people who present themselves as being in a place of expertise due to their experiences in recovery.

Some people wish to have follow-up treatment after they have been in stable sobriety for a number of years, as crises come up or as life circumstances change. Participants said that professional support to reduce risk of relapse does not seem to be available at all.

Suggestion:

- Improve transition for clients in leaving detox services and residential facilities in connecting with further services
- Develop and expand after-care treatment; develop relapse-prevention programs

5.5.8 Culturally Sensitive and Specific Services

Strengths
Some services exist for Aboriginal people.

Concerns:
Participants felt that very few addiction services and supports are sensitive to the needs and cultural issues of people from different ethno-cultural communities. Different ethno-cultural communities, if anything, provide little in the way of supports to their members.

Suggestions:
Participants in the Boys R Us and Two-Spirit focus groups indicated that Aboriginal youth often feel more comfortable in an Aboriginal setting. Two-Spirited youth would like to have Two-Spirit counsellors and would like opportunities to develop supportive relationships with Elders.

- Ensure alcohol and drug services targeting Aboriginal youth are welcoming to Two-Spirit youth
- Build components in alcohol and drug programs for Aboriginal youth that address Two-Spirited youth. Also, develop components, if they are not already in place, which connect youth with Elders
- Fund positions for Two Spirited counsellors
- Develop programs that are sensitive to the needs of peoples from a variety of ethnicities and backgrounds

5.5.9 MENTAL HEALTH SYSTEM - GENERAL

Concerns:
There is not a comprehensive range of services available for people with mental illnesses.

Some community participants believe that psychiatric medications are over prescribed, are prescribed in doses that are too high, and prescribed without taking into consideration other prescription and illicit drugs people are using.

In the workshop on mental health at the community forum, participants identified that some people who are in early recovery are misdiagnosed, based on symptoms related to recovery. People then take meds that are not needed. Furthermore, the misdiagnosis affects future mental health diagnoses or misdiagnoses. Participants felt that psychiatrists are not always sensitive to factors such as environment, poverty, past history, lived experience, and where people are at in their recovery. Psychiatrists may not consider and consult with the client about whether medications will help or hinder the clients at that point in their recovery.

5.5.10 MENTAL HEALTH SYSTEM - DUAL DIAGNOSIS PROGRAM

Strengths
Participants spoke positively about the Dual Diagnosis program that is part of Vancouver Community Mental Health Services.

Concerns:
There is limited space in the dual diagnosis program, and the program is not able to meet current demand[5].

Suggestions:
- Expand the Dual Diagnosis program
- Ensure that staff at each of the mental health teams and at each of the addiction teams are trained in dual diagnosis issues

5.5.11 MENTAL HEALTH SYSTEM - COMMUNITY MENTAL HEALTH TEAMS

Strengths:
There are two staff people in the DTES hired by the Vancouver Coastal Health Authority to provide counselling to people who are dually diagnosed and do not meet the Community Mental Health Teams' mandate for service.

[5] The Vancouver Coastal Health Authority's ***Vancouver Community Profile***, October 2002, states that between 40% and 60% of people seeking treatment for mental illness also have a substance use problem. (Page 8).

Concerns:
The mandate of the Community Mental Health Teams is to provide service to people who have serious and persistent mental illness. The Teams screen out people who do not have psychotic episodes, except in some situations they see people who have borderline personality disorder, are very suicidal and may also have psychotic episodes. This leaves a large number of people with mental illnesses who are unable to access free mental health services.

One service provider identified that mental health workers frequently change, and for apparently arbitrary reasons. This results in queer people who are in a vulnerable place having to come out repeatedly to new staff members.

A few participants said there is a lot of pressure from mental health teams for clients not to use any recreational drugs at all, which results in people who access those services feeling they have to pretend that they are not using recreational drugs, and thus not being able to be honest about everything that is going on for them.

Recommendation #15:

> **Expand existing treatment programs, develop new programs, and ensure they have the capacity to appropriately serve LGBT people.**
> ***See page 72 for discussion.***

5.6 LGBT SPECIFIC TREATMENT

Half of the participants (49%) identified a need and preference for LGBT-specific supports and services. Some see a need for both general LGBT services and services specifically for queer women, queer men, and transgendered people. In gender-specific services, transgendered people would access services according to their self-identity.

A full 27% of participants explicitly spoke about LGBT-specific treatment services. Participants spoke of the need for LGBT-specific residential treatment, day, evening and weekend treatment, group programming, and an LGBT day and evening centre. Participants and service providers spoke to the need for a space dedicated to LGBT people who are using or desire abstinence. It was thought that such a space might house alcohol and drug services such as one-to-one counselling, group therapy, and day, evening and weekend programs as well as a drop-in space, low-threshold engagement activities, information and referral, education, and peer support components, where there would be facilitated and peer-based support groups, and activities related to health and wellness. A few participants cited the Kettle Friendship Society as an example of a combination of drop-in space and programmed groups and activities that are offered

> If I had my wants … I'd want it to be a safe place that is there 24 hours a day. Nighttime is a bad time for me… [a safe place] that is not only queer-sensitive, but is racism [free]… *"Carol," older lesbian*

in a welcoming environment.

Such a space would provide social opportunities, addressing the high degree of social isolation experienced by people who are using and the challenges of meeting people and developing friendships when people are changing their relationship with substances. It would provide a location for a wide range of supports related to substance use for the queer community.

Critical components in developing services specifically for LGBT populations are: recruiting LGBT service providers; service provider education on LGBT issues; ensuring there is cultural diversity amongst staff; ensuring the staff complement includes people with second languages.

Racism, classism, cultural and language issues create barriers for the full diversity of the LGBT population to access LGBT-specific services. These barriers can be reduced by ensuring staff has training on how to address these issues, that programming in facilities addresses racism and cultural differences, and by ensuring there is cultural diversity amongst staff, including staff with second languages such as Cantonese, Vietnamese, Spanish and ASL.

A few possibilities for developing LGBT specific services include:

- Developing new residential facilities
    - Develop residential facilities that specifically serve the LGBT communities. Offer rotations for queer women, queer men and trans people, and LGBT youth, as well as mixed rotations
    - Advantages - Residential treatment available year-round for LGBT people; provides new beds for treatment; could serve as a centre for excellence in LGBT substance use
    - Challenges: being able to serve diversity of queers from street-entrenched, all ages; all genders; race, class sensitivity; serving people who are dually diagnosed; and physically accessible

- Build on existing treatment centres by offering rotations that serve queer women, queer men, trans people, and mixed LGBT groups
    - Advantages - utilizes existing facilities - no cost to build / maintain; could do rotations specifically for queer women, queer men, and mixed LGBT
    - Challenges - would need to ensure that all staff are very thoroughly trained and very comfortable working with all queers or regularly second queer staff from other facilities
    - Services would not be available year round unless several treatment centres participated. People would have to wait to go to LGBT-specific treatment

- Develop drop-in, discussion, and therapy groups for LGBT youth. Ensure that some of the drop-in and discussion groups are peer-facilitated. Ensure there is adequate outreach to inform youth about these groups

Recommendation #16:

Develop a range of services specifically for the LGBT populations.
See page 73 for list of resources.

6.0 HARM REDUCTION

Participants spoke strongly in favour about all components of harm reduction, and about the urgency of implementing programs that have been identified as components to the four-pillar approach to drug use in Vancouver - safe injection sites, low-threshold methadone, other opiate replacements therapies, and heroin maintenance. They raised concerns about the way some services are currently delivered, and spoke about the need to develop an information campaign. A particular group that was identified as a target for low threshold harm-reduction efforts is trans people who are involved in the sex trade.

Participants in the Facilitators' focus group indicated that any research done into opiate replacement therapies needs to be done in collaboration with drug users, rather than simply with drug users as the subjects. Opiate replacement programs need to consider and address other drugs that clients are using. Participants in this focus group also raised concerns about the policies of the needle exchange programs, and barriers to accessing methadone and barriers to getting help in ceasing to use methadone. The VCHA has since developed working guideline for methadone treatment and policies for needle exchange programs. About 14% of participants use or have used heroin.

> The needle exchange program is something we use for support - the health van that does deliveries. Its great to have access to clean equipment, but the restrictions on it are genocidal - the one-to-one policy that you have to return used needles to get clean ones. That you have to count out what you've got [pulling needles out of a sharps container]. They don't allow the workers to come in contact with used syringes, yet they expect the users to do that… They made [a friend] get them out of [the sharps container], and there were needles in there that 4 people had been using, so that put her at risk for getting stuck by someone else's needles. *"Graham," Hep C positive gay man*

Several groups said they would like to see harm reduction supports that expand on the concept of ecstasy testing kits - they would like they would like to have access to equipment to test other drugs for purity and strength.

Barriers to accessing the methadone programs are the lack of low-threshold methadone programs and language barriers for people who speak English as a second language and are not fluent. "I have heard a lot of times, even though people want to get on to the methadone program, they have to wait a very long time because there are very few … Cantonese-speaking doctors who are able to prescribe methadone. So part of the job [ASIA's] outreach workers do is go with them to go with them to any other doctors who can put them on the methadone program, and translate for them," *("Ming," Chinese service provider).*

Transgendered people, service providers and other participants identified the need for low threshold engagement programs for transgendered sex trade workers. This is due to the enormous barriers that exist for trans people to access addiction services, the health risks that transgendered sex trade workers face, and the lack of low-threshold engagement mechanisms welcoming to transgendered sex trade workers. Barriers include lifetime experiences of extreme marginalization; lifetime experiences of violence; distrust of the health care system; being refused access to services because they are transgendered; and experiences of prejudice and ignorance from service providers and other clients. The health risks they face include high rates and risks of HIV infection, violence, poverty, and social isolation.

The vast majority of transgendered sex trade workers are refused access to services for sex trade workers who are genetic women. (These services can be accessed by transsexual women who have been able to access costly sex reassignment surgeries, however there are enormous barriers for them to access these surgeries.) Currently, there is a lack of safe space for transgendered sex trade workers to gather and have a break from the street.

There are barriers for transgendered people to access supports for lesbian, gay, and bisexual people. Trans people often encounter transphobia from the lesbian, gay and bisexual communities, as well as from mainstream communities. Many transgendered people do not self-identify as lesbian, gay or bisexual, but identify as straight, so having a service be identified as "LGBT' or "queer" reduces the accessibility to transgendered people. People in the sex trade and who are street-involved often encounter additional prejudice when accessing services outside of the DTES and the Granville Corridor.

Recommendation #17:

Develop a drop-in targeting transgendered sex trade workers.
See page 73 for discussion.

7.0 ENFORCEMENT

Issues relating to enforcement were raised throughout the consultations. A total of 17% of focus group and interview participants spoke about the need for drug law reform including the elimination of criminal charges for simple possession, legalizing marijuana and decriminalizing other substances, and diverting the accompanying savings in police, court and prison costs into prevention and treatment programs.

Drug law reform would help to ease the dissemination of information related to informed decision making. It would also help to change drug use from being perceived as a criminal activity with the associated stigma to drug use being perceived as a health issue. In order to move towards drug law reform, the public as well as decision makers need to have a better understanding of the social history of drug use and drug criminalization.

Issues relating to the prison system were raised in three focus groups and the community forum. These included: the high proportion of people in the prison system for drug-related problems; safety and support of lesbian, gay, bisexual and transgendered prisoners; access to harm reduction and treatment programs for substance users while in prison; and reintegration into the community.

LGBT youth and adults in custody centres and prisons are extremely vulnerable, as prisons are generally extremely homophobic places. There is almost no support for LGBT inmates. Different participants commented on specific concerns:

- In youth custody centres, staff do not generally receive sensitivity training in addressing homophobia and rarely intervene to keep LGBT youth safe
- When transgendered people are imprisoned, they are often forced to present as their birth gender, rather than how they self-identify, and they face great risks of violence
- Support is needed for inmates to talk about and increase their comfort level with their sexual orientation or gender identity

Suggestions from participants for how to increase supports for LGBT substance users in prison include:

- Develop LGBT components that build upon existing prison support and education, such as radio programming, and groups that already run in the institution
- Develop or increase training for prison and custody centre staff on issues related to sexual orientation and gender identity, and effective interventions to improve prisoner safety

Currently there is not adequate access to harm reduction and prevention within prisons and custody centres, including access to needles, methadone programs, and counselling.

Supports to help inmates reintegrate into the community are crucial. Connections need to be made with the John Howard Society and other community groups that support prisoners, to determine what is already in place for LGBT people returning to the community, and to determine what the gaps are.

Recommendation #18:

Increase supports for LGBT inmates, including supports related to both substance use and sexual orientation and gender identity, while in custody and in reintegration into the community.
See page 73 for discussion.

Appendices,

Bibliography

and

Endnotes

APPENDIX #1: RECOMMENDATIONS

RECOMMENDATION #1:

Include information about LGBT communities and about substance use in settlement supports, services and resources for immigrants and refugees. Increase supports for LGBT immigrants and refugees that meet their needs in dealing with culture shock, acclimatizing and connecting with LGBT communities in Canada.

See page 23 for more information.

- Include information about LGBT communities and about substance use in Newcomers' guides, teaching modules in Language Instruction for Newcomers to Canada classes.
- Ensure that settlement and integration workers are familiar with LGBT communities and with resources relating to substance use.

Potential partners include:
Agencies that provide settlement services and language instruction for newcomers to Canada; Rainbow Refugees; Lesbian and Gay Immigration Taskforce (LEGIT); Asian Society for the Intervention of AIDS; SOMOS, Storefront Orientation Services.

RECOMMENDATION #2:

Increase access to LGBT information and supports for both Deaf and Disabled queers.

See page 24 for more information.

- Dedicate funding to enable both Deaf and Disabled queers to access relevant information and support (including increasing accessibility of the environments in which programs and services are provided; interpreter services, TTD/TTY machines and lines).
- Agencies serving the LGBT communities need to develop capacity to interact with both the Deaf and Disabled queer communities. They could obtain a TTD/TTY machine and a dedicated phone line, and train staff and volunteers in its use; and educate staff on barriers, issues and concerns relevant for both Deaf and Disabled queers.
- Increase outreach to both the Deaf and Disabled communities.

Potential partners include:
Vancouver Coastal Health Authority; Federal and Provincial Ministries of Health; Deaf Well-Being Program; BC Rainbow Alliance for the Deaf; BC Coalition of People with Disabilities; Information Services Vancouver; The Centre, A Community Centre Serving and Supporting Lesbian, Gay, Transgender, Bisexual People and Their Allies; GLBA Directory; Xtra! West.

RECOMMENDATION #3

Develop social marketing and education campaigns targeting LGBT communities, LGBT substance users, ethno-cultural communities, people with disabilities, and VCHA residents at large.

See page 29 for more information.

Goals would include:

- Increased understanding of substance use and addiction; and the continuum of use
- Reduced stigma associated with substance use
- LGBT-sensitive services publicized
- Full range of services publicized
- Reduced stereotyping and discrimination of LGBT people

Possible Vehicles:

- Multi-media social marketing (television; newspapers; public transit)
- Include stigmatized issues in packages of health information
- Peer education campaigns for LGBT communities
- Series of pocket-sized cards on harm reduction and service access topics
- Distribution through needle exchanges; bars; community organizations
- Harm-reduction / "pleasure enhancement" campaign targeting queer users

Potential partners include:
VCHA; ASIA; SUCCESS; MOSAIC; Xtra West; Pride Vision TV; Community TV stations; GLBA directory; Information Services Vancouver.

RECOMMENDATION #4:

That the Ministry of Education provide leadership, and that school boards and individual schools take action on their legal obligation by ensuring safe school environments for LGBT and questioning youth.
That the VCHA ensures staff working in schools (school nurses, alcohol and drug workers, in-school support teams etc) are able to effectively work with LGBT youth.
That members of the LGBT communities and allies take proactive action in advocating for safe environments for LGBT youth, peer education programs, and Gay-Straight Alliances.

See page 30 for more information.

Potential partners include:
Ministry of Education; School boards and individual schools in Vancouver Coastal Health Authority jurisdiction; VCHA; Youth Quest; YouthCo; Urban Native Youth Association; Gab Youth services; Gay and Lesbian Educators; Gay Straight Alliances; Parent Advisory Councils; post-secondary queer student groups etc.

RECOMMENDATION #5:

To dedicate funding for expansion of existing services, develop additional activity-based programs for queer and questioning youth, and remove all barriers to full participation in programs.

See page 32 for more information.

- In programs that have a high proportion of youth from specific cultural communities, develop or expand programming specific to communities.
- Dedicate resources (funding for interpreter services, for outreach, TTD/TTY machines, etc) to enable Deaf youth to access existing queer resources. Conduct outreach to Deaf communities.
- Ensure all programs are welcoming and are physically accessible.
- Dedicate funding for counsellors and programs for Two-Spirited youth in the VCHA jurisdiction. Develop programs that incorporate cultural practices. Develop peer-support and mentorship programs that connect Two Spirited youth with Two Spirited and other supportive Elders.
- Improve funding for Boys R Us to be open more than three days per week, and open longer hours.
- Develop alternative, fun social spaces for queer youth in environments where alcohol and drugs are neither served nor consumed throughout the VCHA jurisdiction.

Potential partners include:
Governmental: Ministry for Child and Family Development; Ministry of Health; Ministry for Communities, Aboriginals and Women; City of Vancouver; Vancouver Coastal Health Authority
Community Based: Asian Society for the Intervention of AIDS; BC Rainbow Alliance for the Deaf; The Centre, A Community Centre Serving and Supporting Lesbian, Gay, Transgender, Bisexual People and Their Allies; Boys R Us; Deaf Well Being Project; Family Services of Greater Vancouver; GAB Youth Services; Generations Project; private foundations; Richmond Youth Service Agency; Urban Native Youth Association; YouthCO; Youth Quest.

RECOMMENDATION #6:

Work with partners to identify current housing and trauma intervention options for LGBT and questioning youth.

See page 33 for more information.

- These programs must include staff with knowledge and expertise in working with LGBT and questioning youth.
- Develop additional housing and trauma interventions and supports to address gaps.

Potential partners include:
Status of Women Canada; Ministry of Child and Family Development; Vancouver Coastal Health Authority; Pride Care Society; Broadway Youth Resource Centre; Urban Native Youth Association.

RECOMMENDATION #7:

Develop capacity to equitably serve LGBT people in existing supports and supports under development that address housing and other basic needs.
See page 34 for more information.

Potential partners include:
Agencies which provide housing and housing services, such as BC Housing; MacLaren Housing Society; Portland Hotel Society; City of Vancouver; Vancouver Coastal Health Authority. Agencies which address basic needs such as food security and clothing.

RECOMMENDATION #8:

Develop capacity to equitably serve LGBT people in existing Life Skills programs, and programs under development.
Develop Life Skills programs targeting LGBT people.
See page 35 for more information.

- Ensure that some programs focus on substance users, and others are accessible to any LGBT person.

Potential partners include:
VCHA; Coast Foundation; the Kettle; Portland Hotel Society; The Centre: A Community Centre Serving and Supporting Lesbian, Gay, Transgender, Bisexual People and Their Allies.

RECOMMENDATION #9:

Develop a range of social supports serving LGBT communities that are not directly focused on drug use.
See page 37 for more information.

This will result in increased resiliency, increased interpersonal connections and connections to queer communities.

- Develop a range of fun, social activities where people can meet and socialize in an environment where drugs and alcohol are neither served nor consumed.
- Expand the range of social and/or discussion groups currently offered.
- Develop or expand workshops and other support addressing a range of topics and issues on mental and physical health and well-being.

Potential partners include:
Ministry for Communities, Aboriginals and Women; City of Vancouver; VCHA; The Centre: A Community Centre Serving and Supporting Lesbian, Gay, Transgender, Bisexual People and Their Allies; AIDS service organizations; Downtown Eastside Women's Centre.

RECOMMENDATION #10:

Develop a range of social supports related to drug use for LGBT communities.

See page 38 for more information.

Potential partners include:
Ministry for Communities, Aboriginals and Women; City of Vancouver; VCHA; The Centre, A Community Centre Serving and Supporting Lesbian, Gay, Transgender, Bisexual People and Their Allies; AIDS service organizations; Downtown Eastside Women's Centre; VANDU; LGBT individuals.

RECOMMENDATION #11:

Develop a range of peer support, role modeling and mentorship programs in the queer communities.

See page 40 for more information.

- Some of these programs should focus on healthy living, and others should focus specifically on substance use

Potential Partners include:
VCHA; Ministry for Child and Family Development; Ministry for Communities, Aboriginals and Women; City of Vancouver, the (LGTB) Center; AIDS service organizations; VANDU; Downtown Eastside Women's Centre.

RECOMMENDATION #12:

That agencies take responsibility for ensuring equitable access to appropriate service for LGBT people.

See page 47 for more information.

- This would involve agency initiatives in the spheres of diversity, human rights, and employment equity.

RECOMMENDATION #13:

That the VCHA designate a staff member to coordinate networking opportunities for LGBT people providing alcohol and drug services.

See page 49 for more information.

RECOMMENDATION #14:

That agencies ensure their staff have taken part in comprehensive education to develop competency in serving LGBT populations.

See page 50 for more information.

- Development and implementation of training curricula, similar to what was developed through the Framework for Women-Centred Health. Mandatory staff training followed by addition to orientation process for any new hires / new placements within agencies. Ongoing training on issues to be regularly provided.
- Develop library of resource materials relating to LGBT and addictions that can be accessed by staff not just within VCHA.
- Include LGBT content in curriculum in mandatory courses for service providers at colleges and universities.

Existing resources and potential partners include:

- The Changeways program (through UBC hospital) currently provides LGBT sensitivity training for service providers.
- Existing training manuals for people working with LGBT clients on substance use and addictions issues.
- Education around transgender issues: community groups such as Zenith Foundation and BC FtM Network and Trans Alliance Society. Trans Biography Project and Trans Accessibility Project developed by Trans Alliance Society.
- Education around specific cultural issues: agencies such as ASIA, UNYA, and Hey Way Noqu'; community groups such as SOMOS, Rainbow Alliance for the Deaf and Salamaat. Education about LGBT immigrant and refugee issues: LEGIT and Rainbow Refugees.
- Colleges and universities; professional associations;
- Vancouver Coastal Health Authority; Ministry of Health; Ministry of Education

RECOMMENDATION #15:

Expand existing treatment programs, develop new programs, and ensure they have the capacity to appropriately serve LGBT people.

See page 58 for more information.

Potential partners include:

Federal and Provincial Ministries of Health; Vancouver Coastal Health Authority; outpatient and residential first, second and third stage treatment programs.

RECOMMENDATION #16:

Develop a range of addiction services specifically for the LGBT populations.
See page 60 for more information.

- Develop a comprehensive range of first, second and third stage day, evening and weekend programs for queer women, queer men, and transgendered people as well as programs that combine all LGBT populations.
- Develop residential treatment programs for first, second and third stages of treatment and recovery that specifically serve queer women, queer men, and trans people.
- Ensure that programming in facilities addresses racism, classism, sexism and cultural differences to ensure that services that are maximally effective.

Potential partners include:
VCHA; outpatient and residential treatment programs that have out LGBT staff members; Federal government ministries.

RECOMMENDATION #17:

Develop a drop-in targeting transgendered sex trade workers.
See page 62 for more information.

Such a drop-in should also welcome other trans people, and should offer:
- Low-threshold engagement mechanisms: e.g. coffee; food; TV; hot showers, board games, activities, safe place to hang out.
- Peer component, including peer support;
- Role modeling and mentorship component, to provide examples of alternatives to the sex trade and substance use;
- Harm-reduction component; including needle distribution, safe injection site; free access to condoms
- Counselling, referrals, and access to services related to transitioning

Potential partners include:
Vancouver Coastal Health Authority; The Centre, A Community Centre Serving and Supporting Lesbian, Gay, Transgender, Bisexual People and Their Allies; Boys R Us; Prostitution Alternatives, Counselling and Education; Trans community groups,

RECOMMENDATION #18:

Increase supports for LGBT inmates, including supports related to both substance use and sexual orientation and gender identity, while in custody and in reintegration into the community.
See page 64 for more information.

Potential partners include:
Corrections Canada; John Howard Society; Elizabeth Fry Society; The Centre; prisoner's justice groups.

APPENDIX #2: FOCUS GROUP AND INTERVIEW QUESTIONS

Focus group and interview questions for community participants

- What does support mean to you, relating to substance use & LGBT communities?
- What supports have you been using and why those ones, relating to substance use & LGBT communities?
- What other supports are you aware of for LGBT people who are using, have used, or are in recovery?
    - How do you find out about them?
    - What are you looking to get out of a support/program?
- What supports would you like to see relating to substance use & LGBT communities?
- Is there a role (& if so, what) for individuals, groups and organizations in developing supports related to substance use for LGBT people?

    Prompts:
    What are your experiences in using supports, programs & services?
    What makes something welcoming & safe?
    What prevents you from using supports?
    What would you want staff to know?
    Supports relating to overlapping or interconnected issues? (Substance use cannot be disconnected from other personal, social and environmental issues.)

Focus group and interview questions for service providers

- What segments of the LGBT population are you seeing in relation to substance use?
- What services are you providing, why, and what are you willing to provide?
- What is it like for you to provide these services to LGBT clients?
- What resources exist for you do your work?
    (Probes: organization, money, commitment, access to training, personal and professional supports)
- What do you think are the support needs of the people you serve?
- What do you see as the level of supports and community services for LGBT people who are using, have used or are in recovery?
- Is there a role, and if so what, for individuals, groups and organizations in developing supports around substance use for LGBT people?

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