ENVIRONMENTAL PREVENTION STRATEGIES TO ADDRESS LGBT ALCOHOL, TOBACCO AND DRUG USE

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INTRODUCTION

"The study of why some people swim well and others drown when tossed into a river displaces the study of who is tossing whom into the current—and what else might be in the water."

(Kreiger, 2001, p. 670)

All health problems are multifaceted entities, with influences that come from the individual, the community, the physical environment, and the broader society. This is particularly true of alcohol, tobacco and other drug (ATOD) use and abuse. Layered on top of the complexities of ATOD use are the confusing array of influences on lesbian, gay, bisexual, and transgender (LGBT) individuals and communities. Both substance abuse and sexual/gender identities have biological, psychological, spiritual, inter-relational, socio-cultural, legal, and moral components, and both are affected by societal stigma. There is ample research to suggest that rates of ATOD use, substance abuse and dependence, and negative consequences stemming from ATOD use are higher among LGBT populations than heterosexual populations (alcohol and drug use is summarized in King et al, 2008; tobacco use in American Lung Association, 2010). Many authors believe that the higher rates of ATOD use are attributable to the stresses related to societal stigma about sexual and gender differences (Amadio, 2006; Hughes & Eliason, 2002; Mays & Cochran, 2001; McCabe et al, 2010; McLaughlin et al, 2010; Remafedi, 2007).

The increased rates of ATOD use then contribute to other health problems in the LGBT community, including physical health problems (respiratory illness, liver disease, sexually transmitted infections, dental problems, etc) and mental health problems (depression, anxiety disorders, suicide). HIV/AIDS rates are particularly high among gay/bisexual men, men who have sex with men (MSM), and transgender women, and HIV risk is linked very strongly to drug use, especially alcohol, methamphetamine and other stimulant drugs (Stall & Purcell, 2000). LGBT social venues that are organized around ATOD use, such as bars, outdoor events, fundraising events, and some sex clubs and bathhouses also foster the association between drug and alcohol use and riskier sexual practices (Halkitis & Parsons, 2002; Parsons & Halkitis, 2002). Whereas other cultural groups may receive funding from governmental and philanthropic groups, the Gill Foundation in 2005 reported that LGBT organizations received only 0.001% of philanthropic giving that year ($248 million out of the total $212 billion in giving), resulting in fewer resources to apply to health promotion activities than many other communities. In

addition, government funding has mostly been directed to individual-focused research or interventions to reduce sexual risk behaviors in men who have sex with men, but very little funding has addressed any other aspect of LGBT health or the broader social determinants of LGBT health status.

Educational systems, biomedicine, and health and human services have often neglected LGBT communities, but alcohol and tobacco industries have not. As a result, the media messages that specifically target LGBT individuals and communities are often the messages that promote ATOD use, not messages of optimal health. Alcohol and tobacco targeted advertising and marketing campaigns may have more impact on vulnerable populations that do not see themselves reflected in mainstream advertising (Penaloza, 1996). As one source reported, alcohol and tobacco advertising works on LGBT audiences because gay-targeted ads make them "feel desired, understood, safer, and more comfortable doing business with brands that recognized them for who they were" (Double Platinum, nd). Alcohol and tobacco marketers also target racial/ethnic groups, and we can learn from local community efforts to reduce this harm, such as efforts to make Cinco de Mayo celebrations alcohol-free (see The Marin Institute for examples, www.marininstitute.org). Alcohol and tobacco industries are sponsors of many LGBT community events, spending 75% of their advertising dollars on promotion at community events, thus directly exposing targeted communities to their products. Few other businesses actively court LGBT people—LGBT people, like others, are more likely to spend their time and money on business that they perceive want their business.

Basic Definitions

The abbreviation LGBT (lesbian, gay, bisexual, and transgender) is used as a short-hand in this paper, but with the recognition that these terms describe only a small subset of a larger group. The model proposed here may also apply to people who have same-sex behaviors or attractions, people who use different identity terms, or refuse to use labels, and people who indicate that they are not completely heterosexual, as well as all people who differ from societal gender norms and expectations. We do not yet have an adequate vocabulary to describe all of these groups, nor do people in this broad swath of the population unify under any particular terms or communities. It is often difficult to draw a line in the sand between normative

heterosexuality and all the other variations of sexual identity, behavior, attraction, and relationship patterns, nor is it easy to delineate "normal" gender. Both sexuality and gender identifications are on continua without clear cut or discrete points. So the abbreviation LGBT refers to people who identify with one of those identity labels, and people who socialize or organize politically within LGBT communities, regardless of whether they use labels or not.

Terms such as substance abuse, addiction, substance misuse, alcoholism, drug addiction, chemical dependency, and others are used to describe patterns of alcohol and/or drug use that cause harm to individuals and the people/environment around them. Alcohol and drug treatment systems tend to ignore tobacco use, and tobacco activists often neglect the interconnections of tobacco with alcohol and other drugs. In addition, even small levels of use may sometimes create harm, even without any addiction process. The term ATOD use encompasses the entire spectrum from casual or recreational use to addiction, and from legal to illegal drugs.

Public Health Approaches

Too often, substance abuse is viewed as a matter of the personal choices of an individual (in the analogy of Krieger's quote that opens this section, who sinks or swims), and not viewed from a public health perspective. Public health approaches to health disparities have challenged the individual theories and interventions that dominate treatment and prevention approaches to ATOD use. Public health uses a broader ecological framework that highlights the social determinants of health that are often rendered invisible within the current health care delivery system. In other words, it examines the quality of the water and what is upstream from the drowning victim, in addition to examining whether the person could swim or was impaired by ATOD use. Individual approaches are often preferred because they are simpler and they maintain the status quo and social hierarchy. However, the lack of attention directed to the social determinants of health means that individuals often get blamed for their illnesses or lower positions in society, and their health problems cannot be truly prevented or reduced because the root causes of the illness are not dealt with. It is much easier to say that LGBT people choose to drink, smoke, or consume other drugs because they lack healthier coping strategies for stress, than it is to develop strategies that reduce the stress. An environmental prevention approach addresses ATOD availability, distribution, promotion, sales, and use; pays attention to issues

such as place and unique events; and works through policy change (Hoover, no date). It is likely that many environmental prevention approaches already in place, such as raising the legal age of drinking, levying alcohol and tobacco taxes, putting restrictions on tobacco promotion to youth, and other policies have positively impacted LGBT communities. This document highlights some of the unique applications of environmental prevention to LGBT communities.

The remainder of this paper outlines the social determinants of health in the LGBT community, and makes recommendations for ways to address them and improve the health of the community. Figure 1 depicts the theoretical framework that guides the recommendations (model adapted from Davis, Cohen, & Mikkelson, 2003).

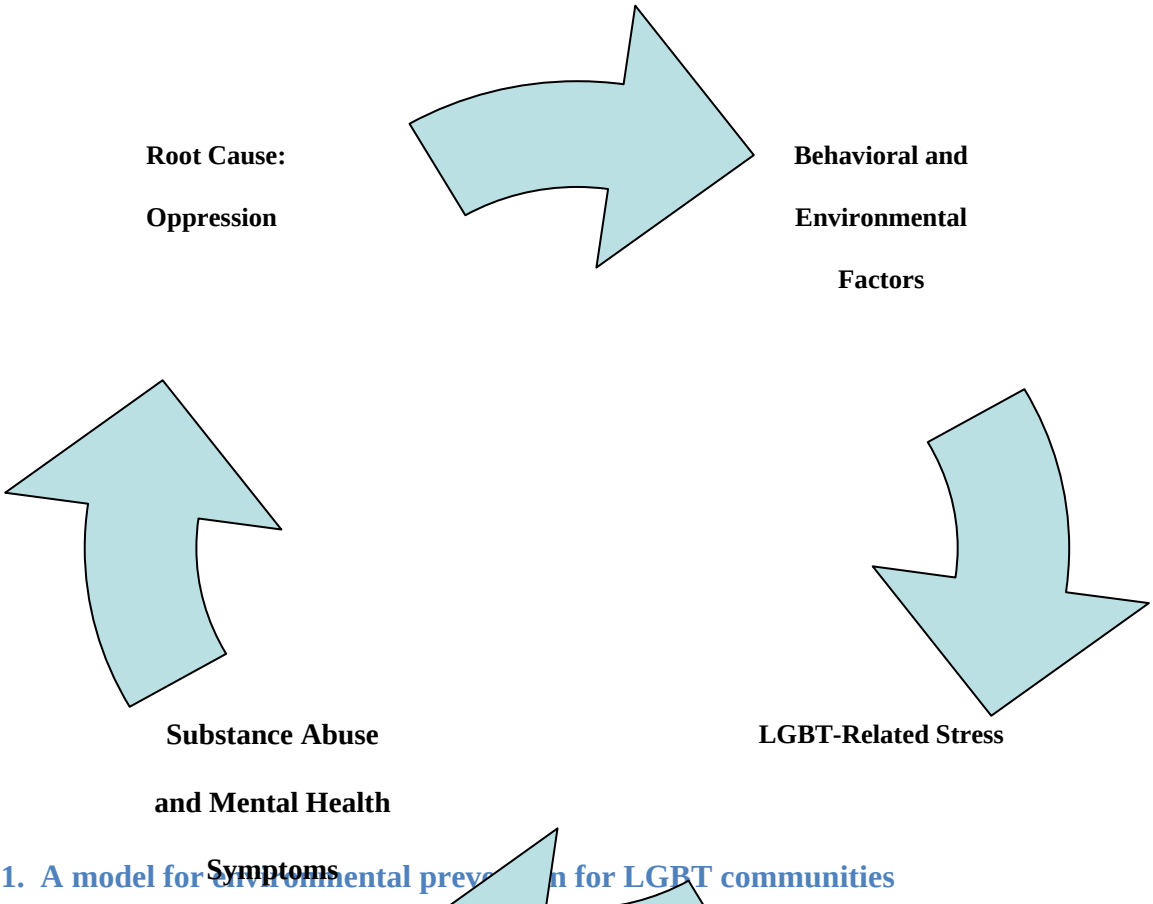

Figure 1. A model for environmental prevention for LGBT communities

WHAT ARE THE SOCIAL DE[illegible]LGBT ATOD USE?

Carmen is a 17 year old girl who came out as bisexual two years earlier. She has been harassed at school consistently and often skips school because she is afraid of physical violence. Her parents are not accepting of her sexuality and refuse to talk about it. They are devout

Catholics and the priest at the local church has made negative statements about LGBT people many times in sermons. There is a youth community center in her neighborhood, but it is run by a fundamentalist Christian organization and refers LGBT youth to anti-gay programs to be "cured." The only place where Carmen has felt accepted is a local gay bar—she looks older than her actual age and easily gets served. Her role models for the LGBT community are a hard-drinking, using, and smoking peer group. She started using alcohol and marijuana heavily to fit in, and began smoking cigarettes regularly when tobacco promoters had free give-aways at the gay bar.

Carmen's story is all too familiar. Many LGBT individuals experience harassment, discrimination, and/or exclusion from mainstream societal institutions and turn to gay bars for a sense of acceptance and belonging, and to ATOD use to cope with the stress of the outside world. Gay bars have held an important social and historical function in LGBT communities as community centers and support networks for LGBT individuals, but are also a main contributor to the community norms about the acceptability of heavy drinking, smoking and drug use (Parks, 1999; Trocki, Drabble, & Midanik, 2005), and they are a venue for unprotected sexual activity for many men (Flores, Mansergh, Marks, Guzman, & Colfax, 2009). Often, what makes a geographic region a "gay" neighborhood is not determined by who lives there, but by the presence of gay bars. For example, the Castro neighborhood of San Francisco is widely known as a "gay neighborhood" although at least 80% of the residents are heterosexual. The defining of gay neighborhood by density of bars is one of the social forces that needs to be addressed in a public health approach to ATOD use. The social determinants of ATOD use in LGBT people and communities stem from the root causes of oppression—the stigma related to adopting an LGBT identity in a society that has created the negative religious and secular stereotypes about minority sexual and gender identifications and behaviors. Stigma has forced many LGBT people into gay bars for lack of other social outlets, and has created enormous stress for most LGBT people.

Root Causes

Negative attitudes in society (stigma) about LGBT people are at the heart of the increased rates of ATOD use, substance abuse, and other mental health problems among LGBT

individuals. The terms used to refer to this oppression include individual level belief systems (prejudice) that we call homophobia, biphobia, and transphobia. These belief systems come from some religious discourses about sin, and from some medical-psychiatric discourses about sickness, as well as from pseudo-scientific beliefs about the nature of sex and gender. Individual belief systems only have power when the larger systems within society support them formally through laws and policies, and informally through invisibility and making discussion of sexuality and gender taboo. At the societal level, barriers to full civil rights are called heterosexism and gender normativity (see Eliason, Dibble, DeJoseph, & Chinn, 2009 for more detail on these concepts). The barriers are embedded in legal, religious/moral, educational, and medical-psychiatric discourses. Unless these root causes are addressed by large scale societal level change, the behavioral and environmental factors that contribute to LGBT-related stress, and then to adverse health outcomes, will be maintained.

Behavioral and Environmental Factors

These are the observable outcomes of oppression as they manifest in local communities and impact real people's daily lives. In a society where lesbian, gay, bisexual, and transgender individuals are stigmatized and same-sex behaviors and gender differences are taboo, LGBT people are exposed to a wide variety of external forces that reinforce the stigma and send a message of "second class citizen" and "not fully human." The U.S. has made progress. Same – sex behaviors and cross-gender dressing are no longer criminalized as they were in the past, but oppression still impacts the daily lives of most sexual minority individuals. Some examples of the ways that stigma manifests in the behavioral and environmental influences on life can include:

- Discrimination (particularly in employment, but also in education, military service, housing, relationship and family issues, access to health care benefits, etc), which can result in lower income and diminished social status;
- Harassment (bullying at school, subtle or overt harassment in the workplace, place of worship, or on the street);

- Violence (external forms of violence such as hate crimes and sexual assaults; and relational forms of violence in families and intimate relationships that stem from stigma);
- Denial of full citizen rights (e.g., lack of marriage, adoption, military service rights);
- Family rejection and exclusion (e.g. outright rejection such as kicking out an LGBT teen, as well as exclusionary behaviors such as not allowing partners to attend family events, or forcing the LGBT family member to keep the "secret");
- Community rejection and/or exclusion (e.g., barring LGBT people from being scout leaders, officers in the PTA, or being visible in community activities, not being elected to public office, tearing down of flyers advertising LGBT community events, picketing or hate mail to LGBT organizations, targeting of homes of LGBT people for hateful graffiti, etc);
- Religious persecution and/or exclusion (for example, when prominent religious leaders preach intolerance, or religious organizations sponsor "ex-gay" ministries or send messages that LGBT people are not welcome as congregants);
- Pathologizing of LGBT identities or behaviors (homosexuality was removed from the DSM in 1973, yet some mental health professionals continue to support reparative or conversion therapies; gender identity disorder has been in the DSM since 1980, leading to the psychiatric pathologizing of children and adults who prefer cross-gender activities or fashions or who seek to change their gender);
- Targeted advertising and marketing by alcohol and tobacco industries and ignoring/neglect from positive health-oriented services and products;
- Limited corporate sponsorship options for LGBT events, media, and organizations that lead to the necessity of alcohol and tobacco sponsorships to stay viable as well as tobacco and alcohol underwriting of HIV/AIDS agencies and events;
- Reduced access to safe and inclusive health and social services, that may lead to delayed treatment seeking, poor quality of care, and/or lack of prevention education interventions that target the community. Health care professional educational programs contain very

little content about LGBT health or how to assess the health of LGBT individuals and communities;

- Reduced social capital (e.g. reductions in social networks in mainstream communities that often comes from participation in events like PTA, soccer leagues, church groups, business organizations, country clubs, neighborhood block parties, community festivals, churches, bridge clubs, fitness groups, etc);
- Community norms that institutionalize ATOD use in LGBT communities and events and lead to attitudes about individual rights rather than public/community health-promotion (e.g. prominence of gay bars, Pride festivals sponsored by alcohol industry);
- Community norms of rebellion and resistance. For example, Crossley (2004) described how this attitude of rebellion can lead to unsafe sexual practices as a "symbolic act of rebellion and transgression which [gay men] are not necessarily consciously aware of" (p. 227). This resistance to mainstream norms and glorification of individual sexual freedom may also extend to ATOD use and abuse.
- Reduced community resources to address ATOD use (few or no social service resources specifically for LGBT people, and mainstream services that maintain the invisibility of LGBT communities or lack culturally responsive services).

See Northridge, McGrath, & Krueger (2007) to expand on these and other social determinants of health for LGBT communities. These factors create the conditions under which some LGBT individuals internalize oppression and they may affect the ways that LGBT people choose to deal with their stress. For example, there may be far more opportunities in the community to self-medicate the stress in a bar where the person feels safe and accepted, rather than engage in community activism to change the circumstances, but risk public humiliation and shunning. It may be easier to find a meth dealer than a welcoming church, and safer to smoke a cigarette than confront a homophobic boss.

LGBT-Related Stress

This concept refers to the types of stress that result from oppression and its behavioral and environmental manifestations. Ilan Meyer (1995, 2003) called it minority stress to highlight

that all oppressed peoples experience it. He defined it as experiences of discrimination or differential treatment as well as internalized oppression or internalized homophobia (biphobia/transphobia), when an LGBT person is negatively affected by damaging stereotypes related to sexuality and gender. Herek and colleagues (e.g. Herek, Chopp, & Strohl, 2007) called it sexual stigma; Rosario and colleagues (1996) called it "gay-related stress." In this document, we call it LGBT-related stress. We begin internalizing the stereotypes when we are children hearing taunts on the playground and witnessing negative comments about and treatment of LGBT people from peers, religious leaders, parents, teachers and the media. When the individual acknowledges same-sex attractions or gender differences in themselves, internalized oppression can lead to feelings of shame, guilt, doubt, and low self-worth. These feelings are distressing and some people will self-medicate them with ATOD use. If the stereotypes are not replaced with factual information about LGBT people and communities, the internalized stress and external pressures continue to escalate. LGBT-related stress is added to the daily stress that most individuals feel from financial issues, health problems, family and relationship stresses and strains, and other common factors that contribute to everyday stress. LGBT-related stress is one of the underlying causes of the higher rates of ATOD use, substance abuse and mental health problems in LGBT populations (Meyer, 2007), and LGBT community norms about ATOD use, individual freedom, and rebellion are other contributing factors. That is, the prominence of gay bars and community norms about the acceptability of ATOD use and the valuing of rebellion may lead some LGBT people to seek out stress reduction through ATOD use because their options for coping are more restricted if they lack family, religious/spiritual, and community sources of support.

STRATEGIES TO REDUCE LGBT SUBSTANCE ABUSE

We need a multi-faceted approach that addresses all three levels of the theoretical model: root causes, behavioral and environmental manifestations, and LGBT-related stress. in order to reduce the harm caused by ATOD use in LGBT communities. These correspond roughly to societal, local community, and individual level interventions.

Addressing the Root Causes

Two major levels of intervention are needed at the societal level, where the root causes of oppression lie. If these are addressed effectively, they will reduce or eliminate the downstream behavioral and environmental manifestations, and subsequently, LGBT-related stress will become a thing of the past. The two levels are education and legislation (civil rights and ATOD-related laws and policies).

Educational efforts to reduce oppression that can be created through laws or policies include at least four types of educational interventions. These interventions would be helpful to many subgroups of the population, not just LGBT communities.

1) Multicultural education for all children/youth, starting as early as possible, that prepares children to live peacefully in a pluralistic society. Such an education explicitly addresses the historic and contemporary forms of oppression, including racism, sexism, classism, ableism, heterosexism, gender normativity and religious oppression as well as their intersections in communities. This type of education fosters collaboration and respect for difference, teaches conflict resolution skills and nonviolent communication, and encourages better communication across difference.
2) Anti-bullying education. Children who are different, and particularly those with gender differences, are often targeted by bullies, resulting in adverse outcomes for those bullied children, who are much more likely to experience depression, suicide attempts, and substance abuse than children who are not bullied. Bullying mimics power dynamics in society, with those in power (mostly male, heterosexual) often dominating and harassing those who are less powerful (people of color, female, LGBT, disabled) and is learned at an early age. Those bullies may continue to yield power over others as they grow up and become the exploitative business leaders or politicians, abusers of women and children, and perpetrators of hate crimes. Early intervention is critical to changing our violent society by addressing the bullies, not just helping the victims of the bullies to cope better.
3) Comprehensive sexuality education. All students need to learn about sexual and gender development, diversity in sexual and gender identities and behaviors, safer sex, contraception, treating partners with respect, relationship communication skills, and ways to be sexually healthy. This education needs to be inclusive of other-sex and same-sex

sexual activities as well as teaching that gender is a continuum rather than only two "opposites." Sexuality education has been inadequate for most students in recent years, and has nearly erased LGBT students from existence (Elia & Eliason, 2010).

4) Workforce development education. All health and human services training programs need to have education on cultural diversity, including LGBT issues. This education needs to be embedded in formal educational programs and continuing education. Only then will assessment and treatment planning begin to gather data on sexuality and gender and staff members consider them as valid treatment issues.

Legislation to address LGBT people and ATOD use includes laws and policies that 1) provide LGBT people with the same rights and benefits as other citizens, and 2) regulate ATOD sales, promotion, distribution, use, and promote equitable availability and access to prevention, treatment and recovery services. Changes in legislation require coalition building, massive public education campaigns, and strong political support.

Civil rights legislation includes federal protections from harassment, discrimination, and violence (such as ENDA, the Employment Non-Discrimination Act), legal protections for families (such as access to marriage and adoption), and full inclusion under all existing laws. This would include repeal of flawed policies such as "don't ask, don't tell" in the military, and making all policies that include "family" to be inclusive of alternative family forms. Because same-sex couples cannot currently marry in most of the states of the U.S, many partners do not receive health care insurance through their partner's employers, and may not have access to treatment services. Currently, the U.S. Census does not collect information about sexual and gender identities, rendering the LGBT population invisible. All national and state level health surveillance systems, and government-funded research projects that are meant to address representative samples of the population must collect data on LGBT people and the needs of LGBT communities in order to develop more effective prevention interventions and to distribute resources equitably. Until the root causes of oppression have been adequately addressed, hate crimes legislation is also necessary. It sends a strong message that targeting people because of a perceived group identity is wrong and will be punished. These societal level changes can only be adopted when a significant portion of the population advocates for these changes and votes for politicians who support diversity initiatives.

ATOD-related laws and policies such as banning smoking in restaurants and bars, creating larger smoke-free zones in public places, and taxing alcohol and tobacco apply to LGBT people and communities as well as to others. LGBT community leaders and public health officials need to support these initiatives and become part of community efforts to improve the health of all citizens. In the next section, some unique issues related to LGBT communities and ATOD policies are addressed.

What Mainstream Prevention and Treatment Agencies Can Do to Reduce the Behavioral/Environmental Manifestations of Oppression

At the local level, civil rights legislation needs to be implemented, monitored, and enforced in the daily practices of society. The recommendations that follow are more easily implemented by individuals working in community based organizations or health departments than are the recommendations for societal level change. All agencies can be LGBT-inclusive at little or no cost. LGBT-inclusive means that the agency has created an inclusive and welcoming environment that is aware of LGBT issues, welcomes LGBT staff and clients, and creates safety to openly discuss LGBT issues (see Standards for LGBT-Inclusive Care, LGBT-TRISTAR, www.lgbt-tristar.com for more detail on how to form LGBT-inclusive agencies). Some of the ways to create this inclusive climate are described below.

Implement civil rights legislation at the local level, and make agency policies and procedures are inclusive. This includes reviewing and revising nondiscrimination policies, patient or client rights statements, sexual harassment policies, and employee benefits packages, including health benefits for partners and family leave policies that recognize LGBT families. Agency-level forms and procedures must have inclusive language that allows LGBT people to report their identities and/or relationships if they choose. Nondiscrimination policies need to be enforced or they are useless.

Mandate workforce development training. All staff members who deal with clients/patients need diversity training, including housekeepers, cooks, volunteers, and especially receptionists, not only front-line counselors or health care providers. In California, this training is often available for free, contingent on funding. Those who work within accrediting groups or within educational institutions need to begin to integrate LGBT content into the professional

training of substance abuse treatment and prevention professionals, physicians, nurses, psychologists, social workers, teachers, and all others who work with LGBT populations.

Hire and retain diverse staff members, board members, and community advisors. Advertise for these positions in LGBT community centers and local LGBT newspapers or websites. The staff and board of directors should reflect the communities that the agency serves. Once hired, the agency must ensure a safe and inclusive workplace for their LGBT employees.

Educate clients, families, and communities that are served by the agency. This can be accomplished via written materials, agency programming, and agency policies. Written information can be posted in prominent locations such as framing nondiscrimination policies and mounting them at the entrance to the agency. Until larger scale changes have taken place in society, excluded members need to be named in nondiscrimination policies/statements, so the policy needs to explicitly include the terms sexual orientation and gender identity. Brochures, fact sheets, and LGBT-affirming visuals (posters, flyers, local newsletters) can be placed in waiting, reception, or common areas. Some agencies can provide educational and therapeutic programming, such as discussion groups about sexuality and gender or may include statements about inclusivity and respect for all clients at orientations to programs. A strong message of inclusion and welcoming of all people supports all forms of diversity. Please note that vague statements such as "We do not discriminate" are not sufficient. It is much better to say to all new clients, or at the beginning of all group sessions, "We operate on a principle of respect for all people and will not tolerate hate speech or negative comments about any groups of people." When clients make anti-LGBT remarks in treatment, they need to be addressed immediately. Prevention plans and programming needs to explicitly include and address local LGBT communities—generic programs are rarely useful.

Form linkages with LGBT communities, such as offering to host LGBT AA/NA and other groups at the agency, hosting ATOD-free social activities for the LGBT community, reaching out to LGBT communities through educational media campaigns, and building coalitions. If there are LGBT-specific services for substance abuse, mental health, or other social services, partner with these agencies on projects and/or develop referral mechanisms as appropriate.

Start LGBT-specific groups. Agencies that serve larger numbers of LGBT clients may want to start LGBT-specific ATOD groups. There is a curriculum for smoking cessation for LGBT groups (The Last Drag, Gordon & Soliz, 2007). At this point, there are no universally accepted substance abuse treatment models for LGBT people. It appears that any existing model (12 Step, Cognitive Behavioral, Motivational Interviewing, etc), can be made LGBT-inclusive by addressing LGBT-related stress as antecedents to substance abuse and as challenges in achieving recovery. There are also LGBT-specific Alcoholics Anonymous, Narcotics Anonymous and other recovery support groups in many cities (search the internet for "gay AA" or "LGBT AA/NA" for the city in which you live to find the nearest ones). If there is no LGBT group nearby, offer to host one at your agency.

What LGBT Community Leaders and Agencies Can Do To Reduce Behavioral and Environmental Influences

This set of recommendations is aimed at LGBT communities or partnerships of health and human service agencies with LGBT community groups. These partnerships can result in mutually beneficial relationships and improve the health of whole communities. Not all mainstream substance abuse treatment or prevention agencies will have the capacity to do this extensive outreach and partnering, but they may be able to partner with key members of LGBT groups or organizations to engage in some of these activities.

Assess and address LGBT community needs and norms. Find out about the needs of the local LGBT community, for example by assessing local patterns of ATOD use and abuse, identifying the density of gay bars, sex clubs, and cruising areas, noting the number and location of sobriety groups, social services, political and social organizations, alcohol-free venues and events, tracking crime rates and types of crimes in LGBT neighborhoods, and noting whether there are Gay-Straight Alliances in the schools or if there is a chapter of PFLAG (Parents and Friends of Gays and Lesbians). Do LGBT community leaders perceive that ATOD use is problematic? In one study (Offen, Smith, & Malone, 2008) many leaders of LGBT community organizations viewed smoking as a personal choice and individual right, not as a public health or local community issue. In San Diego County, a needs assessment addressed community readiness to tackle the relationship between ATOD use and HIV, by surveying key informants

(40 local LGBT community leaders) and community members (n=393) about community involvement, community resources and information sources, and attitudes about alcohol and drug use (SSRL, 2009). This study found relatively low levels of awareness among community members of the links between ATOD use and HIV, but a general level of support for policies and business practices that would reduce risk (e.g. providing condoms and free testing at sex venues, posting information about safer sex practices at bathhouses, etc). Key informants stated that the main barrier to prevention activities related to ATOD use was that alcohol and drug use was part of the culture. Needs assessments of communities can include town hall meetings, focus groups, key informant interviews, observations of physical environments or events, and surveys of community members.

Focus on positive messages. The majority of LGBT people do not abuse substances and show resilience and healthy coping in response to stress. Posters, flyers, interviews in the media and other media messaging can help shift the norms from a "party" culture to one of good health and community spirit. Many communities have LGBT-owned or affiliated coffee shops, social service agencies, political groups, bands and chorus, artistic and cultural groups, and many other non-ATOD-oriented activities and services that can be highlighted in public service messaging.

Help LGBT community members do assessments of LGBT media. Do LGBT-specific media in the local area depict alcohol, tobacco, and drug use in a positive manner? Do pairings of ATOD use with sexy characters promote use? How can the LGBT media become aware and responsible for balancing messages about ATOD use and promoting health? For example, a few years ago, the cover of a national LGBT news magazine featured a sexy photograph of an actress smoking a cigarette, with the caption, "Smokin' Kristiana Locken." Tobacco and alcohol are often paired with images of sex in LGBT publications, promoting an association between desirability and ATOD use. This product placement in non-advertising copy can be as influential as a specific product ad in promoting tobacco or alcohol use. Local communities do not control the national press, but can learn media literacy principles to reduce the impact of these images. In addition, local media can partner with health organizations to shift the community norms. For example, an LGBT mental health provider could have a regular column in the local newspaper or a health-oriented service could advertise there.

Conduct assessments of the built environment in locations that have LGBT neighborhoods, including mapping the geographic location of gay bars in relation to gay social services or health clinics, homophobic and supportive churches, examining crime statistics; and determining access of LGBT community to resources for health and prevention messages. Assess the placement of billboards advertising alcohol and tobacco in LGBT neighborhoods or near gay bars and determine the density of alcohol/tobacco retailers as well as their hours and days of sale. In addition, whether there is an LGBT neighborhood or not, this assessment of the environment involves knowing whether mainstream health, social service, religious, and other social institutions are inclusive of LGBT communities and individuals.

Build community coalitions, such as including LGBT community leaders in existing prevention coalitions, forming linkages with LGBT communities on specific health campaigns, or creating diversity task forces or committees that include LGBT community members. An integrated city/community is one that identifies common issues that can bring together LGBT communities with communities of color, youth groups, and other groups that are often on the "margins." These other marginal groups also contain LGBT people within them. For example, when alcohol promoters try to co-opt Cinco de Mayo to become about drinking, this affects Latino(a) LGBT individuals as well as heterosexual Latino(a)s.

Provide educational materials and support to LGBT social venues. Some research has found that educational interventions in bars are effective, whereas other research finds it less effective (Warwick, Douglas, Aggleton, & Boyce, 2003). This may be a function of local community norms. Posters and brochures about safer sex and the link between substance abuse and risky sex may be helpful, as are free condoms and testing for HIV in bars and sex venues. In some locales, bathhouses and sex venues are required to post information on safer sex practices or post a notice encouraging patrons to disclose their HIV status. Some locales may prohibit alcohol and drug use in bathhouses and sex clubs, prohibit alcohol and tobacco ads in bars/bathhouses, or require customers in sex venues to sign agreements about following house rules in regard to ATOD use and safer sex. In addition, mainstream substance abuse treatment and prevention agencies can offer educational sessions about ATOD use in LGBT community centers and other social venues, thus developing a positive reputation in the community that may foster referrals.

Help build capacity within LGBT communities to change community norms, adopt ethical funding guidelines for accepting alcohol and tobacco advertising and sponsorship of events (as well as pharmaceutical sponsorships), develop harm reduction guidelines for LGBT community events such as Pride Festivals and AIDS fundraisers, and develop, promote, and evaluate LGBT-specific interventions. For example, the Last Drag, an LGBT-specific smoking cessation program developed with support of the American Lung Association has been used in many parts of the country, but there are no published evaluations of its effectiveness. Many agencies host or sponsor LGBT support or therapy groups—these, too, need to be evaluated. There are a handful of LGBT-specific treatment programs, but very little empirical research has been done about their effectiveness because of lack of local, state, and federal funding for LGBT services and studies. Finally, LGBT community groups and newspapers have often accepted alcohol and tobacco advertising and sponsorship because historically, they were the only industries that were interested in funding LGBT events. Without alcohol and tobacco funding, many LGBT functions would cease to exist, even today. Because of this reality, banning alcohol and tobacco funding entirely is not a realistic option, but there are ways to reduce the harm associated with alcohol and tobacco sponsorships. The list below shows a range of ideas for limiting harm of alcohol and tobacco sponsorships at LGBT events such as Pride Festivals. See Drabble (2001) for more details.

Suggestions for ATOD Harm Reduction at LGBT Events (from Drabble, 2001)

1. Help LGBT agencies diversify funding so that alcohol and tobacco sponsorships can be reduced.
2. Limit the size and placement of alcohol/tobacco ads, banners, and other promotional materials (for example, ban the use of large inflatables that dominate the landscape). Limit the visibility of sponsor identification relative to other design features and text so that an alcohol sponsor's logo is not more prominent than the logo of the organization it is supporting.
3. Carefully plan placement of alcohol vendors and smoking areas to create large smoke- and alcohol-free zones, and place these vendors at a distance from family/child/youth oriented booths or activities. Event planning bodies may limit the number of such

vendors they include at events and offer incentives to health-related groups and commercial enterprises in order to create a more pro-health environment. For example, more LGBT people belong to gyms than go to bars, so encouraging gyms (and coffee shops, bookstores, and health clinics) to participate in LGBT community events sends a message of health.

4. Require and monitor alcohol venues' responsible use of alcohol with written policies for training all servers about checking identification, keeping drinking contained within designated areas, limiting the size of drinks (12 oz beer, 5 oz wine servings), limiting the number of drinks one person may purchase, and permitting only licensed vendors to set up booths.
5. Reduce risks associated with driving under the influence by providing taxi and/or public transportation to and from events, offering free soft drinks to designated drivers, and stopping the service of alcohol one hour prior to closing the event.
6. Require that all volunteers and paid workers at the event shall not drink or smoke while on duty.
7. Enforce no smoking zones at entrances and in main event areas.
8. Encourage local health departments or organizations to have booths to distribute information or hold workshops on improving health in the community. Provide science-based factual information about the effects of ATOD use on individuals and communities. As the number of health promoting messages and activities increase, the community norms will gradually shift as well.
9. Encourage LGBT recovery groups to host booths and events at festivals, providing role models for sober fun. Many Pride festivals now have a designated alcohol and drug free area.

Addressing LGBT-Related Stress

At the individual level, LGBT-related stress can be considered an important treatment issue for LGBT clients. Including discussion of LGBT-related stress in the treatment plan is an important form of secondary prevention that may increase treatment retention and reduce chance of relapse. Agencies can consider how best to incorporate LGBT-related stress into the treatment plan of LGBT clients, depending on the type and format of services offered. For example, agencies that provide individual counseling can easily incorporate these issues into the assessment and therapeutic aspects of counseling. Agencies that offer mostly group support or counseling will need to train group facilitators in inclusive language and dealing with clients who make derogatory or stereotypical comments when an LGBT client brings up an issue. Whether group or individual counseling is offered, matching LGBT clients with LGBT sponsors or mentors in recovery provides a role model for living clean and sober in LGBT communities.

The issues that may constitute LGBT-related stress may include coming out or transitioning issues, internalized oppression (shame, guilt, and doubt about the acceptability of one's sexual or gender identity), relationship concerns, family of origin issues, struggles with reconciling religious beliefs with acceptance of one's sexuality or gender identity, issues related to children, coping with experiences of discrimination, harassment, or violence, challenging LGBT community norms, and finding resources for maintaining sobriety in communities where gay bars are the only social institutions for LGBT people. Agency staff members can also teach media literacy and highlight the adverse influence of alcohol and tobacco industry advertising and sponsorships on many subgroups of clients. No one wants to feel manipulated, so providing information about the alcohol and tobacco industry policies and practices to recruit gay populations can be a powerful motivator to change. For example, Project SCUM [Sub-Cultural Urban Marketing] documents from R.J. Reynolds outlined their targeted efforts to recruit gay men for their products. Revealing the power of ads in under-represented populations can empower individuals and communities. In addition, advertisements can be triggers for relapse, so clients of substance abuse treatment need to know how to deal with them.

CONCLUSIONS

Environmental prevention strategies are a necessary complement to individualized treatment and prevention interventions to reduce ATOD use in LGBT communities. This paper has provided some broadly defined strategies for developing environmental prevention plans, but each local community will need to tailor these recommendations to their own particular needs. In most LGBT communities, different strategies may be needed for different subsets of the population. Lesbian communities often differ significantly from gay male communities; communities of color differ from white communities; youth differ from elders, and so on. Some communities have been impacted greatly by methamphetamine whereas others have more problems related to alcohol use. Reducing the negative effects of ATOD use in LGBT communities will require interventions that address reducing societal stigma through the enactment of legislation to extend full citizen rights to LGBT individuals, educational efforts at all levels of society, and interventions that address ATOD issues at the local, state, and societal levels. Attention to these community and systemic barriers to full inclusion of LGBT people in society can be helpful in reducing victim-blaming tactics that maintain stigma, and consequently, lead to LGBT-related stress. Highlighting the ways that alcohol and tobacco marketing has targeted LGBT communities helps to build awareness of the external forces that help create and maintain high smoking levels in LGBT communities. In addition to these systems-wide interventions, each community needs to develop highly specific local-level interventions that address unique LGBT community needs. Unless holistic approaches such as those identified in environmental prevention models are used, negative consequences stemming from excessive or inappropriate ATOD use will continue, further contributing to physical and mental health disorder burden in LGBT communities.

Using the analogy that began the paper, we need to stop just pulling drowning victims out of the river, and move upstream to eliminate the catapults that are tossing so many LGBT people into the raging current. This can only be done by taking the broader public health view of the problem.

REFERENCES

Amadio, D. (2006). Internalized heterosexism, alcohol use, and alcohol-related problems among lesbians and gay men. *Addictive Behavior, 31(*7):1153-62.

American Lung Association (2010). *Smoking out a deadly threat: Tobacco use in the LGBT community*. Washington, D.C.

Crossley, M. L. (2004). Making sense of 'barebacking': Gay men's narratives, unsafe sex and the 'resistance habitus.' *British Journal of Social Psychology, 43,* 225-244.

Davis, R., Cohen, L., & Mikkelson, L. (2003). *Strengthening communities: A prevention framework for reducing health disparities.* Oakland, CA: Prevention Institute. www.preventioninstitute.com.

Double Platinum (no date). *Three decades of gay and lesbian marketing: An evolution of awareness and effectiveness.* New York.

Drabble, L. (2001). *Ethical Funding. The ethics of tobacco, alcohol, and pharmaceutical funding: A practical guide for LGBT organizations.* San Francisco Bay Area: Coalition of Lavender Americans on Smoking and Health.

Elia, J.P. & Eliason, M. (2010). Discourses of exclusion: The erasure of queer youth in sexuality education. *Journal of LGBT Youth*, 7, 29-48.

Eliason, M.J., Dibble, S.D., DeJoseph, J., & Chinn, P. (2009). *LGBTQ cultures: What health care professionals need to know about sexual and gender diversity*. Philadelphia, PA: Lippincott Press.

Flores, S.A., Mansergh, G., Marks, G., Guzman, R., & Colfax, G. (2009). Gay identity-related factors and sexual risk among men who have sex with men in San Francisco. *AIDS Education and Prevention, 21(2),* 91-103.

Gordon, R., & Soliz, G. (2007). *The Last Drag: Final Report July 2005-June 2007.* San Francisco, CA: Coalition of Lavender Americans on Smoking and Health.

Halkitis, P.N., & Parsons, J. T. (2002). Recreational drug use and HIV-risk sexual behavior among men frequenting gay social venues, *Journal of Gay and Lesbian Social Services, 14(4),* 19-38.

Herek, G.M., Chopp, R., & Strohl, D. (2007). Sexual stigma: putting sexual minority health issues in context. In Meyer, I., & Northridge, M. (Eds). *The health of sexual minorities: Public health perspectives on lesbian, gay, bisexual and transgender populations.* NY: Springer.

Hoover, S.A., (no date*). Environmental prevention*. Sacramento, CA: Department of Alcohol and Drug Programs, Community Prevention Institute. www.ca-cpi.org/tarp.

Hughes, T.L., & Eliason, M.J.(2002). Substance use and abuse in lesbian, gay, bisexual, and transgender populations. *Journal of Primary Prevention, 22(*3), 261-295.

King, M., Semlyen, J., Tai, SS., Killaspy, H., Osborn, D., Popelyuk, D., & Nazareth, I. (2008). A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay, and bisexual people. *BMC Psychiatry, 18(8):* 70.

Krieger, N. (2001). Theories for social epidemiology in the 21st century: An ecosocial perspective. *International Journal of Epidemiology, 30,* 668-677.

Mays, V.M. & Cochran, S.D. (2001). Mental health correlates of perceived discrimination among lesbian, gay, and bisexual adults in the United States. *American Journal of Public Health, 91,* 1869-1876.

McCabe, S.E., Bostwick, W.B., Hughes, T.L., West, B.T., & Boyd, C.J. (2010). The relationship between discrimination and substance use disorders among lesbian, gay, and bisexual adults in the United States. *American Journal of Public Health*, epub ahead of print

McLaughlin, K.A., Hutzenbuehler, M.L., & Keyes, K.M. (2010). Responses to discrimination and psychiatric disorders among black, Hispanic, female, and lesbian, gay, and bisexual individuals. *American Journal of Public Health*, epub ahead of print.

Meyer, I.H. (1995). Minority stress and mental health in gay men. *Journal of Health and Social Behavior, 36,* 38-56.

Meyer, I.H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychological Bulletin, 129,* 674-697.

Meyer, I.H. (2007). Prejudice and discrimination as social stressors. In Meyer, I.H. & Northridge, M. (Eds). *The health of sexual minorities: Public health perspectives on lesbian, gay, bisexual, and transgender populations.* NY: Springer, pp 242-267.

Northridge, M.E., McGrath, B.P. & Krueger, S.Q. (2007). Using community-based participatory research to understand and eliminate social disparities in health for lesbian, gay, bisexual, and transgender populations. In Meyer, I.H. & Northridge, M. (Eds). *The health of sexual minorities: Public health perspectives on lesbian, gay, bisexual, and transgender populations.* NY: Springer, pp. 455-470.

Offen, N., Smith, E.A., & Malone, R.E. (2008). Is tobacco a gay issue? Interviews with leaders of the lesbian, gay, bisexual, and transgender community. *Culture, Health, and Sexuality, 10(2),* 143-157.

Parks, C. (1999). Lesbian social drinking: the role of alcohol in growing up and living as lesbian. *Contemporary Drug Problems, 26,* 75-129.

Parsons, J. T., & Halkitis, P.N. (2002). Sexual and drug-using practices of HIV-positive men who frequent public and commercial sex environments. *AIDS Care, 14(6),* 815-826.

Penaloza, L. (1996). We're here, we're queer, and we're going shopping! A critical perspective on the accommodation of gays and lesbians in the marketplace. *Journal of Homosexuality, 31(1/2),* 9-41.

Remafedi, G. (2007). Lesbian, gay, bisexual, and transgender youth: Who smokes, and why? *Nicotine and Tobacco Research, 9,* S65-S71.

Rosario, M., Rotheram-Borus, M.J., & Reid, H. (1996). Gay-related stress and its correlates among gay and bisexual male adolescents of predominantly Black and Hispanic background. *Journal of Community Psychology, 24,* 136-159.

Social Science Research Laboratory: SSRL (2009). San Diego County LGBT community substance abuse and HIV community readiness assessment. San Diego, CA: San Diego State University.

Stall, R. & Purcell, D.W. (2000). Intertwining epidemics: A review of research on substance use among men who have sex with men and its connection to the AIDS epidemic. *AIDS and Behavior, 4(2),* 181-192.

Trocki, K.F., Drabble, L, & Midanik, L. (2005). Use of heavier drinking contexts among heterosexuals, homosexuals, and bisexuals: Results from a national household probability survey. *Journal of Studies on Alcohol, 66,* 105-110.

Warwick, I., Douglas, N., Aggleton, P., & Boyce, P. (2003). Context matters: The educational potential of gay bars revisited. *AIDS Education and Prevention, 15(4),* 320-333.