Substance Use Disorder Treatment Programs for Transgender and Gender Diverse Patients

Anshul V. Puli, BS, and Alex S. Keuroghlian, MD, MPH

Transgender and gender diverse (TGD) adults in the United States have a higher prevalence of substance use disorder (SUD) compared to cisgender adults across various substances, including alcohol, nicotine, and cannabis.[1] TGD people face significant discrimination, stigma, and violence, which are associated with at-risk substance use in this population.[2] Culturally unresponsive SUD treatment can exacerbate these stressors, which are compounded as TGD patients navigate a variety of care levels across health system settings (eg, primary care, emergency department, inpatient detoxification) and sobriety programs—including Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Self-Management and Recovery Training (SMART)—where they often face stigma, discrimination, and even violence due to hostile sociocultural attitudes and policies. Given the higher prevalence of SUD in this population, there needs to be increased attention to designing SUD treatment settings that, rather than causing harm, serve to optimize SUD outcomes for TGD patients. This commentary discusses TGD responsiveness of SUD treatment at different clinical care levels (outpatient, partial hospitalization, residential, inpatient), as well as how to reduce stressors and make current treatment programs more inclusive.

Most studies on SUD care for TGD people use a mixed-methods (interview, survey) approach with relatively small cohorts. Kelly et al[3] and Lombardi[4] specifically focused on describing the experiences of TGD patients in SUD care. Kelly et al looked at care in Rhode Island for 12 transgender people with SUDs (stimulants, alcohol, cannabis) in varying treatment programs (mutual help groups—AA and NA; group therapy; inpatient; residential). In treatment, these patients experienced stigma and discrimination from staff, with 1 transgender woman reporting she was turned away from an all-female treatment facility on the basis of her transgender status.[3] Additionally, provider turnover was noted as another stressor, as this meant TGD people needed to repeatedly educate new staff on their gender identity.[3] General barriers to care included transportation cost, group therapy timing, and limited insurance coverage.[3] Patients reported positive SUD treatment experiences when gender-inclusive environments existed, for example, through the presence of LGBTQIA+ symbols on pins, queer-identified residential staff, and inclusive ground rules for group therapy sessions.[3] Of note, in this study, both TGD-specific barriers to and facilitators of care pertained to staff interactions with patients, highlighting the importance of interpersonal care delivery approaches for fostering an inclusive environment.

Lombardi[4] collected and analyzed 90 TGD people's experiences receiving SUD care in California. Most in this sample reported alcohol, tobacco, or cannabis use. The study measured transphobic events, which were defined as "discrimination due to being a trans man or woman." Recent experiences of transphobic events were associated with recent drug use and self-classification as having a drug use problem.[4] People in treatment programs and mutual help groups (AA, NA) reported more frequent transphobic events from staff working in these programs than from other patients.[4] At treatment programs, most were required to use showering and sleeping facilities based on their sex assigned at birth. Others reported verbal abuse, no discussion of TGD considerations, and requirements to wear attire aligned with their sex assigned at birth.[4] Transphobic events from staff were associated with past-month substance use.[4] Similar to Kelly et al, Lombardi found care delivery impacted inclusivity but noted certain SUD care environments and recent substance use mediated this effect.

These studies describe predominantly discriminatory and stigmatizing SUD treatment experiences among TGD people. Non-inclusive SUD treatment can reduce treatment engagement and worsen SUD symptomatology. This effect could be influenced by harmful, exclusionary behavior by staff and other patients, which emphasizes the need for implicit bias and sensitivity training of staff, as well as the application of organizational trauma-informed, inclusive care approaches.

Given historical and ongoing discrimination, there is a need for more inclusive SUD treatment programs for TGD people. Yet, Williams and Fish[5] found that lesbian, gay, bisexual, transgender (LGBT)–specific SUD treatment is only available in approximately 18% of programs in the United States. Further research from Ji and Cochran[6] has shown that among outpatient, partial hospitalization, and residential SUD treatment programs claiming to offer LGBT-specialized services, approximately 80% did not provide

LGBT-specific services in practice.[6] There is much to learn from the treatment programs truly offering LGBT-tailored care. Notably, these conduct LGBT training for staff, individualize culturally tailored treatment for LGBT patients, deliver specific social services for LBGT people (eg, housing, community outreach), and create programs entirely designed for LGBT people.[6] Of note, providing LGBT-specific programming does not always ensure culturally responsive services for TGD people, for whom gender affirmation and related barriers are critical considerations. Overall, the overwhelming lack of gender-inclusive programs and variability in services reflects an important unmet need for TGD people seeking SUD care.

Recommendations for TGD-Inclusive SUD Treatment

TGD-responsive care hinges upon a nondiscriminatory, gender-inclusive, and gender-affirming environment, requiring organizational and systems-level change. Nondiscriminatory care requires provider and staff training on foundational concepts and terminology related to gender affirmation, as well as mitigation of the adverse impact of negative stereotypes about TGD people and substance use.[7] These trainings should prepare staff to avoid negative assumptions about TGD people while learning to adopt an intersectional lens to holistically work with patients' multiple oppressed and minoritized identities.[8] Additionally, staff should be trained and prepared to intervene, de-escalate, and address sources of harm that TGD people may experience within the SUD treatment setting. Programs should be structured such that correct patient names and pronouns are systematically elicited, documented, and consistently used. Intake forms should allow for voluntary, diverse, and open-ended responses to gender identity questions.[8] Workforce development ought to focus on hiring TGD staff and on generally screening for job candidates who demonstrate readiness to contribute to TGD-inclusive SUD treatment, with all staff encouraged to share their own pronouns.[8] Safe and gender-inclusive shared spaces (bathrooms, showers, communal rooms, signage) help reduce the potential stress otherwise associated with navigating a gender-binarized treatment environment.

SUD treatment spans various levels of care, all of which ought to integrate gender-affirming care principles. Most SUD care occurs in settings not specifically designed for TGD communities. Implementation of gender-affirming care across all SUD treatment programs is vital, as TGD patients have expressed concerns about losing access to gender-affirming hormones and surgeries after substance use disclosure.[7] Primary care clinicians are vital in maintaining care continuity even after substance use disclosure and possible SUD treatment program admission. Residential and inpatient SUD programs must also adopt protocols to ensure continuity of gender-affirming medication prescriptions. Individualized SUD-focused psychotherapy can address TGD-specific drivers of at-risk substance use (eg, transphobia family rejection) and associated risk factors.[9] Tailored cognitive behavioral therapy can help identify substance use triggers pertaining to TGD-related stigma, discrimination, and internalized transphobia, as a way to build resilience and leverage patients' strengths.[10] Given the lack of official guidelines for TGD-inclusive SUD care interventions, quality improvement initiatives can focus on identifying potential sources of harm, prioritizing the needs and experiences of TGD patients, and optimizing population-specific effectiveness.

These gender-affirming SUD care recommendations can apply more broadly to general psychiatric care. Nondiscriminatory and inclusive treatment involves staff training on gender-affirmation and addressing sources of harm, as well as the establishment of gender-inclusive policies and spaces for rooming, restrooms, and showers. Consistent with the World Professional Association for Transgender Health (WPATH) Standards of Care Version 8,[11] care teams must ensure that TGD patients maintain access to gender-affirming hormones throughout general psychiatric treatment, across all partial hospitalization programs, residential programs, and inpatient hospitalizations.[11]

While clinicians may adapt general inclusive care guidelines for TGD patients from the existing WPATH Standards of Care Version 8, there is a need for specific research to create and implement culturally responsive SUD services for TGD people.[11] Further research should focus on characterizing TGD patients' SUD care experiences and evaluating SUD program inclusivity and cultural responsiveness, for example, based on patients' Gender Minority Stress and Resilience Measure (GMSR) scores.[12] The GMSR is based on stressors faced by TGD people that are either "distal"—occurring through interactions that TGD people have with their environment—or "proximal"—occurring within a TGD person (eg, internalized transphobia). Demonstrating improved GMSR scores through implementation of specific gender-inclusive SUD care practices may enable development of data-driven guidelines for TGD-responsive SUD care. Much of the published literature documenting TGD patient experiences focuses on improving care by reducing harm; we recommend research also identifying areas of resilience and offering strengths-based support within SUD treatment.

Future efforts will benefit from TGD community guidance in rigorous SUD treatment program design, planning, implementation, and evaluation to best inform clinical guideline development and dissemination. Moving forward, studies ought to focus on improving quantitative measures of the extent to

which clinical program development occurs with meaningful participation of TGD community members. While research thus far has identified a lack of gender-inclusivity in SUD care delivery, the application of solution-oriented implementation science approaches will expand access to effective and TGD-responsive SUD care.

Article Information

Published Online: November 11, 2024. https://doi.org/10.4088/JCP.24com15581

J Clin Psychiatry 2024;85(4):24com15581

Submitted: August 27, 2024; accepted September 13, 2024.

To Cite: Puli AV, Keuroghlian AS. Substance use disorder treatment programs for transgender and gender diverse patients. *J Clin Psychiatry.* 2024;85(4):24com15581.

Author Affiliations: Harvard Medical School, Boston, Massachusetts (Puli, Keuroghlian); the Fenway Institute, Boston, Massachusetts (Keuroghlian); Massachusetts General Hospital, Boston, Massachusetts (Keuroghlian).

Corresponding Author: Alex S. Keuroghlian, MD, MPH, Massachusetts General Hospital, Wang Building, 8th Floor, 55 Fruit St, Boston, MA 02114 (akeuroghlian@mgb.org).

Relevant Financial Relationships: Dr Keuroghlian reports royalties as editor of a McGraw Hill textbook on transgender and gender diverse health care and editor of an American Psychiatric Association textbook on gender-affirming psychiatric care. **Mr Puli** reports no relevant financial relationships.

Funding/Support: None reported.

Author Contributions: Mr Puli and Dr Keuroghlian conceptualized the manuscript. Mr Puli conducted the initial literature review and wrote the first draft. Dr Keuroghlian provided content expertise and detailed edits throughout the manuscript. Mr Puli and Dr Keuroghlian both contributed to the manuscript revision. Dr Keuroghlian supervised the drafting of the manuscript.

ORCID: Anshul Puli: http://orcid.org/0000-0002-1303-4205; Alex Keuroghlian: http://orcid.org/0000-0002-6624-8354

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