NAADAC
Understanding the History of Substance Use Disorder Disparities
June 30, 2020

>> MODERATOR: Hello everyone and welcome today's webinar on cultural humility series part one, understanding substance use disparity among LGBTQ AI by Doctor Deanna Roper.

I will be the organize for this training experience. The permanent homepage for NAADAC webinars is www.naadac.org/webinars. Bookmark this to stay up-to-date on the latest. Close captioning is provided by caption access. Please check our checkbox for the link.

I would like to ask a polling question here.

You will see five options there. As you are answering this polling question, remember if you have any questions for our presenter, feel free to continue sending them into the questions box of the GoTo Webinar control panel. If you have trouble viewing the poll question, consider changing your view from you to partial view in the GoTo Webinar control panel. You can always minimize or maximize the window at any time when you want to interact, you see the questions box or view the polling question that has popped up. We will give you about five more seconds to answer the polling question on your screen.

Almost 70%, I will close the poll and share the results.

>> DE'AN ROPER: This is great, 51% are asking, that is a wonderful outcome. I love seeing and hearing that. This is really good information for us. So thank you for sharing this -- I think it is interesting to see how many folks are asking these questions.

So, what I would like to do is go over some terms. Very briefly. We are going to have a quick primer and I know a lot of folks wonder about all the hoopla about all of the letters. But if there's not a word that really describes my identity or who I am, it is hard to be seen. Language is so very important in decreasing invisibility and increasing visibility and being seen.

So think about how being seen can be really healing, it helps to decrease stigma, but on the flipside, it is also an opportunity when people also might feel shamed too. And we are familiar with shame and how that impacts substance use disorders.

So sometimes people don't want to tell you who they are out of shame. And we will talk more about that in the training. But also sometimes being seen increases our risk for harm. Queer is an umbrella term. And is used often in communities of color. Younger folks are using this and it's an umbrella term for just the whole LGBTQIA, but it is controversial within some of the LGBT community spirit some folks do not like the term and some do.

Genderqueer, reflex gender fluidity. Pansexual identifies with all identities. demisexual does not have the ability to be attracted to someone unless there is a very strong attraction. Intersex is male or female. Sexual is someone who has a masculine and feminine spirit.

This is our gender unicorn. And another one, just a brief issue here that we need to cover, the main concept need to understand is sexual identity and gender are two different concepts. You can find this on the Internet, but will run through this quickly. My gender identity comes from my brain. It's how I think of myself in terms of male/female/other or maybe none. Gender expression is more present to the world print some identity and expression may be in competition or not. These can change everyday. Or they can remain the same.

My sex is what I was assigned at birth. What did the doctor write on the original birth certificate, my heart tells me who I am physically and emotionally attracted to and that could be any kind of combination and that is my sexual orientation.

Is my original birth certificate matches gender identity and gender expression I am cis gender. We could spend a whole hour just on this one diagram but we don't have time. That is another webinar to come I am sure. When you understand these concepts you can understand why we have the T in all those letters. If you are thinking that you might be invisible you might be right.

You can ask, it is okay to ask him it is okay to ask about sexual orientation and about gender identity. As a matter fact, it makes people much more comfortable in accessing services. It helps create safety. There was a study done in 2018 Rullo by and they found only 3% of the people were really upset when his questions were asked at a medical intake. It's the provider that tends to be more uncomfortable than the client so encouraging to do that.

There are resources at the end of this presentation that will tell you where you can get some of these online trainings.

Let's talk about minority stress theory. That is one of the big topics today.

Minority stress theory is made up of a couple concepts here. Basically being a sexual minority increases the risk of minority -- of stress about being a minority. It increases your exposure to the distal stressor, this is the thing that is unique and chronic. These are the two constructs about his particular theory. The distal stressors, your environmental stressors, they must be unique and chronic to that identity or that population.

However, you might have three different identities, for example, you might be a black transgender female who might be expressing at least three types of distal stressors or unique

and chronic stressors depending on the situation you are in or experiences in the moment, and which part of the identity is being attacked.
This is what we call
intersectionality. Social rejection, discrimination, violence and micro-aggressions and structural stigma -- the social conditions and norms and institutional practices that restrict our rights and opportunities and oppress a stigmatized population, things like housing or employment disclination food we will look at that in a moment.

Proximal of stress is presumed to occur following the distal stressor. It is the coping or managing of the stress. It can be internalized or externalized. Some studies can even predict how much potential of substance abuse there is based on a good assessment about these proximal stressors. So rumination is connected to depression. Another idea is concealment of identity, that means being in the closet. A lot of times when people have such violence and aggression, they choose to manage that stigma by being closeted.

Or, anticipation of rejection or feeling rejection can contribute to anxiety, internalized homophobia, internalized stigma and vicarious trauma. We have that mental illness part or the externalization of those processes, that really are the external coping, which could be substance use. And we see these outcomes and we -- if we are closeted we might get less social support. There is a hypervigilance against racism and violence. We develop anxiety and depression, we develop all kinds of things like mental illness or substance uses.

We have health disparities because we all know how difficult -- you know, the effects of stress on her body is tremendous and we have a lot of research about that.

What we are going to do is talk about minority stress, all those stressors, distal and experience such as micro aggressions, really have impacted this population. So we are going to look at, over the rainbow, some historical moments in the history. And we will see if we can identify some of those distal stressors as structural stigma or violence or dissemination as it relates to sexual minority stress theory.

Before stonewall, we had the very first organization in 1924 founded by Henry Gerber, and he is in Chicago. It did not last long, he did get a charter from the state of Illinois. But he was harassed, he and his members were arrested without warrant. And they were harassed and so finally they decided to shut it down. And so I would say that would be structural stigma, and social rejection as well.

During the Holocaust -- the Jews had to wear a yellow star of David in the concentration camps. A pink triangle was given to homosexuals. They were labeled pedophiles and the lowest in the higher records. Concentration camps were all released at the end of the works of those who wear the pink triangle and many of those were left to put back into prison.

As a community, we have reclaimed this symbol and now it's a symbol of pride. We definitely want to call this violence and structural stigma.

In the 1950s, this will be having the Lavender scare. This is an actual copy of the report sent to Congress entitled employment of homosexuals and other sex perverts in the community.

Several thousand people lost their jobs during this period of time. As you can see from the slide, Congress passed an act about people who are gay or lesbian and arrested them and labeled them as mentally ill. Basically, the whole issue of perversion and we were actually not emotional, emotionally stable.

If you got arrested, you were labeled mentally ill. Again, a great example of structural stigma. Also, most of us are familiar with the DSM which came out in 1952. The publication defined homosexuality as a sociopathic personality disturbance. And then in 1955, eight women met to make the first lesbian organization. Now that's 1924 was the first gay man's organization and 1955, that's quite a few years and decades before the first lesbian organization came into play. But they met because you could not dance in public with somebody of the same sex. It was illegal and you would be arrested.

And then we have this "sip in", this is at a time in New York City that you could not be served alcohol if you are gay or lesbian. They would arrest you. And so in order to challenge that, people got tired of it and so it to challenge that these three gentlemen went to a bar and loudly announced they were homosexuals and that they wanted to be served. It took them three bars before they were arrested but they got the rule overturned in New York that allowed for people to be served alcohol.

They were considered -- if you had -- if you had a group of homosexuals, it was considered disorderly conduct. So I would deftly call this social rejection and structural stigma as well.

And then we had the stonewall in because three years before 1969, we had the Sip In, which is a takeoff on the civil rights "sit in".

So Stonewall came into play and because they got the law overturned that they could be served licker now not be arrested or set the bar down, two or three bars came into play, into business. The most fun bar was the Stonewall Inn.. But here's the thing, if you got caught wearing three pieces of clothing that did not match your gender, that was illegal and you would get arrested. The drag queens, people cross-dressing would come into the restaurant and verify their gender and that was humiliating. Lives were ruined when people were arrested for being in the bars because their names would be published in the newspapers.

What a lot of folks don't know is that a lot of the transgender women were at the forefront of the Stonewall riots. I think on June 28 the bar was raided and someone yelled what you guys do something and so they fought back against the police brutality. And they had riots which was the birth of the gay pride movement.

So, this is actually three pictures, historical pictures, the first one is from Chicago-- gay as the American flag and apple pie. The third one is Gay liberation front. And the third is from Dallas. If you notice in the middle there's a woman holding a sign, and she says, I am tired of hiding, want to be free. Which if you remember that first slide with Henry, the gay man who started that organization in 1924, he started -- he had his first newsletter titled Friendship and Freedom. I think freedom -- all the way back to 1924, we are seeing a theme of freedom.

So, with increased visibility, again, it increases our risk for violence. And other issues. This is an example of our minority stress theory. An example of social rejection. This sign is in the museum in Dallas, for sale by owner, no queers. The middle picture is Anita Bryant who started save the children, she thought the homosexuals were going to ruin the children. And labeled us pedophiles etc. And then we have Harvey Milk, the first openly gay politician in California. He was elected to the San Francisco board supervisors. And he was assassinated in 1978 along by Dan White who was sent to prison and spent five years in prison.

This is definitely social rejection and violence.

Fast forward a few years, and on July 3, 1881, the New York Times prints the very first story of a rare pneumonia and skin cancer that was found in 41 gay men in New York and California. The CDC originally names it GRID, Gay related immune deficiency disorder. Eventually it got renamed by someone who is on national gate task force and a lobby to get it changed to HIV and AIDS.

This is definitely structural stigma and social rejection. We had people who were dying and they could not find a place to live. They could not find a place to die. The government was not talking about HIV and AIDS and were not funding it.

The movement took on a lot more urgency during the 1980s and 1990s, when the AIDS epidemic came up because the government is not addressing anything about it. You see the third picture, "act up" was an advocacy group. The group is holding demonstrations from pharmaceutical companies that were profiting from AIDS-related drugs as people were dying. Nobody in the government would do anything there is no money and they wouldn't even say the word, AIDS. So all the protests are going on and there was boycotting and it took money.

Eventually the leaders of Philip Morris secret tobacco company son opportunity for a loyal audience. And they were the first ones, 10 years later after the article in the New York Times to

give $10,000 to GLAD. and for the first time the leadership in the movement and people who were working so hard felt seen, for the first time. It was a huge corporation that gave them money so that the tobacco companies and began to see that the community was an opportunity for them because if you remember there were quite a few -- that's about the time the laws are coming into effect about not smoking in the building. And those are being challenged, they were trying to get the LGBT community to go to the polls and vote against that.

And so they targeted them with this language, freedom, launch your freedom, freedom to speak, freedom to choose, freedom to smoke. So at this period we have this influx of funding from tobacco companies. This ad on the right is targeting lesbians and these are ads found in LGBTQ media.

They were doing focus groups with us to figure out how to target us. And we were happy to take the money because we were desperate and needed the money. We found through the tobacco legislation, years later, there were a lot of memos uncovered -- they actually had a marketing campaign for these focus groups when they were studying us. It was called "project scum" -- subculture urban marketing in the middle 90s.

Tobacco companies in the liquor companies really started funding us. That is why you see a lot of beer companies and tobacco companies funding pride parades.

Look at the Smirnoff bottles, those are beautiful. . I thought those were beautiful. But it's a vodka bottle. This constant reinforcers about smoking and drinking and these were things -- what I really want you to understand is how they are closely tied to the community, that when you ask a client to change their people, places and things, and they are an LGBT person, and they are used to seeing people like them in a bar because that is the only place to go to find people like them, there are lots of very slick, sophisticated marketing messages about using drugs and alcohol.

So, when you're working with somebody you have to understand the extent of when you ask them to change those things, how isolating that might be. And also if they continued to go, how are they going to cope with a lot of these reinforcers and triggers?

So again with marriage equality in all these great things happening, we have so much more visibility. But -- with our visibility, our risk increases, right?

So, one year later, after the marriage Supreme Court ruling, we had the Pulse nightclub shooting June 12, 2016. 49 people were murdered, 53 wounded. I have not talked about this story of Matthew Shepard, who was beaten and tortured and left hanging to die on a fence in 1998. So many of the people that we don't even know.

This is violence against our community.

As we have more and more increased visibility, we have more violence and risk of violence. We have an epidemic of transgender women being murdered, it is estimated that 130 transgender people have been murdered since 2013 that we know of. We had two women might two transgender women killed about two or three weeks ago. Rya Milton and Dominique Remy Bells. Violence against the community.

On the heels of violence, comes our new Supreme Court ruling for employment nondiscrimination. We gained so much more visibility but our risk increases.

So, time for a polling question. I would like to ask you this particular question. I am curious.

>> MODERATOR: You will see the polling question pop up in just a moment how do you identify? You will see five options there. About 1/4 of you just got up and feel free to answer the question and for those of you who have been sending in questions to our presenter and the questions box of your GoTo Webinar control page, thank you for sending those questions in and continue to send those in for our presenter. In if you have any trouble accessing the interactive poll, please also use the questions box to let us know. For some of you may have to update or change your view from full-size to a midsize and then it will pop up. We will give you about five more seconds to answer the poll.

[Audience activity]

>> MODERATOR: Thank you. I will now close the poll and share the results. And turn this back over to De'An.

>> DE'AN ROPER: This is great. This is fantastic. I really thought we would have a lot of folks in the audience that identified as a sexual or gender minority but I'm wondering, I guess I will just ask you to reflect on your experience, that 68% of you, I'm going to make an assumption which we should be doing but for this purpose -- I will make an assumption that you are probably heterosexual. And I want you to reflect on that experience of how do you identify? And your identity is not listed. That is a really important experience. That your client probably has had multiple times.

It is time to start talking about the research. By research, I really mean the statistics about substance use and so forth.

Research in the LGBTQ community has not really been around very long. And when we did first start searching it was about pathology. And then it was about HIV and AIDS. And focused on

gay white men. And it was not until 2015 that Sansa started asking about sexual orientation international surveys. So most of the research that has been done in the last couple of decades my first of all it is been focused on gay white men, and secondly it's been community samples.

And when we have multiple kinds of research projects going on in the community that are not national but about twice as much then gay men. They also have more health disparities in higher risk. And the use of illicit drugs and marihuana more than gay men. There's black man that are using SMM at a lower rate than white men. YMSM used alcohol and marijuana, polysubstance abuse.

This is the SAMHSA data. It is dated from a 2018 and they found that 6.4 million LGB adults notice the "T" is missing because they did not ask about gender identity.

So when we look at just the LGB community in this national sample, these are the numbers they found. Quite a few people are using illicit drugs, quite a few are using alcohol. And then they also measure mental illness. Serious mental illness. And they found that the rates were 44% of people in this national survey who identify as LGB, and met criteria for an illness.

If we look at cooccur and where we have mental illness and substance use we have almost a 2% rate there.

So SAMHSA data here, I thought I would give you a really quick overview of some of the drugs and then how it compares to the overall population, the heterosexual population. You'll notice the red bar is people who are just using substances and the people in the blue bar are people that have any type of mental illness diagnosed. And then the green bar is serious mental illness.

You will notice these rates here, we definitely have much higher rates of using these illicit drugs, marihuana, opioids, pain relievers etc.

This is our co-occurring SUD. Suicide attempts are much more increased for risk when we add drugs and alcohol to it a right? These bars, the blue is people who have no mental illness and the green are the folks that meet criteria for a substance use disorder. And we can see how tremendously the substance use disorder increases the risk for suicide. So we already have LGB folks feeling bad, suffering from anxiety and mental illness at higher rates then heterosexual people and then we throw in substance use and then we have huge disparities in terms of suicide attempts and thinking.

Smoking. Kind of already covered some of that with the sociological perspective of how those companies infiltrated the community and continue to target the community. There was a new study where the researcher found that LGBTQ folks were getting more social media exposure to

smoking, and it actually did increase the rates of smoking. Compared to their heterosexual peers.

I didn't want to leave out data about transgender folks. This is from a study, and it is a community sample of just transgender people, that identify as transgender, and it's 452 which is a good size for a population that is difficult to study.

Another study there's also another study by Gonzales, and he found trans masculine transgender people have a high risk for drinking, and heavy episodic drinking, compared to transgender women.

Also there was a significant difference in cannabis use and illicit use between transgender males and transgender females, meaning the transgender males, trans masculine are using more substances.

You will be able to reflect on this PowerPoint presentation and I encourage you to take a look at these statistics more closely. But you can notice that we have high rates in the transgender community as well.

These are all related to minority stress as a whole and being a predictor of these substance uses.

All right. A couple more questions here. For you. So I can be curious about you and get to know you better. How comfortable are you treating people who identify as LGBTQIA?

>> MODERATOR: Everyone should see this poll on your screen now. How comfortable do you feel treating people who identify as LGBTQ IA quite this a number and you can use that as a rating scale of comfortability from 5 to 1. Will give you about 10 more seconds to answer this, as you continue to participate in this poll, feel free to send in your questions into the questions box. We will collect your questions and answer them in the order they have been received during the open form virtual discussion will have in a few moments. I will give you about five more seconds read

[Audience activity]

>> MODERATOR: Thank you all so much, I will close the poll and share the results and turn it back over to De'An.

>> DE'AN ROPER: Wow that is great. 36% of people are very comfortable and 56 are comfortable but open to learning more and that is fantastic. Thank you so much.

So, I am going to have to hurry to because I'm running out of time here. But I want to just briefly cover a couple more things, treatment experiences of people in treatment a and tools you can use as well. This particular study was a small qualitative study done with folks who had co-occurring conditions in a residential treatment. 90% of them were out to their providers but there providers didn't talk to them about their sexual or gender identity. Some were even told specifically, don't come out because it might interfere with other people's treatment.

They tended to feel more isolated when they came out. Black and Hispanic clients -- a survey was done among their LGBT clients, it was a mixed treatment. They found bisexuals did not come out as frequently. Bisexuals were much more invisible because they suffer a lot more discrimination on both sides of the fence.

But some of the recommendations they came up with included definitely need a specialized group. Or your sexual minority and gender minority clients. The clinical staff need more education. They said that you should not treat -- clinicians should not treat orientations is a nonissue.

So I found this absolutely wonderful Journal article. If you can get your hands on this, I recommend it. Ask a million people if you can I get somebody and find a student at the University because this is a fantastic source.

This is an author who did this -- they did this lined up questions according to the psychosocial inventory, she lined up, how do you assess each of these with a gender minority person or sexual orientation minority person?

You see where she has her personal -- identity to the right, that would be aligned with those biopsychosocial spirit if you can get your hands on this article it is fantastic. Because for each of those areas, she gives you very specific questions that you can ask, such as what's on the screen her and she does it for every single domain of that biopsychosocial. And she gives it in a case study format.

So just to read one quick assessment for cultural identity. She says, are there aspects of your cultural identities -- notice plural -- that have something to do with your feelings of anxiety? If so, how do you think it influences your anxiety?

She's putting it out there and asking and assessing and will address that in treatment with that client.

So there's lots of things we can do, a big one is training. Which means we have another question here. One last question.

I would like to know -- and I have some suggestions for you as well -- but I really want to know, what kinds of things do you or your organization do to provide a safe space for LGBTQIA people when they come in for treatment? So we will collect ideas from the audience about this. And I believe we are going to post those, correct?

>> MODERATOR: Yes. That is correct, you can use the same questions box that you've been using for questions, and share your ideas, just to help us organize it if you could type like "IDEAS" or "RESOURCE" in all caps, so we can share ideas and resources we got from the community logged in with us here.

>> DE'AN ROPER: Great. Thank you so much.

So one of the last slides here -- has to do with treatment tips. And things that you can do. Things that you can do to help understand the contextual environment of the client, is really important. You have to be able to understand where they come from and where they are being discharged to when finished with their treatment. In remembering the context of all of that and then the context of multiple identities as well. We really did not have a lot of time to get into the depth of that, that we need to, but do that work on your own, and understand the intersection of those identities and the risk as that identity is presented.

You can ask about SO/GI at intake.. Which is a little easier to save and LGBTQIA. Have everybody introduce themselves with their pronouns, put them on your email. A unisex bathroom, bathrooms that are safe. There's lots of resources out there for these types of-- -- tell you how to post bathroom signs etc.

That brings us to basically the end here. And I've two slides that are resources. There are plenty here and if you need more specific resources, feel free to email me. These are wonderful things that have been already covered a little bit in the PowerPoint. But not all of it. But there is your gender unicorn and so forth. It has been my pleasure to present this to you and thank you for your curiosity and bringing your best self.

>> MODERATOR: De'An, thank you so much. We are so happy to have Dr. De'An Roper. We actually have some members and representatives from our LGBTQIA clinical subcommittee which is open for you to all joint you can connect with us anytime, by emailing NAADAC.org and you will see De'An's contact information on the site and you can email her if you want to be part of the subcommittee.

Joining De'An today for our virtual open form Q&A discussion is Joe Amico and Karl Bolton. Joe is an international speaker on LGBTQ + addiction issues, licensed alcohol and drug abuse counselor. The certified addictions specialist, radio host and ordained United Church of Christ person. And he is the past president of the Society for sexual health and the association of

lesbian gay bisexual addiction professionals and their allies. He serves on the advisory board of the addiction professional and the New England addition technology transfer center in the Commonwealth of Massachusetts your of substance abuse services, LGBTQ advisory board pretty is currently the pastor of Tabernacle Congregational church in Salem, Massachusetts.

Carl is with us today, he has 10 years of experience working in a substance use disorder treatment field, he is a member of NAADAC's clinical issue subcommittee on LGBTQIA issues. In addition, Karl as over five years of experience working with individuals seeking cooccurrence substance related and mental health issues. He is trained in dialectical behavior therapy counsel providing therapy to his client that is adhered to full practice DBT, additionally, he specializes in providing affordable aftercare to those who are transitioning from inpatient treatment to outpatient care.

We are really honored to and fortunate to have both Karl and Joey joining us and join Dr. De'An Roper for our live Q&A. So if you can join me and we will turn on our Webcams.
Thank you all. So I will turn this over to you all. I thought maybe if we could start with an opening statement of why you are here and what your passion is about the topic and we will start taking questions from the audience be Joe, do you mind starting
>> JOE AMICO: De'An, what a great presentation and thank you so much for all you have given us. For those of you who do not know, it 1986, Pride Institute in a way to understand that our treatment field has opened. It opened as the first chemical dependency treatment center for gays and lesbians. The other words weren't part of the equation in those days. But in 1989 I joined their staff as a primary counselor. And I left that program in 1999 as Executive Director of Pride Institute.

I joined the Now GAP board. And spent eight years as president. I still belong to the board we helped SAMHSA write an added the introduction to substance abuse treatment for lesbian Gay bisexual transgender individuals published in 2001. And also wrote one of the curriculum and edited the curriculum that went along with that material.

In 2010, I worked as a consultant to a retreat where we established the first inpatient psychiatric and substance abuse program here in the Northeast.

That is my passion, I continue to have that passion to work with this population. And that is why I am here.

>> MODERATOR: Thank you. Karl?

>> KARL BOLTON: Thank you. I am a newbie to the field by comparison. My passion is working with transgender community and specifically people of color who are transgender. Our committee is dedicated to developing national standards for shipment for gender and

sexual minorities. And look at questions concerning gaps in research, gaps and standards of care, and a lack of conversation amongst treatment professionals about who is not here.

Even with our committee we've had questions about who is not there. We focus on transgender folks from residential to outpatient and how we can be more thoughtful and caring for those individuals as they go through our systems.

>> MODERATOR: Let me squeeze in that first question.

>> DE'AN ROPER: I was going to point out that Karl was pointing out to Joe and I that he is much younger than us.

>> MODERATOR: I think you did squeeze that in.

>> KARL BOLTON: You are all more experienced.

>> MODERATOR: We have so many questions, everybody come I will apologize now there's no way we will get to all of them. But we will document and track all the questions coming in from the live audience and send them to our panel-- if we do not get to them we will try to type of answers and post them on the website at a later date. De'An, the first question and also your opening statement, the first question comes from Lorene who asks, how do you get community involvement? You could do your opening statement and maybe address that first question.

>> DE'AN ROPER: Well, my opening statement is really just that, as you can tell, I'm very passionate about training clinicians. I know that there are a lot of clinicians that need this information-- and doing this since I was 15 and got kicked off the volleyball team for being a lesbian. Now I play in an LGBTQ volleyball league that has more than 500 members. And I'm very proud to say that pretty

We had our 30th anniversary this year. So, it is just my life. And by passion. So the question was about getting the community involved.

I think community involvement has been one of those areas that -- since I was 15 and going to the bars -- I was involved in. And I think the way we get them involved with us has to do with us going to them. If you are a provider. If you are a heterosexual person. If you do not identify with the community coming up to go to them and go to the schools. They have student organizations. There are community centers and most of the urban areas. The rural areas are a lot different. But there are community centers that have lots of programming opportunity. You can be a part of the pride parade, you can sponsor folks.

You can host a 12 step meeting in your treatment center or office that is only for LGBTQ folks. Providing a safe place. You could access any of the organizations and ask them to speak to your staff as well. I hope that answers the question. It's a little bit ambiguous but that is the way I interpreted it. Thank you for the question by the way.

>> MODERATOR: Thank you for the question and for the answer but the next question is for Karl. Jeff from Texas asks what can residential treatment facilities do to be more welcoming to trans clients?

>> KARL BOLTON: This is the majority of my experience coming from residential treatment. So this is a serious passion of mine. I'll start with another subject. I worked in a local treatment center and one day one of the coworkers received a call from a woman who asked her, do you admit people of color? She was blown away and didn't know what to say so she said of course. Why do you ask that? And she said do you realize that there's not a single nonwhite person in a picture on your website anywhere? And so she said I did not know that.

She got off the phone and we scoured the website and what we found was not only were the no pictures, there was no comment about anything -- about sexual orientation, gender, race, any category.

What I encourage all folks to do first is to use the power of Google. There's a lot of questions that I get on a regular basis that make me wish I was answering deeper questions. So if you have basic questions about like what are the extra letters for? Or what do those words mean? That puts you in a much better position when you go to a training to absorb information. And to be in a position we can really get to the questions we care about his clinicians, which are about how to impact our clients the best

In a residential setting, I think a lot of times what happens is the executive members will choose to bring a training to a facility -- but not really invest in any policy change, not really think about any of the questions that I think about all the time prayed like, how is your lobby set up to be comfortable for trans people? What room specifically will you house trans folks? And what will you do if those rooms are not available?

What questions you have on your intake paperwork? How is it worded? And who does it exclude? These are practical questions that I think we forget about. So I think a lot of us in one way or another -- we get what is called trans 101 training through college or organizations like NAADAC. And don't really think about trans clients again until a person is trying to access resources.

And so I always invite people to think about for your own facility, especially if your facility has been around for a long time, was their first time in your facility that they admitted a woman?

Was there a first time that they admitted someone who was blackwood was there a first time that they admitted someone who was HIV positive quite

And the answer, and if they were anywhere in the South at least, yes, of course there was. I would invite, I would hope that in those times when they admitted their patients, that they had a concrete plan in place. I think people are truly uncomfortable with talking about what it is to treat trans clients. Because of that failing to have that in-depth conversation, not just about what the terms mean but what does a treatment experience mean from the time that person walks to the door -- literally walk through the door -- to the time they literally walk out the door?

These are considerations that I encourage people to return to their own code of ethics or own knowledge because you have tons read and just imagine, take yourself through a day in treatment as a transgender person in your mind, and see what you find out. And that is what my encouragement would be.

>> MODERATOR: Thank you. Great answer. And Joe, before we get to your first question, I got notes from the audience that our Webcams may not have popped up the right way. If it into a quick scan through and everyone shut your Webcam off and then we will turn it on.

Panel, go ahead and turn your Webcams back on. And I think this might have fixed it. So I am still waiting for some feedback from some of the support team. While they check on that, Joe, let me get the first question for you. I can see all three of you so I will hold off for a post mine. Before I launch my Webcam. Joe, Robert asks how is COVID-19 impacting LGBTQ individuals with substance abuse disorders? By the way, COVID-19 related questions -- Mikal, similar to Robert's question, added how issues of isolation affect this population in a time of isolation like this with COVID-19.

>> JOE AMICO: The questions have some of the answer in it. But thank you for the questions. And how COVID-19 impacts our population bit I would hope that all of us are aware that isolation certainly is a huge issue for a lot of folks struggling with it, but particularly those of substance use disorders. Because one way of dealing with it is to go to self-help and other kinds of groups to support one another. Now the people are isolated, that clearly is a relapse potential and I hope we are looking at that and relapse warning signs.

De'An, you did a great job of talking about minority stressors and this is a time when this minority group, who may have been isolated from their families, isolated from their religions, isolated from other groups, coworkers, it just compounds all of that. I know in Massachusetts, when the governor told us when we had to close our buildings down, we really struggled as a congregation to tell the groups that they could no longer meet here. They call us every week asking when we will be open.

And we feel strongly for them. We know there's online meetings but that is not the same as going to a meeting and getting your hug and being able to exchange phone numbers with people. Having all that kind of contact that is so important.

For everyone in general but especially for this population with the shame they feel ready, this makes the issues even more in terms of the relapse potential.

I want to talk a little bit about those of us in the Stonewall generation, those of us born before 1969, because the COVID-19 isolation has really triggered PTSD from those of us who lived through the HIV-AIDS crisis and epidemic of the 1980s and 90s. Our president during that time ignore the crisis, refused to fund research and treatment for HIV.

GRID was also called the gay plague in those days and I remember that I had clients at the pride Institute that stopped going to funerals after 50+ friends. Died. The huge relapse potential for isolation, PTSD, depression, fear and anxiety, all compounds. And here again, in the state of Massachusetts, when the governor shut everything down, liquor stores were considered essential. Huge relapse issues. So to providers out there, you have after care coordinators, and have them reach out especially to LGBTQIA clients, and graduates and do check ins with them.

>> MODERATOR: Thank you, Joe read the next questions comes from Angela from Virginia in the live audience-- I find a majority of my clients are offended when I ask questions about gender orientation. How would you address that?

>> KARL BOLTON: Working in agencies we have to deal with changes in policy and changes in intake forms and I have found when I worked in institutions there's been a change in the way we do things. Clinicians really lead the way. They lead the energy.

So what I find is if we are uncomfortable with the changes being made, we will often pass that on to the client through subtle cues. Maybe if there is a reluctance or saying something like, I don't want to make you uncomfortable but your is this question. Our intention is to be sensitive. But a lot of times we do create a problem for clients to take on, that maybe they really wouldn't. So I would encourage anyone, when you're asking about gender, you need to look at the emotions you bring into it and you feel a reluctance and uncomfortable?

If you do, we are human and we mirror each other and a lot of times we find clients are matching our own discomfort and even as a clinician, sometimes I have discomfort, asking people. I have discomfort when I suspect that my client might be clearly straight and cis gender and that can be uncomfortable.

I do encourage everybody to think about that as you approach those questions. And to practice, practice, practice. There is no way out of practice and familiarity.

>> DE'AN ROPER: That is a great answer, Karl, and I want to point out in the PowerPoint when we were on the slides that there's a resource listed on the resource pages, the LGBT health education.org, it is the Fenway Institute and they have a video that is free to teacher had asked the questions for your organization. And then they have a manual as well. And that is what they do specifically at the Fenway Institute, the educate people how to do these things and it's a great resources listed there for you.

>> MODERATOR: The next question comes from Jeremiah from the Philippines, Jeremiah asks, is there a manualized best practice or evidence best practice you would recommend specific to each population?

>> DE'AN ROPER: Well -- not exactly. Basically, what we know is CBT, you know, it basic evidence-based practices, CBT and SMART recovery and those things, those really work well. What has to happen is it has to be tailored. That is part of the problem that we do in substance abuse treatment, we think one she will fit everybody command some of us were high heels and some of us were loafers and that's the problem.

But we all wear shoes. And wearing the shoes is equal to the CBT treatment or the evidence-based treatment that you are already using for folks. Things that come out off SAMHSA like the matrix. Things that come out of other kinds of organizations that are out there, the TCU has a wonderful manualized curriculums that well but they have to be tailored and that is what this cultural humility training hopefully opens the door to -- helping you to understand the resources and helping you tell her that.

>> JOE AMICO: I want to put a plug in for the clinical issues subcommittee that the three of us serve on because that has been a huge issue for our field. In working with this minority population. There are not actual established an acceptable standards of practice. And that is what we are working on right now but so if you have an interest in that, get in touch with us and we will love to have you join our subcommittee because we want to come up with Sanders that we could put across the board for agencies.

And were working with the subcommittee and hoping to come up with a center of excellence.

>> MODERATOR: Thank you also much for those answers. The next question -- actually there's a group of people that may have missed some of the language in alphabets. If you could ask about what cis gender means and some of the terms and how different people make classify the terms. I don't know if there is a resource page if we can refer them to something?

>> DE'AN ROPER: Yes, on the resource page, the very first one I think even talks about -- yes, thank you -- the safe zone. The safe zone has a lot of resources that do that. Any of these organizations will have a tab that will give you all of that information as well.

HRC, any of those that you find, really PFLAG, any of the main organizations have all of that information listed or you can Google it, like Karl said it's pretty easy, you can come up with 50 options there. And I encourage you to look up the gender unicorn, and there is a link to the gender unicorn and you can read about that as well. The difference is really about -- two different concepts. One is gender identity and the other one is about sexual orientation. Who I love and who I have relations with. These are two different things.

>> JOE AMICO: And don't feel bad if you don't know every one of them. Every time I go out I learn new terms that are used in different parts of the country.

>> KARL BOLTON: Also, the idea of googling is not just a smart Alec answer, we really want to encourage people to get interested in the subject matter. That we want to serve our clients sometimes without knowing our clients population.

We have a great opportunity to utilize YouTube and Google articles and things like this so we can engage with the topic and have more than just an understanding. But Cis gender specifically means the sex assigned at birth matches with what you identify as. So De'An identified that she was cis gender and she feels correct about that is her gender identity.

Please get engaged in the content and there's some great ways you can get involved just through social media and YouTube.

>> MODERATOR: We have a ton of ideas coming in the audience. Instead of waiting till the end, I will show it now because I thought our panel, while you are here, you may have something to say about these ideas. I will keep typing them, so you will see them pop up as I type them. De'An, Joe and Karl, these are some of the things we talked about and some of them are new ideas especially the organizational ideas. I never thought about that, counselors as advocates make the decisions themselves as individuals, but I love that third bullet point, participate in local Pride Parades and events as an organization proved as a team, as event. That is definitely great.

What other ideas or resources similar to these would you want to include on this list?

>> JOE AMICO: I want to build upon what you said, Samson, I often get asked to do in services at local agencies to talk to them. It's great because I worked with an agency in western Massachusetts, inpatient residential treatment program, and that is what the staff did, they said what can we do? When we talked about different things they said we can do that part so

they did and they put a float in the local gay pride parade to let the community know they were there for them.

>> DE'AN ROPER: And organizations can intentionally hire LGBTQIA clinicians and staff. That is very powerful. And the literature tells us that that is one of your evidence-based practices that can be very powerful because somebody sees someone like them.

>> MODERATOR: Karl you are still muted--

>> KARL BOLTON: The second point, using pronouns in professional signatures. For people that use they/them pronouns or non-binary pronouns, doing this would actually out them. Using a professional signature with them. So is it safe for people to be transgender within your organization?

This is something that I think most agencies do not actually take the effort to look at more deeply. Simply saying that we have done this and that it is different from really different and how racism and trans phobia and classism and others, play a role in the work that you do.

We think that this is maybe -- and examination that only a certain agency should do. But I would challenge that. Even in our most granola neoliberal nonprofits, we would be surprised at the systemic racism, trans phobia and homophobia exists through the organizational structures.

I love the use of pronouns and I would hope that first we examine whether or not it even safer transgender person to work there because that would be a good indication of whether or not that organization is ready to take on a trans client.

>> DE'AN ROPER: Sampson, I think you are muted.

>> MODERATOR: You are right I was muted. I will try to squeeze in one or two more here. Francisco Puerto Rico asks how can the health insurance industry overcome the institutional systemic barriers for LGBTQIA people to access SUD services. A few more asked similar question, maybe even as leaders, organization leaders there are some CEOs here. And advocacy personnel -- what can we all do for improved access to care for this population?

>> KARL BOLTON: This is a passion of mine and I would encourage you that if you are in a leadership organization I would encourage you to talk to your admissions staff. And ask them what challenges they are facing on a daily basis because I think you'll be surprised at the natural resources you have within your organization read and how your workers are at when it comes to these issues. Since I've been in rabbit practice I have suddenly realized how much more productive I am in challenging these issues.

And so, our chain of command, a lot of times and keep us from utilizing our natural resources and I would just encourage everyone to plug in and ask them. And see who is interested in challenging our managed care providers because it is surprisingly behind each giant corporation, there are people. And what I found personally is that if we can actually just breakthrough and send the emails and make phone calls and ask the questions, people will respond. I don't just say that is just a good feeling, I say that from experience. That that is true and in challenging authority and asking questions, so long as were not caught up in a lot of red tape in the organizations, mostly we are successful in it.

>> DE'AN ROPER: I would like to chime in -- for the executive leaders of organizations, there's plenty of CEO healthcare conferences and associations. And that's where you can make inroads because it's really about presenting the research, presenting the research is why the DSM took homosexuality out of being an illness because of the research. Sarah present the research grade a lot of it is there, you can figure out how to do it, find the researcher to work with. Engage with universities. And figure out how to make that data available to people that are in decision-making leadership roles, advocate or legislation at the state level, and use those advocacy tools that social workers are so well trained in.

>> MODERATOR: This was great. You all had some great feedback read I'm going to say one more thing and then you all have a one minute closing statement. I wish we could've gotten to all the questions. We had some excellent questions. And we will compile the questions that the audience sent in and send them to the presenters. And have them answer the questions. We got about four or five comments and questions about lack of diversity right here on this panel. And Karl mentioned it earlier, in the clinical issue subcommittee on LGBTQIA issues we are pushing to get more representation. This committee is open and not close and you can email us now and join this committee and help us solve the problem of underrepresentation or misrepresentation if you feel that we don't have everybody that should be included on this panel, and next year at this time I hope you will be part of that solution and join the committee and help us make this not just a temperate committee but a standing or ad hoc committee, with continued leadership growth and representation.

I know that all of us are on that committee, we meet late sometimes and meet through Zoom and would love to have you join in. Email me. Also in the slide deck, will see the print version and you have De'An's email and you can reach out to her as well. So any closing statements, tips or thoughts from our panel?

>> DE'AN ROPER: I would like to address the issue people of color being available on the board or the committee. One of the issues I was not able to be able to build into the presentation because it is such a broad -- there's so much we need to know -- is that the issues of race and color and ethnicity and all of that is a microcosm in the LGBTQ community, we have

our problems with racism and sociological issues in terms of financial issues and poverty and things like that. Just as the wider community does we do as well.

And we need to do a better job of addressing that just like we are doing at the wider community level. We are a microcosm and have the same issues as those intersecting identities. All voices need to be welcome.

>> KARL BOLTON: Is to build on that, this was going to be my closing statement anyway, we should also be asking the question of who is up here. In every aspect of the treatment we are providing. Not just that but, why? Why are those people not here? We are at a very unique cultural time in our country right now, in which a lot of people are getting really uncomfortable. And asking questions of how do I perpetuate racism and white supremacy? How do I perpetuate trans phobia and homophobia?

And I encourage you, just as we encourage our clients to get into the treatment assignment that is really uncomfortable to unpack their trauma -- I would challenge each of us to look at that, those questions when it comes to trans phobia, homophobia and racism work, but lean in with the clients and don't feel as if you are the only person that is doing this work. Because there are a lot of people out here doing the same. So thank you.

>> JOE AMICO: In addition to those things I certainly agree with both of you, no questions asked. But on a different kind of, saying support you and congratulate you work -- is that so many of you signed up for this webinar entombed in Peter want to say thank you, heartfelt thanks because when I started doing these kinds of presentations 25 years ago, whenever I walked into the room it was mostly LGBTQ folks who were in the room. The fact that most of you did not identify with out today and that you are here, hallelujah, thank you. And keep coming back.

And spread the word. Because that is the way we will make changes. Thank you.

>> MODERATOR: Thank you so much, Joe, Karl, and De'An. And I will explain some last steps on how everyone can get your CE's. Ditto to everything our panel said. Thank you for being here. And here is the list of shared resources from the audience from you all. These will be on the updated slide deck we post online in a moment. Here's the schedule for upcoming webinars and tuning as you can. There are interesting topics with great presenters but as you can see on July 10, our advocacy series continues with Robert Morrison, and this webinar is also launching a cultural humility series. Proceeds from the series will be donated to the Thurgood Marshall College fund this year to support lacks students seeking addiction focused degrees but stay tuned for more webinars in the series as we continue to build it out. But as a sneak peak our next training will be on social class bias: negative impact on treatment outcomes. July 17 we have a world renowned expert on trauma, foster care, cultural humility and the use of self

and the therapeutic environment. Bookmark this webpage, it will keep growing. www.naadac.org/cultural – humility – webinars. So you can stay up-to-date on the latest in this new series, as you can see, again, we are four more webinars planned out on the series and more to come with even towards the end of July we will have another topic on LGBTQIA patient care, and critical issues in overall patient care and patient treatment outcomes. You can visit our COVID-19 resources page, the website is on my slide. We are honored to provide six excellent free webinars that cover top concerns in the addiction prevention and presented by leading experts in the field on topic specific to COVID-19.

Of course, we have our two specialty online training series, one on clinical revision. On the other on addiction treatment in the military and that culture paid you can join NAADAC if you are not a member, WWW.NAADAC.org/joined to learn more of the many benefits of being part of NAADAC.

Note a short survey will pop up at the end. You do not see it you will also see it in the follow-up thank you for attending email from GoTo Webinar. Continue to share your feedback, ideas and notes to the percent or so we can improve your experience.

Thank you again for participating in this webinar. De'Ann, Joe and Karl thank you for your valuable expertise. Take some time and browse the website and learn how NAADAC helps others. Stay connected with us on LinkedIn, Facebook and Twitter and have a great day everyone. Be well.