

CAS WEBINARS
CULTURAL HUMILITY SERIES PART IV
CRITICAL ISSUES IN LGBTQIA PATIENT CARE
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>> Hello, everyone and welcome to today's webinar on Cultural Humility Series Part IV, Critical Issues in LGBTQIA Patient Care presented by Alli Schad and Peter Pennington. It's great that you can join us today. I am the Samson Teklemariam, Director of Training and professional development for NAADAC. I will be the organizer for this event. The permanent home met page for NAADAC is -- make sure to bookmark this webpage so you can stay up-to-date on the latest on addiction education. Closed captioning is provided by CaptionAccess. Please check your most recent confirmation email or our Q&A in chat box for the link to use closed captioning.

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Lastly, under the questions tab, you'll see another tab that says handouts. You can download the PowerPoint slides from that handouts tab and a user-friendly instructional guide that teaches you how to access the online CE quiz and immediately earn your CE certificate. Please make sure to

use those instructions in our handouts tab when you are ready to take the quiz. The presenters also have included a few additional resources. You will see them in that handouts tab. They will be on our website after the webinar.

Now, let me introduce you to today's presenters. Allison, Alli Schad is a licensed clinical social worker. Licensed clinical addiction specialist, and she is a wellness consultant and former director of wellness at UNC School of Medicine in Chapel Hill, North Carolina. She is committed to care, advocacy, and putting systems of care in the field of mental health, health care, and addiction treatment. She was a NAADAC minority fellow and a UNC primary care scholar. Her published work on LGBT tobacco use and cessation is used by Duke Cancer Center and UNC School of Medicine in training tobacco treatment specialists. Alli is a longtime LGBTQ+ activist with experience serving LGBTQ+ support organizations, support programs, and health care initiatives.

Also with us today, Peter Pennington. Peter is the regional business development director for Mountain Region -- treating substance use disorders. Peter received his Masters degree in mental health counseling from Walden University and has worked 8 years in the substance use disorder treatment field, including family education program or, director of admissions, and work inpatient element. He provides training on diversity and policy changes for culturally sensitive patient care such as working on bed placement for transgender clients.

Peter lives in Vinton, Virginia with his husband of 8 years and adopted 6-year-old twins and is a member of an LGBTQ+ softball team in Roanoke, Virginia. NAADAC is really delighted to provide this up webinar presented to you by these two incredible leaders. So Peter, when you are ready, I will give this over to you.

>> Thank you, very much, Sampson, thank you Alli, for joining me on this webinar. I wanted to quickly go through the learning objectives for the day. But we are going to be discussing. First off, Alli is going to be discussing

how do we understand appropriate terminology when working with gender and sexual orientation as it pertains to the LGBTQIA patient care. We will understand what we are going to be talking about, and having that debate available with Alli. Then she will go into recognizing the critical factors that affect and contribute to substance use among the LGBTQIA populations. Then I will be talking about identifying current laws and factors of care that bring support to the patient that we treat and then I will start with the best practices to improve policies promoting safe and healthy environments for LGBTQIA patient care, and I will finish off discussing that as well.

The first thing we wanted to do is talk about some transparent caveats when we are working and talking about today. Some of the information such as you when you see SO or GI that's it referring to sexual orientation and gender identity, two of the things we will be talking about. Sexual orientation is the attractions, the identity based on whether someone is attracted to people of a sex whether they are not the same sex, are the same sex or bisexual. The gender identity refers to your concept of self. You identify yourself as being male, female, or somewhere on the gender spectrum.

The second important thing is the information that we have gained and have -- Alli has some great slides that talk about the different information that we have gathered. It's -- we will talk about the intersex population. The reliability however is not 100% available.

The second thing to understand is the studies really ask about transgender and GNC status. Another word there is GNC. Gender nonconforming. Whether the behavior and appearance of someone does not really conform to the expectations and the cultural norms that are appropriate to their gender. So that's an important one to understand.

The third thing, the existing research is inconsistent methodologies across the board. So we wanted to help you understand that as we go through this presentation. Preferably first thing I want to do is have a quick poll people want to know who you are out there, who is listening so if you

could please share your primary role in your agency and field by selecting one of the following.

>> Thank you so much, Peter. When you see that lot on your screen. 40% of you have voted in a few seconds. So it looks like you are used to our polling feature. Please share your primary role in your agency or field. We will give you just about 10 more seconds. For those of you not just now logging in, a quick reminder, if you have any questions for our presenters you can send those questions in the questions box of your GoToWebinar control panel. We will enter those questions in the order in which they have been received during live Q&A. About five more seconds, and we will close the poll.

I'm going to close the poll ensure the results. In turn this back over to Peter.

>> Thank you, Sampson. It looks like 55% are some sort of addiction counselor, therapist, or social worker appeared we do have some peer support specialist for four-person and recover. If you case managers and some other, which could be students comes to providers, et cetera. We appreciate you for sharing your role.

One of the things I wanted to talk about as we are going into this, this is part two of the series for cultural humility. Dr. Roper did the first part, and you can see her presentation above in the top right corner. We did want to give credit to her and build on what she began. The thing I like the most about her presentation is her invitation to be curious. We want you to be investigative, inquisitive. Curiosity is a strong desire or to learn or know something. So I invite you all to be curious as Dr. Roper did on the last presentation. There are inputs and biases that come in. Implicit bias return refers to the attitudes or stereotypes that affect our understanding, our actions and dissensions in an unconscious manner. We do lack awareness of hours on stereotypes at times and automatic thinking can come into play. It is okay to question how and why something is. I was raised in the deep South, and it took me a long time to understand what

racist ideals were impressed upon me from society from childhood and then in my later years I was able to really look at that and explore that and know that that is part of things and it's okay to question them. I encourage you not only to be curious, but to look at implicit bias.

And this whole idea cultural humility, it's the ability to -- an inner stance that is -- related to aspects of cultural identity that are most important to the person. So really that means we have to bring our own authentic self. Leave arrogance at the door. Embrace your own bias, and it is okay to be vulnerable. And as Alli and I have been meeting to present this, it's led me to correctly question my own curiosity about why things are the way they are. Feeling from joy to anger well come up, and how encourage that to come from all the as we explore this incorporate any questions accurate the end which we will hear be happy to answer.

So objective 1, I will turn it over to Alli from here.

>> Okay. Hey, everybody. My computer is finally working. I apologize for that delay. My name is Alli. I'm really glad to be here with you. So Peter and I have spent a lot of time thinking about how we wanted to reason design this workshop so that we could build on ideas that exist and also build our awareness. So we hope that in the time that we spent together today the first point that we are going to start is with terminology. When we are working with LGBTQIA patients, we need an understanding of terminology that relates to this population in particular.

So the terminology regarding LGBTQIA people is ever-changing. It's different than it was 10 years ago, 20 years ago, 30 years ago. But present day, what we refer to as the LGBTQIA folks, lesbian, gay, bisexual, transgender, queer, intersex, and asexual people. It's also important to know that sometimes these letters stand for different words. Sometimes you can't stand for questioning, -- and the T sometimes used to transsexual, but this term is not going to be used very longer. So I encourage you not to use that. More important, what we are talking about our gender and sexual minorities.

So look at Dr. Roper, we are going to build on what she presented a couple of weeks ago. And the terms that she presented in her workshop started with queer. So it's important to deal that here is an unreal term for someone gender queer refers to people have a fluid identity. They may or may not identify as male or female, masculine or feminine. Maybe a combination of both.

Pansexual people are attracted to people without regard to biological sex, gender or gender identity. Demisexual, little or no sexual attraction until a strong romantic attraction is formed.

And then asexual people tend to lack such attraction to others and may not be sexually active, but they may engage in sexual activity.

So it's important to understand what we mean by sex, gender, and sexual orientation. Generally, sex refers to the physical body. Generally speaking, -- that there are two sexes. Male and female. We are actually going to look at that today. So sexuality refers to one's hormones and genitalia.

And we will talk more about what intersex means.

When we talk about gender, we are talking about gender identity. How someone sees themselves, some of whom identify as a man, as a woman, as both are sometimes neither. And gender expression is how one presents to the world. So how they talk, their dress and interacting with people. And cisgender means that someone identifies with the sex they were assigned at birth. So when we use the term cisgender, an example of this would be if someone was born and then when signed the male sex at birth, they identify as a man.

The term sexual orientation refers to who you're attracted to. And some examples are heterosexual, homosexual, bisexual and queer. And we will see definitions of these in future slides. It's important to know that sexual identity is informed by who you're attracted to, but is not usually informed by. What I mean by that is that someone can engage in same-sex sexual behavior, but not identify as homosexual or queer. This is associated with

homophobia, as was pressures from society to will talk more about that in future slides.

So more terminology to be familiar with when working with LGBTQIA patients is the idea of gender roles. Historically, LGBTQ folks had societally held expectations on how a person should act it's how society thinks a person should act, speak, and dress. And this can be expected to act in society. And what their place is. So in the 1950s, girls were expected to wear a dress. And LGBTQIA folks really do push up against defining gender.

The term closeted is used to describe someone who is LGBTQIA but who does not openly disclose their gender identity or sexual orientation. It's important to know that this is a really personal decision. Whether good or bad, it is very personal. And coming out of the closet, if you will, is a lifelong process. And it really depends on what stage someone is at, at any given time, whether they are coming out or choose to stay closeted. Uncertainly, LGBTQIA people have to choose based on their safety as to whether they will be out or not.

And of course the idea of outing is disclosing someone's sexual orientation or gender identity without their consent. And this can actually be very dangerous for somebody. So I want you to note, that if you are public disclosing somebody's sexual or take orientation identity, you don't talk about a patient or working with your colleagues, that you want to -- with the person you are working with. Because coming out is very vulnerable. It can be dangerous. It can also be really liberating and help people connect to the sense of their identity and who they are.

With sexual orientation, there are a whole bunch of sexual orientations that people can identify with. Lesbian generally refers to a woman who is sexually attracted to other women. They lesbian can be cisgender or transgender. The term gay, emotionally refers to a man who is a homosexual, meaning that he is sexually attracted to other men. But it is

important to know that the term gay can also be identified with homosexual -- that's just a term can be used in various ways.

The term queer is an umbrella term. It is important to know that this trend can also be pejorative or a slur. Particularly in the older LGBTQIA people. We have to understand history of LGBTQIA folks. Just like the term gay was used as a put down, the term queer also used to be thrown around quite a bit. It's important to know that these terms are deeply personal and that it's important that we refer to people we work with based on how they identify. In the terminology they want to use.

It's important to know that the term queer is more likely used among younger populations and -- this is indicating the LGBTQIA community. But there -- I too am from the South and this term is likely used and basically is just a gender inclusive you all, so I say y'all here but when you are referring to people, as a group of people, commonly we use terms as such as you guys. And that really does erase a lot of times other identities in the room. So a term that we can use to make sure that we are creating space for everyone there.

So going back to sexual orientation, the term bisexual refers to people who are generally attracted to both men and women. And asexual people experience little to no sexual attraction to others.

When talking about transgender people, it's important to know that transgender is or trans is in a relative term trans refers to people who do not identify with the sex that they were assigned at birth. So it's important to know that some transgender people will seek medical intervention to become the gender they identify with but not all do. So it's not appropriate to ask people where they are. There is no one surgery. But to ask people that highly identify and ask how we can support them as allies and as care providers.

It's also important to note that transgender individuals can sometimes identify as the opposite sex that they were born as, but they can also identify some of the spectrum between sexes, between genders. In

common terms that refer to this are non-binary, gender nonconforming, and gender expansive. So non-binary people generally don't identify as a man or a woman specifically. Gender nonconforming people have gender expressions that really don't align with socially constructed rules as to how they should present themselves to society. So they may experience presentation or behavior that is out to be the opposite sex and they were assigned. And gender expansive people have a more flexible range as to how they identify and how they express themselves.

And now the term two spirited. I think it's important to spend a little bit of time with this. So the term two spirited actual came around in the 1990s. Two spirited people have been living on this planet for much, much longer than that. But the term was created because unfortunately, -- genocide in the United States I really did erase a lot of the Native American culture. And importantly, that means a lot of their language was lost as well. There are some that still have terms in their own indigenous language is to talk about two spirited people. Some don't. So this term is actually really useful, basically for creating space and recognizing people that have both a masculine and feminist spirit. It's also important to have that historically two spirited people within some Native American tribes were singing with reverence and could sometimes be seen as a religious leader, healer, or a shaman or as a strong warrior.

And finally, the term intersexed. You see I have the ED crossed out. And it's important to know that there's a lot of biological variation among humans. So again, there is a society --supposition that there only two sexes, but there is actually third naturally occurring sex, and this third sexes are equally distributed across the great globe. On the matter where you go, one in every 2000 or one in every 1500 babies are born with genital ambiguity. And that would lead a doctor, if the doctor was to assign it intersex -- it important to know that if you allow children to grow, if you them to go past the age of 5 years old, we can see that there are more variations than they -- were assigned at birth. So there's a growing -- at the

terms at the bottom of the page something you want to check out there. But research tells us is that 1-2 in 100 people can't be considered intersex because of the hormonal variations that affect the physical body after the age of 5. But there is this real push among medical communities as well as intersex individuals to not intervene to assign sex to an intersex baby when it is born. Unfortunately, there has been a lot of harm caused to intersex people where surgery was done when they were infants to assign a sex to them that unfortunately they did not identify with when they grew up. So gender identity did not match the sex they were assigned. So in order to avoid this kind of harm, it is advised to determine medical intervention till that intersex person is old enough to make the choice for themselves. And there are some terms to avoid. The term disorders and differences of sex of element were generally is widely, but intersex people don't like to use the term because they are really asking -- it's not a disorder, it's a naturally occurring phenomenon.

And do not use the current term hermaphrodite because it is rooted in mythology.

So we covered a lot of terminology very quickly. These are some useful tools. What terms are there and what are they mean? So this is the gender unicorn. You see here that it's listed on the website. It's really easy to pull up a PDF but if you don't like unicorns, that's okay pick there is also a ginger bread person you can reference. And that ginger bread person was saved as a PDF.

So as polling question number 2, we want to understand only your professional situation, but also how you identify. So imparting some sensing that can take over.

>> So we are launching your polling questions peripheral for just a minute there. So you should see that polling question pop up on your screen, asking how you identify. You will see five answer options there. And we will give you just about 10 more seconds to answer. We have some awesome questions that came into the questions box. Please feel free to

keep sending in your questions. Later on toward the end of this webinar, we will do a live Q&A with our presenters and we will answer the questions you have sent him, in the order in which they have been received. I will give you about five more seconds to answer this polling question.

Perfect. Thank you so much, everyone. We are going to close the poll and shared the results. And I will turn this back over to Alli.

>> Great period thank you for completing this. We can see that about 20% of us identify as lesbian, gay, or bisexual. We don't have any transgender folks here today. 2% identify as two spirit and 2% as intersex as well, and 76% is other. Now, I really wish there were others we could have included, but unfortunately we were not able to but this really shows that we are a diverse group of people attending this webinar today. I think that's important to note that we as providers are a diverse group, as well as the people that we work with.

So we are going to move on. Unfortunately, this is a little slow.

Now, we will speak to the population that we are serving. And is a point that we know the rates of substance use among these populations so we can start to meet their needs. What we'll see is that substance use for LGBT people is higher than in the general population and unfortunately, due to the limited data, and the information I can find on substance use among these people. So the first thing we will go over, I actually did a survey among lesbian, gay and bisexual adults. So this material does not specifically speak to transgender, two spirit or intersex. But we can see here is that alcohol use is higher among lesbian, gay and bisexual individuals than the general population. What this also does is bring your attention to the fourth column, the darker blue column on each of this couple of slides to really understand or to see the difference between the rates of substance use among LGBT adults versus the general population. So what will see in addition to -- specifically the rate for alcohol use is actually higher among LGBT adults and the general population. Alcohol is

the most widely used substance among lesbian, gay and transgender in the vigils, but then we will see that the most commonly used illicit drugs among lesbian, gay and bisexual adults are marijuana, psychotherapeutic drugs, hallucinogens, cocaine, inhalants, methamphetamines, and then heroin.

Looking at opioid misuse among LGB adults that a general population.

Marijuana use is also higher, quite a bit higher, actually.

Cocaine use is also higher among lesbian, gay and bisexual adults.

Misuse of prescription stimulants is also higher. You can see that the statistics go for long it younger lesbian, gay and bisexual people as well as adults 26 or older.

The percentage of hallucinogen use, specifically LSD is higher in the general population. And if I were to look at data on substance use among transgender people.

So what this says is binge drinking is, as well as drug use. So you can look at the first set of columns and the last set of columns. And what will see here is the use of illicit substances as well as binge drinking is much higher among transgender people in the United States than the general population. And the National Center for Transgender Equality, shows 27,000, transgender people in the United States in 2015. So that's where this data comes from.

And what you can see by the darker blue column is that transgender people who work actually have much higher rates of substance use that even transgender people who are gainfully employed. We are talking about the -- economy and what they are referring to is engaging in sex work as well as selling drugs and other illegal activities for pay. And -- is because a lot transgender people the discrimination -- and they are forced to engage in underground activities to survive. So selling of sex or drugs in order to be able to support themselves economically in this country.

So when we talk about substances, it's also important that we recognize tobacco use among those lesbian, gay, bisexual and transgender folks. I

wish I could speak to the IA, but the research is this. Shows that LGBTQ people do use tobacco both smoking tobacco as well as e-cigarettes at rates greater than the general population. And what is very important to note is that there is a lot of marketing towards LGBTQ people specifically. So you'll see at the top of the slide here, that says when someone yells, dude, that's okay, we'll be there. It was speaking to the hurt that these people deal with, the homophobia that they experience and so we got your back will be your friend. We'll be your ally.

So what's important for us to recognize as providers who provide care to LGBTQIA people, it's important that we approach them as allies.

Unfortunately, there is no information available about substance use among intersex people.

So here, we want to understand a bit of the terminology and want to look at the rates of substance use. Impact factors can continue to substance use by LGBTQIA populations in the United States.

Before we dive into it, it's important that we understand the -isms and phobias. Basically these are pervasive oppressive forces that -- many people, regardless of identity. have experienced. And talking specifically about LGBTQIA people, it's important that we understand -isms and phobias that they experience. And these are things such as heterosexism, homophobia, and transphobia.

What heterosexism is, is basically discrimination or prejudice against homosexuals on the assumption that heterosexuality is the normal sexual orientation. And so their systems of bias, that really favor people who are heterosexual and have access to services or there can be things like bigotry and acted or the culture, if you will, that LGBTQIA people experience.

Homophobia is the dislike or prejudice against homosexual people. And transphobia is dislike or prejudice against transgender or gender diverse people.

So it's important that we understand the factors of LGBTQIA substance use, so that way we can provide support that is tailored to LGBTQIA people that we serve. And I think it's important to look at factors under the concept of minority stress. Essentially what minority stress is, is high levels of stress experienced by stigmatized people. When we break down minority stress into three factors so there is an active stigma, which are the actual experiences of discrimination or rejection that people experience. Social stigma, is just the awareness of prejudice. And internalized stigma are the feelings of shame or self evaluation that a person can adopt based on experiences with social stigma and enacted stigma. That something like internalized homophobia or transphobia. What we find in research is that chronic stress and adversity are absolutely linked to addiction. Our research and experiences that would constantly work with substance that they have experienced. And these show that LGBTQIA victimization and verbal and physical violence are actually correlated with substance use, school suicidal ideation and suicide attempts. What is important to reckon eyes as we as providers can provide that support and substance use treatment may mediate the risk for suicide among LGBTQIA people. In regards to transgender people, the research has shown that increase substance use is linked to stress, particularly in regards to sexual orientation, so this could be if a transgender woman identifies as gay or lesbian, for example. The tendency to use substances among transmittal is related gender dysphoria. There is discover between the -- how they identify their source that tension between -- and the sexual gender itself. Has also correlated with -- outside of and affirms gender. So what that would mean is that if a transgender person wants to pursue treatment for gender affirmation, the sooner they can get that treatment, the better. So if we look into stigma, and the way we can think about this is with experiences of discrimination. And there is research that was recently done by NPR, the Robert Johnson Organization and Harvard --

information about their expenses. But the survey found was that 22% of LGBTQ people report discrimination in pay as well as discrimination at work. 22% of LGBTQ people experience discrimination and when trying to find housing. 20% of LGBTQ people experienced discrimination when applying for jobs. 20% when experiencing higher education. 16% of LGBTQIA people experience discrimination when interacting with the police. 16% experience discrimination when seeking health care. And 10% experience discrimination when trying to vote or participate in politics. So given this point of time we are right now in the American political system with Vote Up, it's important to know that our clients may express disconnection and may need additional support there.

So it's important to look at the specifics. And if we look at experiences of transgender individuals specifically, we will see that they experience more discrimination generally speaking than lesbian, gay, bisexual people. So you can see that transgender people experience more discrimination when trying to find housing with 35% of transgender people experiencing discrimination. 20% of transgender people report discrimination when trying to seek health care, and 5% experience discrimination when seeking higher education.

That's also important that we look at the experiences of discrimination along with diverse populations. The LGBTQIA community is a diverse one. So when we look at experiences with discrimination, we see that LGBTQ people of color experience discrimination at greater rates than white LGBTQ people. LGBTQ people of color, when applying for jobs, it experience this more.

There are experiences reported by LGBTQIA people -- more than 50% of respondents indicated that they have personally experienced violence against their sexual orientation or gender identity. And we see that in being called names as well as comments.

15% of LGBTQ Americans report that people have acted sometimes as if they are afraid of them because of their LGBTQIA identity.

Was also important to know is that within LGBTQIA populations, based on race, people have experienced discrimination differently. This data behind this particular study shows that LGBTQ people actually experience racism within LGBT spaces. So this is looking at the experience of sexual minority men of color, but the race is experienced -- and so it's important to know that when working with LGBTQIA people, we are working with varied diverse people and publishing. And how they are situated in society, and it affects the way -- and sometimes this can increase the risk of substance use. But we can see here is that bisexual people experience but can be considered by phobia or sexual exclusion from LGBTQIA communities, which are linked with decreased well-being. They also experience this with any general society as a whole. Sometimes being ridiculed or ostracized, if you will, for not being gay enough or straight enough.

Transgender people have similar experiences as well.

So when looking at substance use, I think about minority stress is, again these are things like discrimination, rejection, or violence by family or society. We can see this with the rates of homelessness. In fact, 40% of homeless youth identify as LGBT. Only about 5% of the US population is LGBT. So that is disproportionate. We also recognize is that teens are come out to their families have negative reactions about half of them. And 1 in 4 are forced to leave their homes. These experiences affected people in personal relationships, but until last month it was absolutely illegal, there were no legal protections for LGBTQ people in about to employment. And we know that discrimination, and unfortunately evidenced with transgender people in the data we just saw, engage in the underground economy for survival.

That's also important that we understand as therapists and clinicians, how these affect people within the LGBTQIA communities. But conversely, most states do not have legislation which protects LGBTQIA people against hate crimes. And eventually what we have is that gender identity hate crimes growth each year. And they are widely underreported.

And we can see in the slide violence against transgender people, specifically within the educational system. And this is evidence by transgender people in that survey being more than 27,000 transgender people in 2015. Indicating that they left school while they were engaged in K-12 education. And this mistreatment was directly or indirectly related to their identity. And 72% of those 27,000 transgender Americans indicated that they dropped out of school because of this.

Look at the statistics, you'll see that mistreatment is definitely happening more often against people of color and they are more likely to drop out of school. In particular, you will see those rates of mistreatment specifically among LGBT -- Native American transgender people, it's most common against Middle Eastern transgender people and transgender people in the United States. And partly, this mistreatment in education continues in higher education as well. And we see the verbal, physical and sexual harassment reported by transgender people whether in college or vocational schools. You can see that survey responses reported this type of abuse and it was highest among people of color, specifically American Indians followed by black transgender people.

So it's also important that we talk about and have an understanding of the intimate partner violence. Unfortunately, the less we have been talking about whether enacted in the systems or the family that one was born into or adopted into, that also sometimes carries on into romantic relationships. What we can see is that the lifetime prevalence of rape, physical violence, and/or stalking by an intimate partner is highest among bisexual women, and highest among bisexual men as well. Specifically among transgender people, 27% of transgender people in the United States report being sexually assaulted in their lifetime. 13% of lesbian women and close to 17% of heterosexual women, and sexual violence other than rape has been highly reported among bisexual men as well with 47% bisexual men having this experience as compared to 21% of heterosexual men.

So all these experiences are correlated with substance use. When we see that with research of the general population, experiences with violence among the general population, in the LGBTQIA populations, what experiences have your clients reported that may have contributed to their substance use?

>> Thank you, Alli. Everyone will see this polling question pop up on your screen here. It looks like a lot of you already got it. Thank you for that. Just to repeat that, as Alli mentioned, this question is asking in your work with LGBTQIA clients, what experiences have they reported that may have contributed to their substance use? You will see 5 answer options there. As another reminder, great questions you have all sent us into the questions box of your GoToWebinar Control Panel. Please continue to send in questions. Any questions that we do not get to during our live Q&A later on in the webinar, we will make sure to document those questions. Send to the presenters so you can get answers on a Q&A document and post them on our website at a later date.

We will give you about 5 more seconds to answer this current poll that you see on your screen. Terrific work. Thank you also much. We are going to close this poll and show the results. I will turn this back over to your presenter.

>> Thank you also much for engaging with our webinar today in answering these questions. We really do appreciate it. So what you indicated was that 29% of you have clients who report physical and/or verbal violence. 51% have reported exposure from family or social networks. 2% have reported underemployment, 6% housing problems, and 12% of you haven't known that you have worked with an LGBTQIA person. And I really do appreciate your sharing this. It really indicates that we have to be able to have open conversations and be able to address the things that come up in our clinical work. But also the fact that we have to ask if people identify as LGBTQIA people. That we would normally address these things and identify problems.

So it's important that we are working with LGBTQIA people that we not just see them at risk, but we see them as resilient. It is important that we rely on strengths and people that we work with as well as the resilience. And there is resilience in their individual dockets was the community. It is so important that we be able to support that.

-- More uniquely positioned to help support the resilience of LGBTQIA people. In fact, LGBTQIA people are more likely to seek care than the general population. Of course you may still see them -- they are not a huge swath of the populace them, but support to reach out for support. We'll support that we understand how someone is uniquely situated in society, and that is seeing that situation has its strengths. And opportunities for support and love and connection and belonging and strength and beauty and abilities and privileges. And that, the course, they'd out of times people that we work with have experienced -- but is also important that we work without hurt and we were to reframe some of that sometimes. Where we can embrace the idea of positive -- most of his stigmatized -- aspect of self is associated with a connection to a greater community that is working for social change. So not only is there an ability to have support with community, but ability to do something with that community to improve expense.

And with that, I will turn it over to Peter.

>> Thank you, Alli. I certainly appreciate that. Thank you for sharing all that information. We have talked about the vocabulary, you did a great job, Alli, of talking about the different -- of these individuals. There critical factors that contribute to substance abuse in those populations. It's amazing how the LGBTQIA populations use substances across the board, no matter what substance it is, then the general population. And all the trauma that goes with that. I wanted to speak a little bit about objective 3, which is identifying the current laws and practice of care that bring a risk or provide support to the LGBTQIA patients in treatment. It is very interesting, as we have been working on this over the past month or two,

the laws have already changed. So we had to go back and rearrange some of the slides. But I will get to that in a moment.

I wanted to first kind of bring this together into a picture. Life, liberty, and the pursuit of happiness. That is actually in the Declaration of Independence, as most of you know, of the United States of America. This idea that we can have life, we can be free, and we can pursue happiness. I think we might all be able to agree that is not always equal among all of us. If you look at these three pictures, the first one on the top left, are two people that apparently are married or getting married. I thought about that, thinking I wonder if I saw these two people holding hands and kissing walking on the street. And I thought about that in the town that I grew up, and the town that I currently live in versus Paris, France or San Francisco. What thoughts might come to people's minds as they are walking down the street holding hands?

Then we look to the picture on the bottom left. If we use this and identify as a healthy marriage would people be irate over this or would they say people apparently love each other, others physical touch, they are smiling, people can say that's very beautiful pair people might look at that and think it's not. What is this idea of a healthy marriage and why do people consider this differently among us in the US and the world?

And the picture on the right, is this a family unit? Is it two dads that are not related at all and one has two children and one has two children? Is this a couple with four kids? Are they just friends together in the backyard or why does that not come into play? People consider that that's actually a husband and husband with two children and two godsons. And it's also important to understand that gay marriage actually became legal in 2015. So not quite five years ago, my own marriage to my husband was not recognized by the state of Virginia. We got married in 2011. We had to wait four years before the state actually recognized our marriage, which can affect a lot of things. Everything from health insurance to house buying. Who is on the lease? The deed?

So I want to start with us just to kind of get an idea as to the spectrum of what we are working with. It's not binary, it's completely open to anyone, and it's important to really understand where people are and how they view themselves.

Alli spent some time talking about discrimination, and I wanted to bring to your attention some data that I collected. When transgender individuals seek medical help.

40% of the people report being out to all medical providers. 60% were scared to tell the doctor they were transgender. It is shocking to me that people cannot be open to their medical professionals about this, and how can they help them if we don't know who they are. There are certain options to people to work with themselves, and if they can be honest to the doctor, the doctor, that is a shocking discovery to understand that they can't get the help they need and end up with these other traumatic experiences. High suicide rates. We already talk about substance abuse disorders.

20% of these individuals also reported experiencing verbal harassment in a medical setting. And this can be by other patients, by nurses, by doctors. Almost three out of 10 people have experienced some sort of harassment in the medical setting.

19%, about 1 out of 5, have actually reported being refused medical care due to gender identity. Imagine going into your doctor and having to check the male, female, or other box, and because of what you checked, they will not treat you. That has happened to 20% of the people.

And 28% report avoiding care altogether. If you're not listening to me, if you're not talking to me as I identify, then I'm just not going to go altogether. So there is a huge gap with the medical help that's been given and offered to everyone. And the transgender individuals that we are talking about that we have already said need to help from the substance use disorders they might have, but actually getting the help that they need.

So I thought about not posting this and then as I did, I thought if I'm really thinking about not doing this, I probably should do it. But these are some excerpts from five years ago some individuals that have gone on Twitter and other social media and have actually posted issues that it happened with them at their medical professional offices.

One person says I went to the doctor for not hormone or genital related. And the doctor asked about hormones or genitals. The doctor should be listening to what their coming in with, not making assumptions thinking about what they want to do. Not every transgender individual wants hormones or the surgery. It's all in each individual's personal, how they are, how they feel, and what they want to do.

Then it says would you mind calling me Dan? I'm a trans guy actually. And the gynecologist says well a guy is not what I am seeing, miss. I would be running out of their office as quickly as possible. To be degraded like that by your own medical professional. A gentleman says my first endocrinologist repeatedly molested me saying it was okay because he was just checking for growth. That can have lasting consequences on a traumatic scale for individuals. My primary came out barely even knew what trans was. Changed primaries out of concern that lack of familiarity. I will be talking about that in the outpatient side. We will speak about that, but lack of education and understanding. He says, how can you be trans? You're not wearing a dress, no makeup and you need to shave, from a gender therapist. The gender therapist was making these assumptions of someone based on these gender norms of how that could be. I guess this therapist's idea of what trans was different from the individual who was talking about that.

It's amazing how these experiences, and these are just a few of the things that these individuals decided to share. How many people internalize this, shame, guilt, fear, of experiencing I got to get help. I need to get help, but look at the people that I'm with. I'm talking to a counselor. I'm talking to a doctor, to a specialist, and they don't see me or they don't hear me or

even care to know that their biases and assumptions really cause me harm.

I want to briefly talk about the federal law issues were transgender and health care. This is one that I was showing a law that allowed for transgender individuals some access to there was a change on July 10th this year to section 1557 of the patient protection and Affordable Care Act, which actually narrows the legal definition of sex discrimination to not include protections for transgender people. The wording of it became very open ended. So that the transgender individuals no longer received the same rights for sex discrimination as other individuals. So they still have ethnicity in there and have race and have sex, but not necessarily the sexual discrimination that applies to transgender individuals.

And I was thinking but the homelessness rates that Alli was talking about, the 40% of youth that is LGBTQIA, and there are some laws that are coming through right now, a lot of them are in the House and the Senate to be voted on, and it one of them is talking about homeless shelters. And based on homeless shelters and women's shelters, the majority of them do separate based on this binary concept, which can be understandable. However, for transgender individuals, this is another one of those nightmares. Such as which bathroom do I go to? Because if someone imagined a person assigned male sex at birth that identifies as a transgender female peer wants to go to the female homeless shelter. Does this now depend on their we call it the passibility, how they look? Does their look identify as the cultural norm for what a male should be? Or female? That is an issue because if someone who identifies as female has had certain surgeries and has taken four hormone therapies, they show as a female and they're told to go to the male shelter. Then you are looking at other things like harassment, assault, even rape. For that because of certain laws that are put in automatically putting those transgender people in more harm's way when they are trying to seek help.

So a lot of barriers to treatment. We talked about stigma and discrimination. This idea of gender conformity. This idea of okay, something that someone has either got to be male or female. When one plays with a truck, that should be a boy toy and what they play with a doll, that should be a girl toy. I have twins that have just turned 7 actually, and we work with them on that all the time. About what constitutes male and female. The concepts that are taught to these children in school and society happen at a very early age, including blue and pink and what that represents. Why not the other way around? Why can't boys love pink and girls love blue? Why can't girls play sports and got boys garden or do anything that might be perceived as that.

If the idea we go back to about curiosity and understanding your own implicit biases because that does play a factor in discrimination. If someone comes to you and identifies as a female but looks male, it can challenge her implicit biases and struggle to see them and see them as who they are. There is a lack of provider training and education on this. Which is one of the reasons why this cultural humility is so needed across the globe. Because people don't understand. Some people don't understand they are biased to this and based on religious concepts or whatever someone chooses, maybe it's a I just don't know how to treat them. And I think there are probably people out there that just want to learn how to help these people that need his help.

Health care and access barriers. I will talk a lot about the residence treatment centers that I have visited have male and female bathrooms. Some don't have their own bathrooms. You had to share. So a lot of these grocery stores and other places have family bathrooms now are unisex or having to choose and having to figure out that black and white and there's a lot of gray in between, it's hard for people.

And of course assault and being in isolation. People that are afraid when they do speak out or – they're assaulted, beaten, they are abused. Which can lead to a lot of isolation. And it's kind I hate myself I must be dead

because everyone else is saying that I'm bad. Even when they don't, this fear of isolation, your family will accept you. And your employer doesn't accept you. And the government doesn't accept you. It's a very, very hard thing for people who are transgender and the LGBTQIA for that matter, to deal with.

I do want to focus on this idea of misgender. This is not cisgendering, or someone who is identifying as the same sex as they were assigned at birth. They identify and see themselves as who they were when they were assigned sex at birth.

Misgendering is using the pronoun that does not correctly reflect the gender with which one identifies. In our slides that Sampson put together for us, it does have our pronouns that we prefer to use. I prefer the he him his pronouns. That's how I get identify progress I want people to address me. So when people talk about me, good or bad I guess, it should be the used that way. If someone says Peter is there, she doesn't like to do this, that is misgendering.

There is a big issue with misgendering among the transgender population. As Alli was talking about, there are so many different ways of expressing yourself. Just because someone's identity is on the inside then the gender especially on the outside can be very different. There are some non-binary individuals who prefer to call themselves gay. Then there is a Z and not have ways of being addressed. A non-binary individual doesn't have a concept of male or female. So one day they might feel like expressing themselves as very feminine and another very masculine. When someone is speaking with them, they tend to make assumptions very quickly based on the way they are dressed. If you're just like a man I will call you he. If you're dressed as a female, I will call you she. It's important to know that using the wrong pronoun does cause a lot of anger, is out of fear and someone.

It makes them think that you are not looking at them and addressing them as they want to be addressed. Using the right pronouns is a simple way of

letting them know I see you. I understand who you are. And I treat you with respect.

Dead naming is another phrase. You might not know as well as misgendering. It's someone's use of the birth or other former name, a name no longer used, the non-binary person without their consent. There are individuals born, assigned sex female at birth, and the family names that person Christine. And later on in life, Christine identifies as a transgender male, and either goes through hormonal therapy or not. Let's just say that Christine prefers to be called Chris, Christopher, and transitions completely to what they identify as their male concept. Start wearing jeans and T-shirts and just lives their life as Christopher. And Christopher gets in a relationship and goes back to his family and they will not use Christopher. They refer to this Christopher as Christine. And refer to use the other name. That is dead naming. It's a complete refusal to identify that this person no longer wishes to be held to that concept of that former name. It's another way of saying I don't agree with what you're doing. I don't see you as that and I will refuse to do it.

And this all leads into a lack of support and rapport for people. There's a lot of mistrusting as we have seen in the health care settings for people. It makes them very anxious and odd nets which can lead to avoidance. It can lead to using more substances. There are a lot of problems that can arise.

This is the education that has come through. A lot of places are getting much better. I call in a lot of facilities to know to ask about bed placement and ask about how they do this.

One of the laws I was exciting to find and did not is the idea that in hospital settings they do not have to place people based on sex. Men have been placed with women, women don't have to be placed with women. Some of that some nursing homes have experimented with this concept of just admitting people and having them, regardless of how they identify or their sex assigned at birth, most of your treatment settings are

there is no law regarding bed placement and substance abuse disorder facilities. This is only for the ones that are co-ed. here are some facilities out there that are women only or men only. This goes from residential treatment solve settings to outpatient therapy. There is all kind of treatment across the continuum of care. Before the onset actually have beds for have to say, the majority of them are based on male/female assignments.

There are three common issues I want to bring to people's minds for residential treatment. The biggest issue, of course, is once someone is in a program, or the goal is no use at all, to become clean from everything and leave treatment without using any kind of mind altering chemical, and then there is the methadone treatment where you can go to outpatient and they are using some sort of medicated assistive treatment.

Drugs can be brought in. This is because of fear people might try to sneak it in because they don't want to go through withdrawal. Some people go in on drugs because they don't want to get clean. Therefore student treat by family or jail and bring drugs with them. Usually they are trying to share it. Sex is the number two thing. People that are using substances when they no longer have the substances, it's usually a quick fix. If the thing is I don't know how to deal with myself or how do I do identify or have people identify on the outside. It is a problem for people when they actually have to feel their emotions. Sex is one of the second-best ways of releasing those endorphins, and getting that immediate pleasure.

The thought is if we put men and women in a room together, they will have sex. But what about gay men? What about lesbians? What about bisexuals? What about transgender individuals? This concept is binary and does not accurately split apart the populations that we serve in treatment.

So this concept is a big problem for the transgender individuals when they may identify a something, but look like something else or their perceived

notions of society, how they identify, it really creates a problem similar to the bathroom issue. Do I get yelled at or beat up? Which one do I choose? The third issue is they can require a higher setting, which includes psychic and diagnosis problems. The residential setting I work in is a 3.7 level, which is where there are no meals, but it's able to dispense medication. So some of them have gender assigned bathrooms, some people have bathrooms that are community bathrooms. The facility I work in actually has a bathroom for every room, but even then, depending on who is there, it can cause issues.

I wanted to talk quickly about two case studies. Case study 1, about 6 years ago, I experienced this, and case study 2, which came from last year. I do want to tell you that there will be a question after this based on your experience and what you find.

Case study 1, this individual was admitted to the facility I work in. At that time, there was no intake questionnaire that asked them anything other than male or female. So this individual was placed in a male room, based on what was told to us at admission, and early in treatment this individual started to hang out with people and get more active and sociable and get involved in groups. And one day this individual decided to show more of himself, express her gender more. This person identified as transgender and came out one day wearing a skirt and red heels.

There was a lot of mixed reviews. Everything from staff, there were some negative words that came from staff. I can guess as to what their feelings were. And for some of their patients. There was a lot of laughter and ridicule. A lot of what the hell are you doing. A lot of those things that happened.

This individual immediately crawled back into their shell. The treatment facility I worked in was not a -- anyone could leave. And this individual left the next day. Ran out the door. And I to this day do not know where this person is or this individual or have been given a chance have any

conversation. But it really brought this idea to me in our facility of what are we doing? Why are we not educating staff? Why are we not preparing for this? Where the policies and procedures in place to protect these individuals that we know need help?

So I will quickly go on to study number 2. This was a case that ended up very, very good. I got a phone call from a friend who works at an all-female facility, local people. She said Peter I have a problem. I have a man in front of me who was discharged from the hospital. The hospital placed the sex assigned a birth as female. This individual identifies as a male. And when discharged, went to this female place, and my friend said Peter, I can't admit them. This is a struggle.

We did not accept this man's insurance at the time. We had a CEO who was extremely understanding and wanting to help people. And she said, you know what? We are just going to offer this man a free bed. He's already had a bad ride. Let's make this happen.

At intake, we asked what is his preferred pronouns, how does he identify, and then we have the discussion, which is where do you feel most comfortable. We want to please you or you feel most comfortable, but we also want to make sure that you're going to be safe.

Turned out this individual did not mind rooming with whoever, just wanted to feel safe. The clinical team already had policies in place and we identified two individuals that were extremely understanding, and one was a gay man and one was identifying as lesbian. The three of them roomed together. This individual stayed for all treatment, and it's all well that we had some problems with discharge planning because we wanted to make sure that this man was in the place that was going to be very good for continued care and that people understood. So we actually added a fourth week of treatment that was scholarship for this individual.

He thanked us tremendously. The patients and staff were brought around this individual to protect and support him, and it was just a great thing for me to see that this happened.

These two studies bring together something that I will talk about shortly. I do want to bring up a polling question, what you consider the biggest improvement in care from Case Study 1 to Case Study 2?

>> Thank you so much, Peter. Everyone, you see that polling question pop up on your screen. If it's good that you think and through appear to have about 15% of the live audience answering this question already. Just a recap, the question is asking what do you consider the biggest improvement in care from Case Study 1 to Case Study 2? You will see for answer options there. As another reminder we will have Q&A during this live webinar and will answer all of the questions you have sent in the order in which they have been received.

If you have more questions please feel free to send them to the questions box. If we don't have time and we don't get to them, we will have your question as a Q&A document period will send them to the presenters and work with them over the next couple of weeks to get questions documented on a Q&A document and posted on our website. About 5 more seconds to answer this poll.

Perfect. Thanks so much. We will close this poll ensure the results. And I will turn this back over to your presenters.

>> Thank you, Samson. It looks like asking a friend about their gender identity to be involved is 47%. Right after that is the education of staff. A few people, 9% think the bed assignment preference and 3% chose discharge planning from admission. I am happy to see all four did receive a vote. Because there are a lot of factors that go into this.

As we move from the case studies, I want to talk shortly about best practices to improve the policies promoting safe and healthy environments for the LGBTQIA patient care. I will be talking briefly on the residential setting so the cases I just talked about and some of the best things we can do. And Alli will take over from there. It will be dedicated because it should be universal. So how do you identify which pronouns you prefer? It says I understand, I am with you, but I need to know how you want to be treated.

How you want to be identified. Because that does allow us to show them that I'm here for you. I understand your language. I just want to know I treat you with respect that I want to know who you are.

We identify how we want to be called on a name badge, because every patient that is at the facility that I represent does have to have a name badge in order to get medications. We will call them by leaning they will want to be called.

We also have safes on stickers. Safe zones that have -- as you're entering this facility, this counseling office, I want you to know that I am an ally for you. And this is a place where you can be safe and be yourself.

Residential settings, bed assignment are important. At least three facilities where I work have the same policy in place that we have created. We do prepare by identifying others that could be comfortable roommates, depending on their how they identify, who they are comfortable rooming with, and knowing the laws of different states. Certain states can have different laws. But we don't have to adhere to this that assignment if it is going to help the client be safe and it doesn't affect other people's treatment expectations, we want to be as open-ended and help everyone that we can.

Individual treatment. Understanding what gender groups are, certain facilities have male/female gender groups. Making sure that that individual's place in the gender group that they would like to be, the one they identify in. Counselor assignments are important. Some counselors specialize in certain things. Foregoing personality disorders, so certain counselors have certain specialties. And assigning one that understands concept such as LGBTQIA individuals having worked with them understanding them, can really help provide a good experience for them. Having the appropriate pronouns in your notes is vitally important. Because all persons have access to the notes on their charts, and they see if they are being misty ended on the chart, it's not going to be good for them. They will go back into their shell.

Substance abuse disorder treatment is about sexual identity. That is not have to be the forefront of the treatment. This person is coming to treatment for their substance use disorder. So having their sexual identity, their sexual especially forefront of edit everything is not appropriate. Their sexual identity is in the context of the subject use disorder treatment they are receiving. As a part of the picture, not the whole picture.

And rapport, rapport, rapport. Be their cheerleader or confidant. Let's move on and figure out how we can get to the goals and how to meet the goals that you identify with.

Follow-up care is another important concept. The resident the treatment that we have, sometimes need to be stepped up to a higher level of care or stepped down to a lower level where there is partial hospitalization. Individual counseling, so making sure that we have built the systems in place as business director, those other places that know how to treat these individuals and will treat you with respect. They trust us when we have a good discharge planning place that follows that care such as single transition, that allows them to be who they are and continue to be who they are and grow.

Staff education is another important concept. Detail, misgendering, and the consequences.

(Technical difficulties.)

However in the visuals defined -- how are we -- are we treating these people effectively. Diversification of staff. This is important with the facility I work on, we have the LGBT covered. I'm not exactly sure about intersex, but I do look at my own expansive -- we have a diversified staff. So we did have a transgender female under treatment and we actually provided a group format or multiple people were involved in this person's treatment, not just a counselor. They had in an admissions team that identified as diverse individuals. A lot of people came together, so diversification of staff can build a lot of rapport and they can ask questions and understand.

And then clarifying diverse groups. Your small process groups, they are going to be smaller and have a lot of emotions and things coming out and individual counseling, understand what's appropriate to share in these groups and what is probably best to should be shared individually. Maybe the individual is not ready to come out in a small group. And that's okay. So understanding these concepts before they can speak and can't speak will help them feel comfortable.

So now I will turn it back over to Alli.

>> Great. Peter, thank you so much for your discussion of the best practices.

So all of this begs the question, how do we do this? And I think they really good place to start is assessing your institutional culture. So there a specific question that we can ask about our institution so we can begin to adapt these best practices. So one, we need to ask how is our institution experienced by LGBTQIA people? Have we asked? If we haven't, we need to. Does our institution have an explicit mission with objectives on serving LGBTQIA people? Are our physical spaces as well as the distributed information and materials affirming to LGBTQIA people and represent diversity within LGBTQIA communities? Are LGBTQIA people at each table a part of all conversations and decisions about LGBTQIA patient care?

Does our institution take a public and internal stance on national incidents that are relevant to the lives of LGBTQIA people?

So in addition to examining our institutional culture, that's also important that we provide resources to empower clients. Again, we need to assess this. So here are some questions we can ask.

Do we have resources to address social determinants such as violence and trauma, housing, employment, transportation, and food insecurity?

Do we have a process and mechanism to address homophobia entrance phobia in-house and to help patients address LGBTQIA oppressions and traumas they have experience in general. Do we provide services in

diverse language is? Because of course, LGBTQIA communities are very diverse.

Do we have a process and mechanism to address the intersectional identities and experiences of our clients regarding gender, race, sexual orientation, specifically.

And do we provide or have culturally affirming referrals for mental health and substance use disorder services?

And are our staff members trained to respond to and to address oppression in the context of client care? That historically as well as the treatment.

So it's also important that we support resilience and strength in our clients.

So generally we can pick up that is individual resilience. We can think of resilience as facilitated by coping strategies. But we can also think of resilience through the support of communities, and institutions. And it's a form to supply part of action, is also vitally important that we address the same needs among employees and our staff. So we can start by first seeing our clients as at risk or can we see them as promise. Can we commit to ongoing individual education of ourselves and strive to address the unique needs and strengths of our diverse client and staff populations? Can make institutional changes via ongoing staff education as far as affirming and responsive policies and protocols and establish the transparent and supportive positions to promote the LGBTQIA people in treatment as clients or staff?

All these suggestions come specifically from -- so I absolutely suggest that you check it out. It's the national LGBTQIA health education center. And information about their resources is in our reference list.

So in addition to asking these questions to assess where we stand in our institutional best practices, we have some concrete do's and don'ts.

Ask patients about their pronouns. And use their self identified pronounce.

Ask about sexual orientation and gender identity. Create a safe and welcoming environment. And you can do this with a number of end

interventions. You can post now discrimination policies invisible places. You can educate yourselves about LGBTQIA issues and this is something that needs to be ongoing. We need to educate ourselves again and again. We want a culture of humility rather than a culture of competence. Maybe I wear an ask my pronoun button. This tells us that you are a safe person to talk with and that is okay to address issues of gender and sexual orientation.

It's important to allow transgender and gender nonconforming people to use the bathroom and rooming option of their choice. It's so important to acknowledge that we are all human. And that's totally okay. We are not perfect. But what is important is that we learn from it. And say thank you and not just I'm sorry. Because the person has a lot of courage and they deserve to be recognized for the courage they had just exhibited.

And it's important that we are always allies.

For some reason you have feelings of discomfort while working with LGBTQIA people, it is a port to seek training.

So in supporting resilience, do ask. Here are some questions to ask. What do you love about yourself? What has helped you to going even when times are incredible he hard? How can I best help you as you keep pushing forward?

Along with the do's, we need some don'ts. So don't make a client choose between substance use disorder treatment and hormone therapy. The best outcomes for transgender clients but specific -- who are already on hormone therapy is to enable them to do that.

Don't allow transphobic or homophobic comments from staff, providers, or clients. Make sure that people who work at the facilities are trained. Make sure to follow-up.

Don't make LGBTQIA patients have to educate staff and providers. It's so important that we take responsibility for our ongoing training as professionals as well as the institutions providing care.

Don't assume that sexual orientation, experience, health status, gender identity, or desired medical intervention. Always make sure to ask.

And of course, don't assume trauma or hardship with your client. Always be sure to ask them about their personal experience.

So here are some strategic steps to promote LGBTQIA supportive organizational change. First, make sure to engage with your local LGBTQIA community resources. They are great to be able to learn about and support LGBTQIA communities in our area as well as the needs they have.

Number 2, create LGBTQIA nondiscrimination policies. If you don't have them already.

3, update your intake forms, make sure to ask about sexual orientation and gender identity and the space on the taken forms. And also taking a relationship and history questions, make sure that they are LGBTQIA inclusive and not hetero sexist.

4, make sure to train all clients and staff on affirming LGBTQIA care. Again make sure that this training is ongoing. 5, have leadership engaged and onboard with her efforts. So any intervention that you establish, they are more like it to be sustained and effective if leadership is onboard from the beginning.

6, and sure to assess the gaps as well as your strengths, because you have them, as well as the needs of the organization you're in.

And 7, create a welcoming environment. This can be done by images and treatment centers, promotional materials and on the website. And have a diverse patient population. Make sure that the pictures and your promotional materials are looking like the people we serve. And of course make sure to have LGBTQIA staff.

So with that, we are at the end of the informational part of our presentation. We will end with a big thank you. Thank you so much for coming. We hope today you found encouragement and understanding and

we really hope that you will meet remain open-minded, humble, and dedicated people we hope that we can always count on you to be allies. So as you saw, we had a bunch of references. Here they are. And here are some more. And we have more. And even one more page. I know you can't read all these now, but you can access the information again after today's webinar. We definitely encourage you to do that.

So with this, again thank you, and we will move on to the next part.

>> Alli and Peter, thank you so much for this incredible presentation. So informative and so many questions that we have from our audience.

Everyone, as Alli mentioned, thank you for being here and that references for that four-part slide that you enter, we actually grabbed three of those references that are free public domain, and we saved the PDF files in the handouts tab of your GoToWebinar control panel. So right under where it says questions, you'll see handouts. You can see there now, you can right-click or click on any of those PDFs and save them to your desktop now.

We are actually going to shift now to a live Q&A. I'm going to invite Alli and Peter to turn on their WebCams, and I will be turning mine on as well we would love just to connect with y'all and answer some of the questions that you have coming in. So I wait for Peter and Alli, it looks like we are all here. Thank you guys for staying on for this Q&A. So Peter, the first question specifically to you about your organization. Someone was asking about your facility and the pronouns you were talking about on name badges. Could you clarify, does that facility, do you recommend pronouns on name badges for patients and staff or was that just for staff?

>> That is for both. And I do recommend that everyone -- it allows us if someone is not comfortable using a certain pronoun I have on the badge, seeing how the staff member is doing it even if the intake shows them that yes, I can be who I want to be. And it allows for misty entering not to happen. It's right there on the name badge. You can see it. You can refer to it and also address them by their name.

There are some facilities that require the name because some of your -- have the legal name. And that does need to be on there. But you can also put in quotes right beside it, their preferred name and our staff is trained to call them by leaning they would like.

>> Awesome. Thank you so much. This question is, how do you respond when a client asks you about your own personal identity or gender disclosure or sexual preference disclosure?

>> I'm honest. I believe that visibility really matters. And so when someone asks me, I'm open about how I identify. That is an opportunity to really start breaking down stigma and barriers as well as an opportunity to grow the relationship.

>> For me, it depends on the situation. If I am in a clinical setting, individual session, running a group, I turn it back on them so that I'm not the focus. I don't want to be. This is about their treatment, not about my sexual identity. However, I am an openly gay man with children. I am proud of who I am as a person. So I am not against disclosing that if I think it will help. In the situation.

>> What is the biggest critical factor to consider when trying to create that safe space?

>> I think the biggest critical factor, when someone comes in the room and they don't feel like it's a safe place, I think a visual is the most important thing up front. I can say something all day, but it's all in how I act. So those stickers can be very important as the person is walking the room. They can notice that. As you mentioned, staff having their pronouns on their can be very important. And as Alli and I both mentioned, on any kind of assessment, asking, what is your preferred pronoun? How do you identify. Those things.

>> To add to that, I think it's so important not just to ask about that, but to make sure that the training has the conditions to be able to provide responsive, adequate, compassionate treatment. It's not enough justice

send a signal that you're welcoming, but you have to make sure that you really are creating an inclusive environment.

>> Excellent. Thank you all for these questions. These are some good ones. The next question, and I think this came in different ways from multiple people, why do you think there is so much hostility towards LGBTQIA populations?

>> You want to take that one first, Peter?

>> I can. My thought, goes down to unfamiliarity. If someone is not familiar with something, they are not used to it, they are likely to become afraid of it or flat out deny it. That's why we began this like we did with let's just be curious. We understand our biases, and from that, let's learn something not everyone is like that. The automatic thinking comes into play. And once you have started down that hill thinking, you know what's best, that's where a lot of that hostility can come from. Then you throw in people's ideals and concepts, that's not the way it is, that allows for a lot of anger and hostility.

>> And I really appreciate how you answered that, Peter. I think it speaks to a person's bias and ignorance a lot of times. The one thing I want to say to that, too, is it so possible to change. It's so possible if we educate ourselves, if we continue to challenge ourselves, we can become aware of what our biases are and we can change. So we don't have to take them at face value, they are malleable.

>> Excellent. We are getting some specific ones here. Someone is asking what you would you say would be the best practice for doing it up drug screening observation? We try to let clients of preferences be honored, but there are some regulations.

>> That is a great question. Our facilities, I oversee two, do like to ask their preference. Your dog urine drug screens are important, it does keep the patient honest and the last thing we want our drugs in the facility. We are not as worried upfront about what is on UDS as long as ignores are

going down, but it allows for honesty and transparency as people are going through.

There are a lot of people that misuse drugs that -- having someone monitor that is important. But asking, saying we are going to have to be done, I'm sorry for the inconvenience. And having different members of the staff available at different sexes and different identities does allow for that to be a little easier for them so they can choose who they want to be with.

>> I got nothing to add to that one.

>> The perfect answer, Peter. Thank you.

>> This next question is, is there any research on internalized trans phobia for medically identified transgender individuals?

>> I'm not sure, but we can definitely dig into the research and find out.

>> Great. We will add that on the Q&A document. Another one is what are steps we can take to spread awareness of the issues experienced by the LGBTQIA populations?

>> I think that kind of brings things back to why is there transparency? I really do like Peter's answer. The answer is always it depends on the situation. But I believe in being honest and having conversations. We don't want to put ourselves in an uncomfortable situation sometimes. Another thing that we can do is work with our local LGBTQIA communities to partner with our health care centers as well. We are always educating ourselves, and we are always doing that when we partner with each other and we do it together. So be willing to have conversations that are vulnerable and uncomfortable. Just because it's uncomfortable doesn't mean we did something wrong, we are probably doing something very, very right. But being uncomfortable is a first step.

>> You are exactly right, Alli. I will add in our diversification of staff, we have hired individuals of the various sexual identities and sexual expressions. And I like to hang around them. I like to get to know them. I like to be able to ask appropriate questions when it's appropriate. The only

way for me to learn and grow is to get around other people that aren't just like me. That's one of the reasons why I joined the LGBT softball group. I love sports, but also put me around other people that we have to rely on each other to accomplish a team goal, and we learn from each other. It's an amazing thing to be with these individuals, and not necessarily what they are, but who they are as a person. Get to know them. Because they are people and they have fears and they are wonderful individuals.

Everyone I have met has been.

>> This is great. Another question is asking how do you address issues for an ethical approach towards a transgender person doesn't comply with PREA regulations, special regulations towards adolescents? I believe the regulations are about those programs that are connected to corrections and some of them are just highly regulated community programs or reentry programs. Let me know if you want me to re-ask if that was a long one.

>> Could you ask that again? I'm not familiar with adolescents.

>> How do you address issues where an ethical approach towards a transgender person doesn't comply with PREA regulations, especially regulations towards adolescents?

>> I wish I could speak on that. That's one of those I'm not sure.

>> Okay.

>> The only experience I had with that is when someone is forced to do something. And they have to either by law or regulation, being able to abstain from answering a question can be an option so you're not lying and you're not giving of yourself for that. Adolescents have an added issue on the legal side because of a parent or guardian involvement where there are limitations to HIPAA issues and things of that nature. Then you're looking at the parents' ideals, how do they perceive things? If there's hostility in the parental unit towards the adolescent who is transgender, there is going to be a lot of problems. And education and everything we can do to help out, train staff, train people and help to bring this to the

forefront, which brings us cut idea of cultural ability. It's a good way to do this.

>> The next question is asking, do you have any data or information about gambling, problem gambling, or gambler disorders amongst LGBTQIA populations?

>> I was just doing the headshaking. I don't have any specific data on that one.

>> The facilities do get some calls about gambling, but I know there are a lot of issues there, and a lot of facilities that specialize in gambling. I could ask them. Think that's a question we can get answered, just not today.

>> Okay. I'm going to try to squeeze in two more. These are really important questions. I know we had a lot more coming, so we will move these questions to the Q&A document and in a couple of weeks work with Peter and Alli to get those answered. So two last questions. This one is asking, are many inpatient treatment programs already adjusting their policies for LGBTQIA patients? And have we seen a change in patient satisfaction?

>> Yes, yes, and more yes. I was so happy to hear when I was doing my research, and looking outside of our own policies, which I think are great, I began to be afraid, think and but it's not good enough? But I called a lot of other facilities and people that I know, and a lot of them are here although there is no state relation, the transgender population is out there and does ask help. And an intake that we use is used throughout the country. And they are asked those questions, how do you identify. And it's not just a binary male/female. So a lot of facilities across the nation are taking that into consideration. I can't speak to the -- placement that they have, that's probably tougher than the intake and clinical staff because of the binary concepts that the facilities have taken. Even down to the bathrooms, men and women. If someone could just change that to bathroom. Progress on those things, it's out there. Could it be improved? Absolutely but I'm very

proud that everyone I have talked to has a policy on treating transgender individuals.

>> And it's good that you ended with that, because that's our last question.

So Alli, and Peter mentioned this as well, but Alli, you have mentioned a spike in violence with trans people of color. And specifically, African-American trans population. And so our counselors are asking, what can they do to be better advocates for the trans population and trans people of color and African American trans population that are reporting this increase of violence and the fear that is causing in that community?

>> I think there's a lot to be done. A whole lot to be done. We can start with providing individual support. But also to be able to take a public stance that this isn't right. We are not only talking about homophobia, transphobia, that we are also addressing racism. Which is a long-held will entrenched system of injustice in this country.

So I do believe that it is so important that we work together intersection Ali across initiatives that we support the work of each other, and that we aren't afraid to stand up to say something when we can do something. As will is to create policies in institutions that we work. That we not be afraid to be a bystander and say something when something happens. I should probably say that if it would. It's okay to be afraid and say something anyway. You don't have to feel complete with courageous, and what you say and do doesn't have to be perfect. We can start just by saying something. And that matters.

The small changes have a tendency to build upon each other.

>> Thank you both, Alli and Peter, thank you so much. We can turn our WebCams often I will go ahead and wrap up and give you some critical information you're looking for regarding your CE quiz. So every NAADAC webinar has its own webpage that houses everything you need to know about that particular webinar. Usually immediately following our live event, you will find an online CE quiz link on the exact same website you used to rest for this webinar. That means that everything you need to know will be

privately hosted at the website above. You see our slide here, some really important information, but more importantly, you'll see highlighted in yellow, online CE quiz coming soon. We are working quickly to update our system and make sure that link is active when you go to this webpage. But worst case scenario, it will be active first thing tomorrow morning.

Here is the schedule for upcoming webinars. Please tune in if you can there are some really interesting topics with great presenters just like today.

As you can see, we have two really important webinars next week, August 5 and August 7. You can join James Campbell and Celeste Hutchinson on increasing effective clinical supervision for SUD treatment providers. And on August 7, Cynthia Moreno Tuohy, executive director will join Israel Ali and Julie Shroyer to continue our advocacy series. You can bookmark webpage on the slide, so you can stay up-to-date on the latest in this new series. All 8 trainings are now open for free registration right now, and as you can see, we are really fortunate to also have with us Dr. Pierre Luigi Mancini, Dr. Miguel Geyer, Don Courriers, and I will be honored to wrap up the series with a special presentation on September 9.

Please visit our COVID-19 resources. The website on the slide is here. NAADAC has been able to support supply six seminars presented by leading expert in the field. Currently, NAADAC is offering two specialty online training series the first is clinical supervision in the addiction profession. You can visit the visit at the bottom of the page for more information on this exclusive content. Second series is a diction treatment in military and veteran culture. To learn more about that and excellence of content in the series, you can visit the webpage at the bottom of your screen.

As a NAADAC member, here's a quick review of the benefit the benefits of becoming a member with us. By joining NAADAC, you'll have immediate access to well over 145 CEs which are included as an exclusive NAADAC member benefit. You also be able to register for our annual content the

conference, safely provided to you through a virtual platform. Join us on September 24-26, 2020, to connect and succeed together. Early bird registration is opening soon. Please note that a short survey will pop up at the end. Please take some time to give us feedback and share any notes for the preventers and how we can improve your learning experience. Special thanks again to Alli and Peter for their valuable expertise, leadership, and support in the field. To encourage you all to learn more about how NAADAC helps others. You can stay connected with us on LinkedIn, Facebook and Twitter. If you're interested in learning more about NAADAC's subcommittee on critical issues in the LGBTQIA community, you can email us anytime at naadc@naadc.org, and we do have a dedicated committee on issues in the LGBTQ population. We would love to invite you to those calls into that committee. Everyone, have a great day and thank you for joining.