It's 12:00. We can start. Welcome everyone. By the time we are done with instructions, Erin will be here. Look into advancing -- Advancing Awareness in LGBTQ Care Part IV Affirming Responses for invisibilized LGBTQIA+. Presented by Raven Freeborn and facilitated by me and also Malcolm Horn. I am Jessie O'Brien. One of the facilitators here and I'm the educational coordinator for NAADAC webinars, it's an NAADAC.org/webinars. You can visit there to see the upcoming webinars we see our docket. Closed captioning is provided by CaptionAccess, so please check your most recent confirmation email or the chat box. I will put that in there, but it does is by pretty quickly. We will post it again for closed captioning today. Principle everyone is pretty familiar with Zoom at this point, but I do like to bring your attention to a couple of features that are not in Zoom meeting. The chat boxes, so congratulations. It is there. Feel free to chat it up.

The other is the Q&A box. You can put your questions there and upload questions that you like, and you can see ones that multiple want answered. Very helpful.

In terms of handouts, there is. There is a link to the slides if you want to get a copy of the slides. And also when you go to that link there will be a user friendly instructional guide on how to access the CE quiz and certificate once this is all done. So there is the link.

Just a reminder also, that every NAADAC webinar has its own webpage about that webinar. So you register their peer when this is over, we post the link to the CE quiz so you can go there to get the link for the quiz. There is an instructional guide to help you with the certificate process, and it's always good to follow the instructions because it's a little bit convoluted.

If you need your CE certificate to say live on it, and some of you probably do, just make sure you take your CE quiz in the next 24 hours. That way it will say live on it. When we are done with the Q&A, we do also post if we haven't gotten to all of your questions, they copy of questions and answers for the presenter. But it takes a couple of weeks to get up there because the instructor has to answer them. That's all of my logistics. I'm going to go ahead and bring on Dr. Malcolm Horn. She received her Master’s degree in social work from Walla Walla College. She served as the president of the Montana chapter of the NASW as well as Montana State NAADAC for affiliate. She was most
recently the regional Vice President of NAADAC for the Northwest region. She is certified as a MAC SAP. She currently works at Rimrock, a CARF accredited treatment facility that treats the entire a SAM spectrum, as a director of mental health services. She corn if the continuing education for licensed staff, supervises and coordinate the intricate program, provides educational outreach to the region and conducts adjunctive family and in different docket a visual therapy. She also teaches two courses at Montana State University billings in their credit addition specific program. She recently attained her doctorate degree in psychology. Malcolm, you're on.

>> Thank you, Jesse. Welcome, everyone. I'm so glad to see such a good stuff in the chat box. I'm super proud to be part of NAADAC and they are providing quality education to everyone in our field. Is my pleasure to introduce Raven Freeborn as our teacher today. I'm eager to hear what she has to say. Raven offers healing and hold space as a full spectrum doula, healing justice and liberation strategist, harm reduction is, community educator, and storyteller. She is amazing. She is the founder of Legacy Healing and Therapy Services and Third Way Solutions, two unit community focused businesses offering strategy, coaching, and therapeutic partnerships for individuals, groups, and organizations. Freeborn's mission is to build beloved community that reckons with the truth of historical oppressions to actualize equity justice and liberated solutions for all people, but put the particular people who are black, brown, queer and trans identifying. So it's my pleasure to turn it over to Reagan thank you, Raven for being with us. I will turn it over to you.

>> Thank you, Malcolm, for such a warm welcome and to NAADAC for inviting me to be with you all today. I'm going to press all the magic buttons so you can see my screen. As I was at it is, my name is Raven E. Freeborn. And today I am talking with you all about how we can do some shape shifting in our world and in our field to recognize the unique experiences of the LGBTQIA+ population. So let's start our learning objectives. I do want to spell them out for you, and I want to point out for keynotes. One, that we are going to take time to differentiate between historical, societal, cultural, and personal manifestations of homophobia, which I will call heteronormativity and transphobia and our individual responses to stress and trauma. So we are going to differentiate what those look like.
We’re going to practice modifying our approaches in our clinical studies. And my goal is that you will be able to welcome to the world with an ability to devastate understanding of historical issues that impact mental health in the LGBTQIA+ populations.

I want to share a little bit more about myself. Before we jump into the content to my lived experience informs your learning today. So sharing in the chat, says I have never seen Themme. I identify as a non-binary person. And my pronouns are an intentional decision to express who I am and how I am in language. So this is a form of femme which helps me -- have identified my gender in the context of the gender binary. It's really an intentional decision. And I can be intentional about exposing who I am without hiding or worrying about that someone will misidentify or misunderstand me.

So as you heard, I am a licensed clinical social worker. I may do love your family human justice practitioner, a policy wonk, and student of justice. I am coming to you from in the so-called capital area of the country, District of Columbia, Washington, DC, and I am a Texas born Southerner. I was born in Texas. I love Texas deeply and it's a part of my politics to help you want -- help you understand issues of southern folks especially Southern queer people.

I would love to see what everyone else is coming from, because there are 236 of us gathered in this moment. So as I'm talking, feel free to share you are in the world into you are.

I come from people who are to this very day, navigating personal journeys of dependency and recovery. In my introduction to this field is by way of my pseudo-mom, Cheryl Culberson, in Texas. It was my first real social work job during my career, where I learned how to transcribe the art of clinical handwriting. And I really learned that when you're listening to someone, you are most ugly writing in a way that no one else can understand. So I had to transcribe that into notes and documentation for my pseudo-mom and I learned a lot about what it meant to be a part of people’s journeys.

My quiet in this work is me. I am a black queer person who presents their gender in a way that is culturally and societally appropriate and yet is not what it seems to be. I am really curious about what yours is. Her Jesse asked earlier, how many of the sessions in this four-part series you have been a part of the peer but share in the chat if you can
why you are here. What it means for you to be here learning in this moment. I hope that you inform a little bit of what you're lived experience is, while the content is rolling out. This is going to be as interactive as possible. I really shy away from two dimensional learning platforms and try to reach toward peak people so I encourage you to reach back to me in the chat box. We will have a Q&A session at the end, and I do my best to respond to what is happening in the chat in real-time. If I missed something, I ask you to repost it and there are some lovely folks from NAADAC who are making sure that we get everything we need to so that we leave this place with enough information to be able to do those four things.

And I missed one of those four things. So we talked about differentiating, modifying and demonstrating. Those are the three formal learning objectives, but the fourth one that I really want us to do is reckon with the history of social oppression. Reckon with the reality that LGBTQIA+ folks have been and continue to be looked at under a lens of what is normal and what is alternative.

So we will bring that lens into our learning today. And if you walk away with one of these learning objectives kind of well to your little toolbox, I hope our reckoning with this is at least one of them.

So thanks for sharing in the chat. I am seeing lots about just personal identities and time spent in evenings working with the LGBTQ community. And especially folks in the rural area. We know that we are living three-dimensional lives across two dimensional platforms these days while we stay safe in the pandemic.

So let's take this moment to reach towards each other a little bit more. And I'm going to offer some poll questions. So the first is going to pop up on your screen. How much time in a day do you think about your sexuality? It's either none, 5-10 hours, 10-15 hours, or do you spend all day thinking about your sexuality? How much time mitigating you spend thinking about your sexuality? You don't take about it at all, 5-10 hours, 10-15 hours, or all day. While your responses come in, I'm going to talk a little bit about the word, invisibleized. If you Google, it's not an actual word. It's a word that we use in social justice are arenas where we want to think beyond -- we really value a person centered approach in all that we are doing. And when we say that there are communities that have been stoically marginalized and oppressed, it is not their doing.
They are not doing that. To discuss how people have been marginalized in some way, it gets closer -- to help people have been invisibilized in some way, we look at the practice and the products of oppressive systems.

That poll just ended and these are the results. 63% of folks, that's about one or 20 of the 189 people who voted said that you don't spend any time in the diet the update think about your sexuality. 9 people out of 189 said I spent all day thinking about my sexuality. And then 58 of 189 people said they spend 5-10 hours, and 2 of 189 said they spend 10-15 hours.

We will get to the next poll questions. Same question but at this time about gender. How much time in a day do you spend thinking about your gender? None, 5-10 hours, 10-15 hours, or all day? So again, we are thinking about the lens that oppression and marginalization lay upon the experiences of people who are walking through their day-to-day lives, having to navigate the alternative that they are up here to the norm of society that we live in. So when we use the word, invisibilized, we are able to express what someone is experiencing and we are also acknowledging the work that we have to do to fight it. Oppression and marginalization don't get us close to the justice liberation that most people deserve. So when we are moving toward the lens of invisibilized, with it more critically about what an individual's experience is and how that is apparent or not in their day to day lives in behavior.

I did not include 1-5 hours? If that's your experience, put it in the chat. So based off of the poll, which may be skewed recognizing that we are missing a category, 122 of 185 said they spend no time. 49 people said that they spend 5-10 hours, 10-15 -- excuse me, five people said 10-15 hours, and nine of 185 said they spend all day thinking about it. And we have some folks in the chat saying they are definitely the 1-5. Thanks for pointing that out and for participating in this poll.

Our last one, a different iteration of the same question, how much time in a day do you think about your gender expression? Gender expression. So we have thought about our gender itself, we have thought about our sexuality, and we are now thinking about our gender expression. If you are in the 1-5, put that in the chat. Otherwise it respond to the poll. Is it none, 5-10 hours, 10-15 hours or is it all day long. We see the 1-5 coming into the chat. And this last question is different from the other two, because gender
expression is not something was spend a lot of time talking about. So when Sherry, I hope where I am saying her name right, asked about my pronouns, it is an intentional expression of my gender identification. To express as a non-binary person, to show that I show up with this identity. That is more about how I navigate the world then but you can understand me to be and understand how I may relate to you in any way.

So as we close this poll, will see what folks are saying. Lots of people are saying 1-5. And to see that 124 out of 177 people who voted said none. We don't think about our gender expression throughout the day. 38 of 177 people said 5-10 hours is about the amount of time I spent thinking about my gender expression. 7 out of 177 said 10 to 15 hours, and 8 said all day. This is a reflective opportunity for you to think about what it means for you, someone who is navigating the role, for these identities to show up and how much time and effort do you practice in thinking about who you are being perceived as and what is available to you based off of other people's perceptions.

Thank you all for participating in an effort the folks who are reflecting now about how the time to think about gender, sexuality, and gender expression.

So I have gone through trainings and even gone to trainings early in my career about the experience that the LGBTQIA+ community is, and typically, we spent a lot of time talking about pronouns. We touch spend a lot of time talking about sexuality and the ways that sexuality may vary. I'm not want to spend that much time in offering that is learning material today, so at least you have available to you three other sessions, or you can learn more about the experience.

What I do want to focus on today are 4 things. As we recognize the spectrum of realities. The first being the gender binary. And these definitions are offered to you via gender spectrum, a website where you are able to get materials and resources for youth as a health care practitioner and as a teacher to inform your understanding of the LGBTQIA+ population. So the gender binary is a system in which gender is constructed into two strict categories of male or female. Gender identity is expected to align with the sex assigned at birth and gender expressions and roles for traditional expectations.

So I use myself as an example in this learning series because my gender is one or I say that I am non-binary, which is in connection to folks who are trans. Not using a different pathway of expression a connection to who you are and what your body is made of.
So I choose not to identify either as part of the binary that is constructed in our day-to-day life, which means male or female.
This is supported by sex assigned at birth. Which is the sex, male-female or intersex, that a doctor or midwife uses to describe a child at birth based on their external anatomy. So you'll see under that in brackets, I put AFAB, and AMAB. Which stands for assigned female at birth and assigned will let birth, and I apologize that I am missing assigned intersex at birth, which often is not the case. For to the place into one category of the binary, either female or male.
So when they are wanting to understand more of the person's history without putting them into a category of gender that they do not identify with, we talk about what happened at birth. Were you assigned female at birth or mail at birth so we can have better understanding of their social experience. And how that contributes to the way they identify and what they need to work through in a therapeutic process or recovery process.
Sexual orientation is actually an interpersonal, it's the only interpersonal definition of here, interpersonal term. This is basically what you do with another person and what that person is a pair so sexual orientation is defined as who we are physically, emotionally, and/or romantically attracted to don't spend a lot of time talking about all the components of the invisibilized LGBTQIA+ population, because within that is sexual orientation. It is gender, it is gender binary. It is transgender, it is intersex, and is also the orientation through witchery relate to other people peaks so how you connect to someone romantically, sexually, physically, and emotionally. We could be here all day talking about what is possible in the world, at least what we have that validated as the possible in the world.
And the last term I offer to you today is social gender, which is gender expression, which is the way we communicate our gender to others through such things as clothing, hairstyles, and mannerisms.
So this gets confusing. It really does. Even as a person who identifies within the LGBTQIA+ population, it is confusing to understand how I am supposed to interact with someone in a way that does not disturb their personal dignity. That affirms their worthiness. And that acknowledges that they have every opportunity in the world to
decide who they are and how they are. So managing for that confusing first step is reflecting on it and admitting, this is confusing. And the second step is to move toward the goal.

And one of those goals is gender congruence. So before talking about gender congruence, I want to spend a little bit of time talking about intersectionality. That is a term we are using a lot of social justice. A lot of our social justice lawyers and our keyword warriors on the Internet are using intersectionality without applying its true context to their discussion.

So this is a term that I use in teaching to help us see how intersectionality is applicable to our daily work in therapeutic spaces, and advocacy spaces, in policy spaces. So Kimberly Crenshaw in the 1980s who is a lawyer and an activist coined the term intersectionality. Which describes the shadowed interlocking pattern of historically modulated oppressed identities and how that is cast onto populations of people.

So intersectionality or what we are using essential intersectionality now, is a way to describe how oppressed we are. Gender congruence as part of that understanding and process, but it asks the question how harmonious is your existence?

So when we acknowledge that yes, it's confusing to look at all the different parts of the LGBTQIA+ population, and to consider how things may become contradictory if we are really thinking about centering on expanses of people, if we move toward the role of gender congruence, which is part of the goal of gender justice, then we are going to acknowledge a few things.

We are going to think about how we expense comfort in our body as it relates to our gender. We are going to name our gender in a way that adequately corresponds with our internal sense of who we are. We are going to express ourselves through our clothing, our mannerisms, our interests, and activities without the constriction of our gender binary. And we are going to be seen consistently by others as we see ourselves.

If we focus on gender congruence, things are a lot less confusing. Because we recognize it is our responsibility to show up as we believe that we need to in order to maintain our dignity and our -- and we create the world that demands the same of others.
So as was said earlier, gender congruence answers the question, how harmonious is your experience rather than how repressed are you? And typically when I am teaching or instructing, I move from this place that is just a centered liberation oriented, and I do my best to minimize the discussion that we are talking about the ways that oppression lives in our bodies the way that it shows up, the ways that it expresses us, these are things that are part of our understanding if we applied ourselves to continue personal the personal develop in a growth. So the role here for me is to mold move closer and closer to the experience of social justice period ultimately, healing justice.

I said earlier in my introduction of myself, that I am a healing justice practitioner and ultimately, a student of justice. Healing justice is a political strategy that was conceived in 2005 and launched in 2006 by the southern healing justice convinced -- collective to - - systemic oppression and build community survival and responses rooted in seven traditions of resiliency to sustain our emotional, physical, spiritual, psychic, and environmental well-being. This definition comes directly from the catering southern -- kindred southern kindred justice website and it reminds me of healing centered engagement which is a determinate framework coined by Dr. Shawn Wright. So oftentimes in our profession, and this is my experience, that we not apply it to the general population. My experience is that we are looking for a level of authority based on credentials to determine how we can create and modify interventions for some of the most invisibilized and marginalized population. And human justice is a chance to recognize that people's lives expanses and cultural traditions inform the way they show up as we move from gender congruence and towards a the rated and just future. And that healing centered engagement piece, a person says is very close to human justice and that it is a political framework. It is one that we apply within our clinical studies and also it requires that we apply it to ourselves and move within activism and advocacy to a political solution.

So I'm a social worker. Social work is the only thing that I have ever studied. When I was in college, I actually started as a music major. At the University of North Texas in Denton, Texas I wanted to be like Eric -- and a joke that I tell people, it's also true, is that I quit music school because I wanted to make more money so I became a social worker. So I did my study in Texas and I'm a licensed social worker here in Virginia.
But social justice is part of the framework of the National Association of Social Workers code of ethics. And this is a very long definition of it. But I wanted to offer it as a way to orient our minds to the responsibility of social justice within our clinical approach. So social workers, we pursue social change, and if we drop down to the second sentence, our social change at work -- focused on issues of poverty, an appointment, discrimination, and other forms of social injustice. Ultimately strive to provide access to information, services, and resources. Equality of opportunity at meaningful participation in decision-making for all people. When I some all of that of no up, part of my goal and work is to make sure that we have every opportunity to shift power and attention from the way of marginalization oppression prevents people from making social progress and move all of that into the lives and experiences of those who are invisibilized. So I wanted lift up gender justice before we move into how it is that we get into the modifying of our learning objectives. To modify the approach to the next thing. So this definition is offered by the third waves fund, which is activism based foundation that offers funding for organizations and grassroots activists and individuals, organizers, who are pursuing gender justice. And this definition and picture offers a framework of gender justice. So it says gender justice as a movement to end patriarchy, transphobia, and homophobia and who create a world free of misogyny, the violence that is validated and normalized, that women experience and that meekly cringe a little bit because that the way we talk about it, women experience, targeted by men. Did I say that right? Women experience. So the thing about what does this mean for the person navigating their own life? In the center coming see gender justice. And what I want to invite is that you all position yourself into the middle of that circle. In the middle of that circle, think about how the time that you spent thinking about your gender, your sexual orientation and your gender expression influences your access to reproductive justice. How does the time that you commit to that influence your access to a community free of violence? How does the time that you spent thinking about that influence your ability to have health resources and access to health care? How does that time influence the education that you received were that you continue to contribute to or seek? How does that influence your nationality or your understanding or
your identity as someone in this country or the country of your origin and belonging?
How does the time that you spent thinking about your gender, your sexuality and your
gender expression, influence how much money you make? How much you are able to
contribute to the resources of your community or your family? And how does that
experience influence the way that you navigate your own cultural identity? Your
ethnicity, your race? Your language? Your religious practice? We could go on and on
but when we center ourselves into things that are in the center of this image and pursue
that which is congruent and harmonious, it one, gets a lot less confusing and two, we
realize it's all interconnected.
So this opportunity gives us -- this gets us closer to the opportunity to ask that question,
have a meaningful answer. How harmonious is my lived experience? What does that
mean for us? And what does that mean for the person navigating their own web of
intersections?
So let's take a moment to reflect in the chat, you are chatting a lot, and I love to read it. I
want to invite you all to consider and reflect on this question. As a provider, what risk
are you most often assessing for? As a provider, what risks are you most often
assessing for? And you can surely chat those things for can this is an opportunity for us
to connect with the realities of doing this work in a way that is affirming. As we get
closer to the end, you will actually hear my thoughts on affirmation in our space.
So a lot of photo saying suicidality. Absolutely. The risk of harm to self and others. Self-
harm. Someone said gender congruence. Absolutely. What else are we seeing?
Depression, trauma, health care access. Child safety. Multilevel discrimination. Safety
and detox. Suicidal ideation. Homelessness. So we spent a lot of time thinking about
mostly safety, and the way that safety may inform all of these other things. And family
rejection. So continue to show that in the chat. I'm going to move towards this story in
our next slide.
When I first started out getting my hours after undergrad excuse me, after graduate
school for my clinical license, I was taught to absolutely prioritize safety and to think
about all the ways that concurrence may exist in the lives of people that we are working
with. And when we think about co-occurrence, I go back to my first days as I was
completing my BSW, that was to me how to someone who is navigating their own
recovery, their own experiences with addiction, sobriety and dependency, how does that inform their overall health quickset and I was binary myself. It was either the person is navigating or they are experiencing and navigating their own addiction or they are navigating their recovery. Nothing else. And that leads to depression and suicidality or some level of low risk and connection to the natural support system in the community. And so I was not taking about the strengths, about what else was possible in their lives, and secondly, I wasn't taking about the ways in which the binary that we are taught as far as gender and even the yes or no construct, it influences our ability to offer a good assessment. I would be remiss if I didn't mention what co-occurrence looks like in the lives of LGBTQIA+ folks. This chart comes from SAMHSA. It helped us understand what it looks like as far as data for people who are struggling with use of illicit drugs, use of alcohol, or both.

And right in the center we see that 1.9 million people or 12% of people 18 or older had both these experiences and a mental illness. So both the expenses of a substance use disorder and a mental illness.

And when I look at this, I think about how we categorize people into these places in the recovery process, that becomes the focal point of our treatment. So as we continue to talk about what this looks about -- like in our own processes, I'm seeing those mentioned, focusing on strength, focusing on motivational interviewing. The key about trauma and the relationship integrity. Thinking about all these things and let's layer onto that, the way that we can expand that definition of co-occurrence to focus on health. This were that you see highlighted, criminalization. When we use our social justice orientation, to look at the experiences of LGBTQIA+ folks, critically those who are invisibilized, those who have and I'm using my hands to talk, I'm sorry, but multiple layers of experience of oppression that ultimately results in a layer that is far from the norm, the social norm or the cultural norm, being unseen, and validated, and in some ways unexpressed.

The unexpressed identity many of us knows is one of the main barriers in our recovery process. Because we have to get through the layers of shame to actually articulate what that is. We have to then go to her clinical process to recognize and affirm that and then unpack that identity so the person can fully develop.
I am missing this when we look at health because criminalization is a process and a byproduct of an oppressed society, where people who are in the most need access to health actually ended penalized or punished by it. So 28% of the LGBTQIA+ population in this country, in America, lives in a state with an HIV criminalization law. That can work a few ways. My research, it is one, having an HIV diagnosis without informing your sectional the sexual partners can result in criminalization. If you are familiar with this, please say so in the chat. Another thing in our countries having a positive HIV status and engaging in sexual activity that results in someone else having a positive HIV status can result in caramelize agent. That means you have entered into the criminal justice process and the results of that can vary based off of your intersectional identities.

So criminalization is something that men are experiencing excuse me, black men experience at a higher rate in our country, and black women, the rates of criminalization and the experience of black women is increasing as crime itself is decreasing.

I mentioned indigenous people because as we think about a history of social oppression in this country, colonization is a root cause of adverse health include violence and people navigating dependency and addiction in the cultural population of indigenous people. So one of the byproducts of that is that indigenous people have the lowest full-time employment rate at 37% amongst LGBTQIA+ populations. I’m sorry I didn’t mention that.

And so looking at how social oppression and the patterns of social oppression influence someone’s ability to be resourced economically at how that existence is a byproduct in the real cause of oppression is colonization.

So adding at that history, we can do more to speak of the truth and reckon with that, think of how we have to adjust our treatment, and the assets of services that are available in the way the services are designed. We will talk about that at the end.

So mentioning use, because youth are often part of an invisibilized population because of the level of agency autonomy and access to educational resources that is available to each child based off of their cultural experiences in family decisions.

So the data tells us that youth who are LGBTQIA+ identifying, experience feelings of rejection that leads to six times more likely to report higher levels of depression and
three times more likely to use illegal drugs compared to their peers. As their peers being those who do not identify as LGBTQIA+.

Without -- offering just anecdote and lived experience, for folks who identify as gender fluid, gender fluid meaning being a choice to express her gender as you choose in any given moment. And so we can see someone who chooses to express a masculine identity in their close and their language and their relationship to others one time, and they choose to express it differently another time. Agent or non-binary. When we look at the research as to what treatment options are available, intensive treatment options are available for folks are navigating the experience of addiction or dependency, we seek minimal accessibility of treatment options for individuals who are gender fluid. What I mean by accessibility, it's different from obits availability. You can offer services and -- say we will treat someone here who identifies as gender fluid, accessibility is about the relationship between your practice and service and someone's ability to navigate that with ease without disruption or a loss of their personal dignity. And so do they feel like they don't have to compromise and make their lived experience less harmonious in order to seek treatment. Are they able to join a group based off of how they identifying?

And the lesson that I want to mention in this category is communities of people who are not recognized by mainstream or alternative social norms. This is what I call the plus. There are many forms of the LGBTQ acronym. It is LGBTQIA+, and the -- which is lesbian gay, bisexual -- intersex, asexual, a gendered. And the plus is an opportunity for anything that -- any identity we have not yet validated to be a part of the experience. And the ability to give name to your experience whether it's a gender expression, to show up as you choose to show up, is a part of the developmental process. And people are historically invisibilized when we have not yet given name to an experience. So we do end up in this compromising situation where we want to validate everyone as they choose to show up and you just run out of terms. So how do you develop a relationship with someone and assess for gender congruence if we don't yet have the language to acknowledge how it is that they choose to exist?

So when it consider this in a public health framework, I know that when we look at research around LGBTQIA+ people, is often in the field of public health. And that public health is offering us enough research to understand how the experience of health is
informed by communication, by your environment, by your relationships and by your access to resources.

And what I'm seeing in the literature as we are spending a lot of time talking about public health and personal health experiences. I appreciate the public health approach because the social ecological framework reminds me of the person in the framework that we use in social work or simply seeing things as person centered and that the person is influenced by the environment and the environment is influenced by the person.

Determines what I want us to reckon with this morning.

When I think about disparities and what disparities are actually made of, I believe that they are made of systemic oppression, structural oppression, patriarchal violence, and medical racism. So to offer some definitions, I have been in Virginia for a while, and I read an article where a person who was in an appointed position in the system wasn't quoted to say we don't actually know what structural racism is, so why are we talking about it? That person was either removed from their position or voluntarily resigned from the position after the backlash because that statement came from a place of not recognizing that there is anything of importance of structural oppression and systemic oppression in our day-to-day work. I'm curious from other folks, if you understand structural and systemic oppression, say so in the chat box.

And I want to talk about -- I see multiple exclamation points. So in the research for structural oppression, can be defined that as I am not finding one agreed-upon definition.

So I'm going to offer a definition that synthesizes what I read. In the NE Casey foundation really helped me to identify what developed this understanding. Structural oppression is the process by which disparities become negative health outcomes. Two examples are the prison pipeline in particular the other prison pipeline is actualized for gender nonconforming, transgender and non-binary students. And the fatality rates of domestic violence.

Again the definition is the process by which disparities become negative health and life outcomes.
The rate of violence in the light that lives in lived experiences of black women is disproportionate to the wider compilation of race and gender and the rate at which black women are likely to experience lethality or likeliness to be killed as a result of the partner relationship is disproportionately higher than that of anyone else based off of race and gender.

So for young black boys and girls in school, their behavior manifestations of trauma or of an undiagnosed learning disorder is more than likely to lead them into the school to prison pipeline and less access to resources in their lifetime resulting in a negative outcome. That's structural oppression.

Systemic oppression is the capacity of practices that are used to create bias, discrimination and stigma that ultimately hinders the progress of people. The capacity of practices that is used to create bias, discrimination, and stigma to hinder the progress of people. This looks like redlining in the home appreciation values for black Americans, particularly in the South throughout the last few decades and the disproportionality of black children in the American health care system compared to the larger population of children in any other given area. So the complex of the of practices. There are multiple systems that relate to the housing justice system and the disproportionality of black children.

And when those things are corroborated, within the system of our structure, as we are looking at how we see things like medical racism, which is bias and lack of access within the system that is particularly against people of color and disproportionate in black and effort in communities.

And the last thing I will mention is patriarchal violence which is similar to systemic oppression. It's a complex pattern that ultimately prevent women, and LGBTQIA+ publishers from making social progress. It also advocates the use of violence against those groups.

So mentioning all of this to get us to a place where we can have an understanding about how public health disparities are discussed, and there's a tendency to marginalize, the this does not recognize the historical systemic oppression, historical patriarchal violence and historical medical -- the manifestation of that for LGBTQIA+ populations is on your screen for travel read some of the things that are here.
The research is particularly around transgender or the LGB adults. So that third bullet, LGB adults are more likely to receive health care service in emergency rooms, which we know does not lead to long-term health outcomes. Transgender adults are 50% more likely to have suicidal ideation. And we can begin to think about how health influences recovery. So what does health literacy look like for the people that you are serving, meaning I'm understanding the options and of it all to them? Are they understanding the services before they consent to them? Are they able to participate in conversations about decision-making in a way that is consensually shared between practitioner and patient?

How easy is it for them to navigate complex systems? If you go back to that wheel of justice and gender justice and you put yourself in the center, how much does the time that you spent thinking about your sexuality, your gender and your gender expression influence your access to health, health care, and health resources?

Or folks able to communicate the needs of their body in a way that is dignified and that is validated with the practitioner and do they understand how to participate in self-advocacy, which is the collaborative sharing of meaningful power between practitioner and provider. Principle another way that health disparities are talked about and categorize is within the experience of partner violence. The last is a secure, 43.8% of lesbian women and 61.1% of bisexual women have experienced rape, physical violence, and/or stalking by an intimate partner at some point in their lifetime as opposed to 35% of heterosexual women. The second one, I was talking about this earlier, LGBTQ black/Afghan American victims are more likely to experience physical intimate partner violence compared to those who do not identify as black/African-American. So women are thinking about what it means to consider health is a disparity that affects LGBTQIA+ populations, we ask ourselves the question, is the relationship validated within the treatment environment quicksand is that relationship structure one that is easily understood and discussed between practitioner and provider? Do you have the tools and resources available to you in and LGBTQIA+ affirming lens that can assess for someone's lethality and risk for violence in the relationship. We also need to look at their system of care, which is manifested in their access to housing.
We looked at research that it told us that expanses of LGBTQIA+ individuals within social services is designed to support their housing options, they reported experiencing overwhelming instances of discrimination, harassment, violence, and sex segregation pick sex segregation no space off the gender that was assigned to them at birth. One of the statistics that I don't see on the screen which is very interesting to me it comes from the Williams Institute report that is also listed in the references page, it mentions that LGBTQIA+ individuals report receiving less follow-up with landlords and other housing agents than individuals who identify within the LGBTQIA+ population. So all of this information, if we go back and discuss the things earlier, help us to see how oppression and marginalization are activities that result in the invisibilized experiences of individuals within the LGBTQIA+ population that should be accounted for and assessed when we are thinking about all that we are assessing for us as practitioners. The suicidality, the history of trauma, the family relationships, the belonging a natural support system, all of those things. This is part of that process. The way that we discuss it should be as person centered as the way that we move towards gender.

So I offer this information, but I'm curious, for US practitioners, what disciplinary frameworks do you use to support your work? I am a social worker, I was going to be a social worker, so -- I received my degrees and licenses and public health framework is one that I engage in often to understand and connect with people who are having -- who are navigating historical manifestations of trauma. Someone who offers person first language. That is a framework that we can use to support our practice. Our client centered approach. I'm currently teaching graduate courses at a university and I remember making this joke that I can now say I'm an old practitioner because when I was studying social work, we talked about the biopsychosocial and now we are talking about the biopsychosocial spiritual and I just feel it little bit dated. Because that was not in my textbook. I see people are mentioning trauma, client centered approach. So all of those things that you are using, is it likely that you have this information through the lens of think about how the disparity, health disparities, the manifestations of injustice informs someone's recovery process? It was not available to me until I began to apply myself and apply my learning in very specific ways.
So let's think about our practice considerations. There are some legal considerations that we want to think about as we are working with LGBTQIA+ individuals in our treatment centers and our private practices and our community groups and outreach in some way. One of the things to consider is the consent process. So I share with folks that I did not consent to this experience of life where my gender presentation is also other. And so engaging with me from a consent first place is one of the most meaningful ways to develop a healthy relationship. And in my own practice I find that is one of the first components of working with individuals with gender expressions are not seen as socially acceptable, beyond the norm or alternative.
A consent process looks like a meeting with the can you help me to understand? Can I ask for further clarification? I want to just double check that I am reading this correctly or understanding this correctly. I think that's one of our basic components of our client centered work and also I have to emphasize how important it is in this process. We talked about criminalization. And how that is a byproduct of patriarchal violence, which leads to health disparities and having access to resources. And we also must mention confidentiality. In the process, of a recovery journey, we may be discussing what life was like within a different gender presentation.
And it is absolutely expected that within your own practice and in your note taking and your relationship that you're keeping with this individual that you maintain confidentiality or I did I someone of their gender expression that is not current or up-to-date based on your relationship with them. That confidentiality extends to what you connect with other providers. If you're looking at an interdisciplinary team and you need to pass on information order connect someone with resources and someone's name is nothing name that they identify, how do you maintain confidentiality in a way that supports that person? Are you practicing a person centered lens approach? Are we also considering the ways that risks can be experienced within someone's employment, marriage, other than parental relationships, and navigating their own gender expression and recovery process? We are going through multiple emotional developmental recovering emotional development all processes through the stages of life at one time. So what risks are going to continue to
their employment, marriage, their relationship with their parents or their parental relationship with children? And other people they may care for.

And to talk about belonging. So you see the closet is up there in quotation marks and I never thought I was in the closet. I let people know if you are in a relationship with me, you are always in a queer relationship because I am a queer person pick up until I met my wife, my family did not know about my dating. I didn't think I was hiding it in any way, I just knew that once they needed to know, they would know.

So some of the theory of the closet helps us to see how the term, the closet actually centered in whiteness and being a white queer. So someone can exit or enter the closet but not at well, but in a way that is simple as opening the door.

And for the cultural experiences of black folks, I to this day being married to my wife and my wife's friend is how their family turned me to her. And in some relationships are in some personal dynamics, people challenge that. But the closet is something that at least within my wife's case, it was the friend experience. And I have many queer aunties in the community who have been roommates twit with a friend for many years, and their family knows that. So the closet is not a factor. A coming out story is not a factor. What when it becomes a factor is conflict and confrontation and facing your journey towards gender congruence. And also the congruence of your sexual orientation and your personal identity.

We talk a lot about family of choice and community of influence. Family of choice means who it is that is your support system in the community that you are navigating. Queer spaces are spaces that are designed socially to embrace people with the same at times hierarchical relationships and roles based on mother, godfather, cousins, siblings, based on your relationship to a community or not.

And also when we arrived at the stage of development really decide whether to parent our dots or to address the parenting that we received were the parenting that we did not receive. That is another place in our emotional development where we must go back and recover the skills of that stage. So these are considerations for the recovery process.

Largely, within the recovery process, it is always my recommendation that we consider harm reduction as a primary skill within our clinical tool bag. And harm reduction is
something that is applied to the ways in which someone is using or not using and also all of those factors of health congruence, justice, and liberation. So if we can go back to that circle and put ourselves in the middle, what are the relationships, decisions, risk factors and protective factors that will reduce the harm that you are to receive or contributing to society so that you can get closer to your gender communities. So you can get closer to congruence within your sexual orientation. So you can get closer to the economic resources that you so deserve. So why would you -- risks that you face any recovery or sobriety.

talk about the emotional challenges, but merely we need to think about the emotional development of process and those considerations in the living and relying categories that can influence somebody's ability to move through and get to that place of maturation within their emotional health.

We want to think about fractured and fragmented identity. This comes really from at least in my practice, and African holistic psychological lands when we think about what it means to be part of a family system and how when one is removed from a family system, it fractures everyone's identity in that circle. So we often talk about the paper chain, if you were to cut out a little chain of paper dolls, when you remove someone from there, that chain, it fractures the entire chain itself. So identity that is developed as a mother or as a father, is a sibling, as a caregiver, whatever else you need to identify, is fractured and fragmented. So as much as we can go back through and offer space for maturation wherever or whatever approach you're using is going to be helpful that recovery process.

And accounting for the length that someone is moving toward gender congruence, how do they associate with previous expressions and presentations of their gender and their recovery, sobriety, dependency, or navigating a timeline of addiction? How did those things correlate? Where can you a make the presence of shame in getting to know that emotional maturation?

One of the lessons I want to think about in the clinical approaches morality versus spirituality. And I do have to say versus because within being queer, I can say within my own journey to be as congruent in my gender and sexual orientation as I am, at the
beginning I spent much time researching what it meant to be queer and of the spiritual practice that I was raised in. And how was I going to reckon with that? So there was a morality component, the cultural influences that govern decision-making. Is allowed? Is it recognize? There is a spectrum of values and choices and how those values and choices are seen within the reality of that spiritual practice a religion, changes the ways that you are motivated to pursue the recovery and sobriety or not. Additionally, our cultural practices within spirituality, do we still have access to them as people who are LGBTQIA+? What is the level of authority and community of influence that is within our lives? As we are navigating our recovery, sobriety, and our identity? Moving towards that place of congruence.

What is the perspective on healing and health based on that spiritual practice? And inwardly personal point of reference, meaning as we are going through the development of process emotionally, and the spiritual component to that, how are we repairing the fragments and fractures to that identity within the spiritual factor along the journey of emotional maturity that helps us get towards maintaining recovery and serenity long-term and in the present?

So before we get to our questions, I'm going to move rather quickly through these next slides because since I offered my proposal, I actually have been reckoning with this affirming and trying to move us more towards that place of liberation. So I'm going to offered that we consider what we mean being affirming versus responsive. Affirming care is care that is dependen on unbalanced power exchange based on the practitioner’s competency and relative understanding of the social issue. So you may be more affirming in this moment because we have gone through a little bit of information. But I always tell folks don't go on the streets and try to be up and I'm already, and I am a LGBTQIA+ warrior and advocate. I did prepare you with a little bit of learning. But there is an unbalanced power exchange because there is a limitation to which you can be affirming if you don't know how to navigate that population.

And we want to come to a place of responsive care which is evolving professional dynamics that support the new lived experiences of individuals as it is uniquely expressed, related, and understood.
So if we are moving forward and think about what affirming looks like, it may be recognizing the presence of lived experiences. It's recognizing the presence of lived experiences. It's acknowledging a history of stigma and discrimination. It is offering respectful engagement based on a global perspective of the population. And it is evaluating the risk-taking within the context of normative fatigue. We go back to that plus, and the invisibilized of people's experiences. Until the expressions are pulled apart and you can see the way things are interconnected, we look through the lens of normative fatigue and we evaluate risk at a high level because it is not deemed normal that the alternative or socially acceptable portion of our society.

Responsive care accept all of that which is affirmative and moves towards key things people prepare interventions and engagement based on dynamics of relationship to communities of the lived experience. Disrupting internalization of oppression and injustice within practice structure and individual therapeutic relationships. That means you as the practitioner and the patient. Advancing understanding of justice and equity and broader community. And promoting protective factors to minimize prevalence of social and personal risks. That is that harm reduction approach.

So this is what I'm going to offer. In your affirming practice, are you prepared in your intake paperwork? In my intake paperwork, I do not have checkboxes. Because I don't want to boxing people. So the question is, how would you describe your gender? How would you describe your sexual orientation? How would you describe your gender presentation? How would you describe your pronouns?

Your documentation style. It's a practice that happens all day long. And it's tiring to correct people. So sometimes I step out. And also with your documentation, do you document in a way that is gender affirming and supports people's move that movement towards congruence? If someone is dealing with a variance in a gendered expression, how are you documenting that based off the pronouns? What happens if on Tuesday you document -- he and on Friday gender congruence is more available in the identify as she or me or others? How do you come to that documentation style?

And available via treatment and services. And accessibility and availability are different things. And marketing. I see a lot of marketing that we are using stock photos. Wonderful, and to step into responsiveness, we have a staffing that is representative of
the culture of population that we are marketing ourselves to serve. We are developing community partnerships in a way that is protective of people's lived experiences. Do you have a relationship with the local gay or queer bar? Do you have a relationship of the local gay or queer social club? The death of service opportunities. If the timely way in with the services are offered. And all that we discussed earlier.

We think about the ethics of interpersonal relationships. I can talk about this all day long, but I don't have enough time left, so ongoing to say is within our professions and the way that the queer community is often insular, I have to tell my clients, let's talk about this somewhere. What are we going to do? How do we ethically navigate the batteries and limitations of our interpersonal relationship and advocate for the advancement of our profession in the way that honors peoples that expenses and cultural relationships.

And how are we evaluating our treatment outcomes? Are we eroding someone's product the nearness to low risk based off of homophobia, or are we looking for outcomes that monitor for -- sexual orientation that is congruent and harmonious?

So I'm going to offer that last slide with my contact information. So if you would like to contact me, don't hesitate. I'm welcoming questions and honoring this time with y'all. Thank you so much.

>> Thank you, Raven. That was fabulous information. This is certainly an area that I want to learn more and need to learn more about. There are several really good questions. Loved watching the discussion chat box. So many really good points. Just fabulous I'm very much enjoying this. There were some really good questions in the chat box, and one of them actually had -- seven people wanted to know the answer to this one. So I hope we will get to more than just this one. One of the questions, how much trauma related symptoms present differently for someone in the LGBTQIA+ population and people of color in the LGBTQIA+ population? Can you give us a little bit more about that?

>> That's wonderful question. And it has a really extensive answer, but I'm going to give you the answer that I am most -- I most often end up and up discussing with clients in my own practice is to look at all the ways that -- has become an indicator to navigate trauma. So that means that shrinking down and reducing yourself into a hidden stance
to where you are not even aware of the hit situation that is happening around you, and you cannot actively participate in a way that is harmonious or congruent based off your identity. So I would say for both of those populations, when you look at particular people of color within the LGBTQIA+ population, but also the larger population of all diverse folks.

So I would do some research on that and look into how farming affects the nervous system and how that can manifest over time. Sorry to cut that so short.

>> That's okay. And I think we have time for one more at least. This one is kind of similar. How can a group counselor make a group feel safer when counselors are stained in safety and sensitivity but the client may not be? I know in Montana we see this a lot. Counselors can be affirming all that, and sometimes we have patients, that is not the way they roll. And that can be really hard on a group in be a real challenge. So put would be some ideas or feedback for that? How can we help clients, how can we help educate our clients as well?

>> Accountability and recovery is one of the key components is managing your own behavior and relationships that you have had for that you will have. So accountability and a metric and a method of accountability in groups is really important as everyone is becoming more educated we are all navigating confusing parts of life. I understand who you are, where you’ve been.

But I can discuss how you are accountable to harm when it happens and how we can all participate in disrupting harm within the group, you give more opportunity for people to connect with compassion and reduce the amount of shame that may prevent folks from not speaking up for speaking out when that happens. So I will go towards accountability and transforming justice teaches us a lot about that.

>> Thank you. There some other with a good, people asking for some of the resources if they can be shared, not sure that we can do that. I'm sure the graphic, the perspective, I think those can easily be shared. And another question I thought that was actually very interesting, I understand that identifying with a term can be empowering. However I struggle with labeling people. The question is how has everyone else found a balance? That's also very good. Don't want to be labeling people and having them be
stuck with a level yet that can be empowering. So if you could give us some insight so that that would be great as well.

So we mentioned emotional maturity develop at the end. That's how I kind of put myself in clinical practice. One of my favorite questions to ask is how are you arriving today? Very different from how are you. But you can answer any way. You can give me an emotional response, a sensational response, or can expect to me will, I'm arriving more in my femininity that I did yesterday. So it's giving you an option to self identify and then accepting that you will be corrected at any point in time. So if you ask that question, how does that show up in your life, how is your gender being expressed? House or sexual orientation being expressed, someone is can stated and you can go back and say it one time you said this was true. Has it changed? Is a modified? How is it adapted as you are recovering or you engage in your sobriety?

So I would move towards that. And also sometimes just using that psychoeducational approach. I had a conversation with the client the other day about -- and their people like that they said? I said here's the information. You tell me where you fall. In your concurrency.

>> Interesting. Thank you. And we only have about three minutes left, but there’s some really good questions. I want to see the answers to these. This was an interesting one that I'm not exactly sure -- I'm not sure how to mitigate this appropriately. How did you and navigate working with professionals and individuals were expressing views of TERF, Trans Exclusive Radical Feminists, when the world minimizes doesn't -- these expenses. Similar to the other questions, but are some really good poignant thoughts and there. Do you have any insights on that one?

>> People keep bringing this question up here and that term, TERF, is folks who identify as radical feminists and do not include trans woman or any identity of womanhood, that is not assigned female at birth.

So I would go back to that slide around the justice, what it looks like to insert themselves in the center that, encourage relationship, not confrontation, but the relation and understand that we are all living in the world with intersections.
For me, that's why I do is try to find that relationship. We talk all day about our differences and that could take forever -- of going back to their very social work perspective.

I think we have time for another one. And this is an interesting question. Would you -- to a physician before gender affirming surgery to say the client is living is the opposite gender even when the person is not binary.

Only two minutes. There is a coalition, and I meant to include this in the presentation. I will follow up with you, but there is a coalition of health care practitioners that are reckoning with this letter. And the need to sign this letter. So I love my license, and I will not confirm or deny. However, I value relationships and encourage people to reach out so that we can discuss how to deal with that social construct.

Thank you very much. I don't know if we have enough time for another question, so I think we should probably turn it over to Jesse. There were some great questions in the Q&A box and Jesse will wrap around with how you look at the answers for that. This participation has been fabulous. Thank you again, Raven, for your time, your energy, your knowledge and thank you very much for everything this morning. And Jesse, I will turn it over to you.

I don't want it turned back to me. I have to tell you, I've been sitting here eating my sandwich and some chips and just engaging and loving the presentation. I really appreciate all of the chat box and how it is interspersed. Just the whole thing, who wants to hear from me? I don't want to hear from me.

I will try to make this short. I was going to leave the -- for your Q&A, but everyone ask for your contact information. So you may get 233 e-mails, Raven, I don't know. So be prepared. There is Raven's contact information. You can get a hold of them there. I am sort of speechless. That was wonderful. And people have asked also how to access the other presentations, and this one as well, if you want to watch it again, I think it's worth it -- with it.

Just a reminder that after this is over, we will post the link to the CE, as well as an instructional guide it's on the same webpage where you registered for the event. So it's all there. Just a reminder if you haven't any certificate process, just follow the guide. It will walk you through it. It's pretty easy to follow.
And also if you want your certificate to say live on it, please make sure to complete the CE quiz within the next 24 hours.

So here you go. You asked, here it is. This webpage that is blowing up, it's where you can access all four of the webinar series, advancing awareness in LGBTQ care series. This one will be there probably by tomorrow.

So if you haven't seen them all, they are all wonderful. And it's been one of the most successful series that I think we have had. So check them out.

We also have some upcoming webinars on September 24 Malcolm is going to be back again. There she is. Advances in Technology in the Addiction Profession part 8. Leveraging technology to enable enhance clinical supervision. And on the 29th, through rose colored glasses went cultural competency isn't enough. You can read the rest, and helps the couple you will join us for some of those.

Also we have our NAADAC conference coming up, which is why there was a big gap between September 29th and November 17th. That's because this is happening. And all of these. There is a lot of stuff. So if you're missing webinars, don't worry. You will have the content so sign up. The conferences at the end of October, from the 28th through the 30th, and we have three Fridays full of preconference sessions. You can choose to do one each day, they are going to be available on demand. There are six CDs that you can get pierce of check those out. That's the webpage at the bottom.

We spoke of the advances in technology in the addiction profession specialty series. The last one is on Friday they are available on demand and if you do all of the miniseries, you can apply for the certificate of completion in advances in technology and the addiction profession certificate.

So we have a wellness series also a specialty series and that wrapped in June. And there are six sessions in that series. And it's all about content and how to implement wellness in treatment programs. There is one on food, so if you missed those, check those out.

Also a reminder of all the benefit of being a NAADAC member. There are a ton of them. Explore it. If you are not a number already, we hope that you will join us. We love having members. And I think that the CE's are the biggest one. They quickly payoff the fee of membership.
So that's it. Thank you everyone, thank you Raven. Thank you, Malcolm. This will be available on demand. And a reminder that a survey will pop up. So take just a few minutes and give all your feedback. Because you all had so much in the chat box, put it there. And that's it. Have a wonderful weekend. Stay connected with us. I hope you all are well. Goodbye.