Welcome to the last session of the day. A Rainbow Pipeline: The Earnest Impact of Addiction on the Black LGBTQ+ Identifying Individuals thank you all for being part of our virtual summit today. I am Peter Mott and I am thrilled that you have joined us this afternoon. When you think about the title of our conference, Engagement in the Black Community A Virtual NAADAC Summit, engagement is all about learning more about the person you have a relationship with in order to gain a healthy relationship. As addiction professionals, our goal is to engage ourselves with our target population. In our situation, we don't always have a choice of selecting the ethnic group we are working with. It's our responsibility to repair and power ourselves with the knowledge to be culturally informed providers. As a committee member of NAADAC's newly formed committee, critical issues in the black community, I am honored to have an opportunity to have my voice heard on a national level about the issues and concerns black people of all groups face in accessing behavior health services. I am not the presenter, so let me get to the business of that this afternoon. I am going to be the facilitator for today's session. Closed captioning is provided by CaptionAccess. Please check your most recent confirmation email or the chat box for the link to use closed captioning. To access CEs for the seminar, turn to the webpage at the NAADAC website where you accessed this presentation. You will see a button under each session that says access CE quiz. If you click that button, it will take you to the quiz that you will need to take to earn your CE certificate. If you have any questions about this process, please read the CE instructional guide which is available on the NAADAC website and attached to the chat box during the session. Please also remember we have a live and interactive question and answer time with our presenter. So make sure to send in any questions you have in the Q&A box. You can also vote up questions you see that others may be asking during the quest the presentation that you would like to have answered. So it's time for me to introduce our speaker for today's last session. Dr. Porter is a seasoned lecturer, author, educator, researcher, analyst, and counselor. I'm not sure when he sleeps. He has used his talents internationally and domestically in multiple capacities. He holds a doctorate degree and Master's degree from the Chicago School of Professional Psychology. Dr. Porter has contributed internationally to multiple
organizations, including conducting research and developing reports, authoring briefings, and producing materials on public health and trauma related programs, activities, and policies. He served as a technical advisor to the psychosocial attention center known as CAPS and the Peruvian Ministry of Health in developing and implementing mental health services in Peru. He collaborated with and supported several community organizations in South Africa. In Belize, he provided is a short guidance to Galen University. Domestically, he has worked in a capacity of education, counseling, consulting, compliance, and communication. And now a NAADAC presenter.

NAADAC is delighted to provide this presentation presented to you by this experienced professional. Here is the man, Dr. Porter.

>> Thank you. I will bring up my slides here for everyone. Thank you all for joining. That was a fantastic introduction, Peter. Thank you so much. I'm going to jump right into my presentation. I would like to encourage you all to ask questions as we go along. If we get too many, we will try to take them at the end. But I prefer to answer them while I am discussing that particular slide. Don't worry about confusing me, FYI have a PowerPoint. So that let's look at the objectives for today. What I would like you to walk away with our learning and discussing the possible etiology of LGBTQ+ addiction, including topics such as stigma, acceptance, racism, and we will cover a few additional topics.

You also learn about the impact of addiction and addiction treatment and you will also learn about and discuss hopefully, possible manners to alleviate the stigma and barriers at the root of LGBTQ+ identifying individuals and addictions treatment. And hopefully be able to create some sustainable resources for better treatment, attractive, acceptance, assistance, and overall completion.

So jumping right in, there are some really unfortunate things that I came across as I was preparing this presentation. The first is there is little by way of empirical research when it came to LGBTQ+ population and addictions. When I added the search term black, the information became abundantly more scarce, even using minority, its stock dropped substantially.
And with this, we hopefully understand that research continues to show that the SUD rates of LGBTQ+ identifying individuals to be higher than the heteronormative population. What this means is that even though there are larger, the population in whole has a much larger scale problem on the SUD scale, we are not really doing the research. So that those are some of the things to begin with.

As we go through, a lot of what I want you to do is the same thing you would do in your counseling practices and really take the time to imply things based on the bits and pieces of information that I was able to piecemeal for this presentation.

One of the things that comes up. Often in the literature is LGBTQ identifying individuals are less likely to discuss addiction and treatment issues by and large. Mostly that comes from the fact that very many LGBTQ activities are steeped in addictions breeding grounds. In bars, nightclubs, or alcohol and drugs are readily available. And so because it's all normalize, it's not really talked about because it doesn't look like a problem because it is really entrenched in the entire culture.

Gay and bi men have a higher lifetime use of alcohol, tobacco, club, and prescription drug use.

Gay men are 6.5 times more likely to report methamphetamine use and bisexuals three times more likely to report methamphetamine use when compared to heterosexual males.

Lesbians are more likely than heterosexual women to meet SUD criteria and they begin drinking at a younger age, as well as they have higher lifetime rates of cocaine, LSD, MDMA, and methamphetamine use. Also transgender women are six times more likely to seek treatment. Of course, we all know that most people -- or many people don't always seek treatment. So the fact that there are six times more people actually seeking treatment means that the numbers of users are actually higher than six times.

LGBTQ youth also begin using opioids and sedatives at a younger age, and things tobacco at double the rate of their heterosexual peers.

Transsexuals are more likely to meet SUD criteria and drink at number ages than cisgendered individuals. Transgendered men who enter substance treatment are five times more likely to live with someone who has an SUD. What that typically means is
that if the transgender male is doing will there more like her to go back around people
who use substances, which also increases their likelihood of relapse.
Abusing substances also increases the already increased risk for LGBTQ identifying
individuals when it comes to homelessness, domestic violence, suicidality and
engagement in nonconsensual sexual behaviors related to alcohol consumption. And
this is all in comparison to the general population.
Any questions, Peter? So as I was researching, but I started doing when I could not find
information is trying to figure out why I could not find out information. Soy went through
and started analyzing some of the different journals and looking at the history of what
the journals had done. And I thought I would share some of those findings. Think only
important to how we continue our discussion. The Journal of addiction and offender
counseling has published over 280 articles since 1980 all the way to 2018. Anyone want
to take a guess of how many of those included information’s in addictions and LGBTQ?
You can throw those in the chat box.
>> I do have a question. Tracy asks, what is cisgender?
>> Cisgender means individual identifies with their given sex at birth. So if you are a
double X, and you identify as female, you are cisgender. Same way if you have XY, you
identified as a male at birth and you identify as a male.
Moving forward, only five of 280 articles, 1.78% focused on LGBTQ and SUD or
process addiction. Most of those articles only focus on men who have sex with men,
and sexual minority women and transgendered persons were even further
underrepresented. Especially if they were a racial minority.
Of all substance abuse research published in just two years, 2007, 2012, 553 combined
articles, only 21 reported sexual orientation and seven reported a non-binary gender
identity.
Further analyzing, in a study by Cochran, Peavey, and Robblehorn had 854 substance
use treatment programs identified as having specialty services for sexual minority
clients. And an abysmal, less than 8% actually provided those services. So there were
and are multiple entities claiming to have services that are specific to this community
that are not actually providing those services.
When LGBTQ people were mentioned in research, they were typically collapsed into a homogenized grouping. Of what I mean by that is there weren't any breakdowns. It wasn't lesbians, white lesbians, black lesbians. It wasn't gay males, it wasn't transgendered individuals. It was LGBTQ+, the entire spectrum for the LG and B, but the breakdowns were there. They were keeping everyone in one large group. And when looking at the information from the national Institute of health from 1989 to 2011, there were 127,000 abstracts. Only 0.5 Crisco mentioned LGBTQ+ participants. So when we look at how we are analyzing data and how we are formulating what we do as counseling professionals, you have to recognize that there is very little peer-reviewed empirical research on this population that makes it abundantly difficult to even show the importance of how to help this population of people.

Dr. Porter, I have a question. Richard said no recognition. Why is that? What does this say?

Yeah. I think what it says is that it's very easy to ignore an already underserved population if the people who are conducting the research are normally people who have an interest. It shows that there's not enough interest in this population. That's what shows, there needs to be more interest. And if there is interest, then those people need to figure out how we can conduct more research.

Also, Dr. Porter, Ms. King wanted to go back to your explaining of cisgender. She said why are we being called cisgender?

That term is not specific to heterosexuals. That term is specific to anyone who identifies as their given sex. So if you are a homosexual person, if you're a bisexual person, who is identified with the sex of male at birth and still identifies in that matter, that would be considered cisgender. It is not about orientation.

Right. And also charity stated, she has a question, she said I'm sure there's even less research regarding youth.

Yeah. I can only imagine how hard it would be if I added the qualifier, LGBTQ youth, minority. I agree with you on that.

If I need to stop and you go on, let me know.

I can take a couple more.
This is from anonymous, do you find that treating LGBTQ and black individuals have a hard time choosing which minority group to identify with?

We will discuss that later. Whoever got ahead of my slides, start cheating. (laughing).

In the last from Elaine, what percentage of researchers are LGBTQ?

That is a great question. And that begs a really good question. Because I would think that people of LGBTQ orientation would want to study the things that are important to them. Maybe the people who are researchers don't have addiction, or addiction is not part of their lifestyle. Maybe they do have people in their lives that have addictions issues. So is not something that I necessarily research.

Again, I started with the presentation, is that remember, addictions substances are so entrenched in adult gay lifestyle or LGBTQ lifestyle, because most of the congregating grounds surround nightlife, clubs, surround bars. So drugs, alcohol, it's an ever looming presence. And I think that also has a bit of a problem. I'm going to move forward a bit, but keep sending the questions. Thanks so much.

So when looking at the differences, I call these in a couple of slides white out because what it basically talks about is some of the racial differences since we are talk about issues specific to the black community. He substance abuse issues of black, Hispanic, and other cultural backgrounds have been largely overlooked. In the literature. Black LGBTQ+ identifying individuals have the stigma of being a double minority had me abuse substances as a coping mechanism to deal with not only racism, but depression, low self-esteem and so many other things that result from not only being a black person in this country, but being a gay person in this country and having to deal with the marginalization and being on the fringes of society in multiple manners. Black LGBTQ identifying it officials are often invisible in white LGBTQ communities or they are shown through the lens of white racism, meaning that black people aren't telling their own stories as LGBTQ people. White people are telling stories of Blacks the black people or black heterosexual people are telling the story. So similar to the crescent about why Arthur researchers out there and why aren't the LGBTQ researchers reaching out, it's a systematic problem when it comes to minority individuals anywhere.
The black LGBTQ+ experience is compounded across multiple variables, such as assimilation, race class and being simultaneously present in their community but excluded. If you are a black person, a black LGBTQ+ person and live in a predominately black community, often that is not met well. It's not very well received.

On the other vein, if you out of that black committee and move to a predominantly not black community or white community, let's say, then you have to deal with racism. And discrimination and bigotry. So it's the idea of being present and invisible all at the same time.

>> Dr. Porter, can I stop you for a second.
>> You may.
>> Someone is asking about the terms transsexual and transgender. So can you explain the difference?
>> Transgender is a person who has had a surgery, is taking hormones and has actually transitioned from one identifying role to the other. So they have actually gone through the process of physical transformation. Transsexual is a person that lives there life in that way, but more than likely has not actually had the full surgery and gone through the entire transformation process.
>> Thank you.
>> You're welcome.

I did not mean to yell that, I'm sorry. When we are dealing with blackness, here are some other issues that if you really put a microscope on this, and you don't even have to put a microscope on it, you can see how these issues also play into issues with addiction. And when you talk about LGBTQ identifying individuals being black, coming out is often frowned upon. And many people live in a don't ask, don't tell situation where people may know if that is not to be talked about, or people just don't know. And that creates a lot of stress and it puts people in a very specific box or closet, so to speak.

The connection to the black church and the fundamentalism of black church and how it tends to rail against homosexuality. As always an interesting dichotomy because when you talk to LGBTQ+ identifying individuals, they often say church is the 1st place where they felt comfort and felt a sense of connection and belonging and then to find out that they are condemned because of their sexual orientation or they are ostracized for it. It's
a huge problem for many LGBTQ+ identifying people because there is this love of the church but the sense of being unwelcome.

Also the idea that being not heterosexual implies some sort of developmental dysfunction. That something has gone wrong. The parent has done something wrong. There was something that happened to the person that made them this way. That also creates a ton of stress and anxiety because it makes the person feel abnormal when that's not the case.

>> I have some more questions. There are lots of good comments in the chat box, Dr. Porter, and lots of good questions are coming in. Here's a question from Sondra. Can you touch on unique barriers for the LGBTQ+ people experience in recovery especially when developing social interactions or romantic relationships.

>> One, I never recommend assuming a romantic relationships until you have been in recovery at least a year. And I think the other part of your question I will address as we go through the PowerPoint presentation. So hold onto that question. If I do not address it, please ask me again.

>> And Dolores, she us, how do we were to destigmatize mental health concerns and the gender dysphoria diagnosis itself when the criteria is essentially telling clients their lived experiences in gender and congruity constitute a mental illness? I struggle to even understand this diagnosis with consideration to the nature of gender as a social construct.

>> Well, I love that comment/question combination. What I would say is if you look at what the DSM-V talks about, one of the main components is personal distress. Is this causing the person actual distress? And if it's not, then it's hard to actually give a full diagnosis. So I think it's really important for us to look at how is this impacting the actual individual. But then also, it also there is on us to move forward and push what is normal -- or normal is not the right word, and push what is acceptable. Because the more we conducted sort of research, the more information that we make available, and the less uncommon it is, the better things, I believe, become. I'm going to move forward, Peter, so I don't fall behind.

>> So also when looking at dealing with just blackness, there are some major players that I pointed out that cause additional stress for LGBTQ individuals that could push
them into the realm of addiction. Black comedy tends to portray LGBTQ people in stereotypical, negative manners, using distorted one-dimensional information. Often this information is played as truthful and facts. It creates this idea that this is what it always looks like to be an LGBTQ individual. Even if that is not how you present publicly, it's what you look like in private.

We talked a little bit about the black church, so I don't want to go into that again. And then black radio and hip-hop culture where you listen to the radio, especially when I was coming up, there was constant speculation about who is and who is not gay. That was of constant discussion.

And rap and reggae music still to this day carry violence encouraging messages against LGBTQ+ identifying individuals. And often these sorts of messages in comedy, church, and mainstream black culture just go completely and challenge.

A major predictor of suicide in the black community is homosexuality. That comes -- bullying is considered a rite of passage very, very often. And the bullying and the rite of passage comes from this idea of these strongly identified with and rigidly adhered to gender role norms. What that does for LGBTQ people is it forces them to learn how to what we call posture, which is meticulously choosing gestures, mannerisms, their verbalizations, so that people can't identify them as different and they don't have to be taunted or picked on or bullied so they don't have to spin it. These are things that they had to consistently be aware of so they don't get picked on.

And all these issues foster stress, anxiety, and fear and overall causes distress and because of the anxiety. And we all know as addictions professionals, these are things that are very high predictors of substance abuse issues.

So someone talked about this earlier, the idea of being black and gay or being gay and black. Her individuals are situating between choosing how do I more strongly identify? And if I strongly identified as being black, then that means I'm denying a part of my sexual orientation, another part of myself. Because I already recognize that my community does not always receive me extremely well.

And if I first identify as gay, then I am denying a part of my cultural existence because I also recognize that identifying first as gay means I still had to deal with the racism, the bigotry, the stereotypes that come from not living in my own cultural setting.
So it's a compounded sort of situation for black LGBTQ people, and that of course, stress, anxiety, isolation, or predictors of substance use. Additionally, we have to work to demystify the masculine mystique of the black man as big penised, sexually arousing, black women as hot, sexy, seductive and always ready for sex. These are dehumanizing and adept defined term secondly to stress, anxiety, anxiety, and feeling on the fringes of society. Feeling marginalized. Overall just causing issues with how individuals deal with life in a general sense. And LGBTQ identifying individuals must understand and overcome the influence of their own internalized homeowner negativity and internalized racism because they live in a society that consistently reinforces these sort of ideas that there is something wrong with them for being homosexual or there is something wrong with them for being a black person. And you are force-fed these ideas and images through books and television and movies and just everyday interaction. It all becomes internalized, and sometimes people don't even realize they are doing it to themselves.

Moving into treatment, before I do, any questions?

>> Yes. Let's see here. This is from Ashley. Can we make sure our that black gay clients and pretreatment programs for some people very openly homophobic and transphobic? That's automatically a question.

>> I'm going to employ the word safe in there. And I'm going to say that it's up to us to treat them with equality. And treat them with equity on top of that. Because equity is different than equality. Equity is making sure that everyone is balance. And so in giving someone equity, it may mean that your LGBTQ client may need a little more of your attention than a non-LGBTQ client so that they feel safe and they can get what they need. So as professionals, it's important for us to provide equity.

>> Nina states that her understanding is that transsexual is derogatory. Is this something that we should consider when using this term? Maybe some folks prefer the term transgender if they have not transitioned.

>> I always believe the best person to get the answer from when it comes to that is the person. I have dealt with LGBTQ+ individuals in my very recent past. I've dealt with LGBT -- specifically with the T people, the transgender, the transsexuals, and I just ask what they prefer to I ask, what is your pronoun? I asked, do you -- do you use the term
transgender? Do you use the term transsexual? Because that is the person you’re going to offend if you get it wrong.

It’s the same with me. People often ask me if I prefer African-American or black. And if that sort of thing where it different took depends on the person or offended. Some people are offended by being called black. So if you’re unsure, ask the person. It’s uncomfortable, but if the right thing to do.

>> Do you want another question? Larry asks how can we attract more diverse researchers? How can we attract a more diverse pool of applicants into our advanced graduate programs to do research?

>> I think be the change. Go after it. Don't wait for them to be attracted to your program. Make your programs attractive to them. Figure out what is fueling these individuals. What sort of interests do they have, and do I have something that would attract that type of person to my program?

It’s about creating spaces for people who don’t have them.

I'm going to move forward. Hold the questions for a moment.

So some of the issues, when I was able to find information on black LGBTQ+ people in treatment, are as follows. Many do not consider treatment a safe space and perceive homophobia as a prevailing issue among the actual admission counselors. So again, what framework are you coming from when you’re dealing with your specific clients if they identify openly as LGBTQ+? There is a perceived lack of effective treatment of childhood and sexual trauma related issues to addictions treatment among black LGBTQ+ individuals.

There is also an express feeling of institutional and societal oppression in traditional, meaning not specific to LGBTQ+ individuals in substance treatment environments. There are a few of these, so give me a moment.

There was LGBTQ+ people said they experienced a range of homophobic attitudes, acts of stigmatization and discrimination from addictions professionals. So this isn't the other clients, this isn't even the staff. This is the actual counselors that these people were engaging and saying they were heavily sort of issues. Often they were saying they were subjected to rejection from their own ethnic minority, so from black people, for identifying is LGBTQ. And then face discrimination from quite
LGBTQ people for being black. So again, we talked about the get black and gay, gay and black, the ultimatum of deciding where your loyalty is and losing a part of yourself by being forced to choose one or the other as dominant. And just the possibility of feeling internal alienation from both heterosexuals of their own group and white LGBTQ+ clients. If you’re in treatment, the point of treatment is support. And the perception is that you’re not receiving that support, is likely are not going to complete treatment and get the resources that you need to live a healthy lifestyle.

Black men who engage in homosexual behaviors are more likely to identify as heterosexual or bisexual even if they have sex with other men. Which is a huge issue because often people think that having sex with another man automatically means that you would identify as a homosexual or gay, and that is not always true. Additionally, in treatment, black LGBTQ+ identifying individuals dealt with being accepted, respected, feeling safe. Heterosexuals attitudes or overcoming the feelings of disconnectedness and dissatisfaction with their treatment. I will take more questions at the segment.

While there is no monolithic LGBTQ community, they were often treated in a homogenous manner. Very much like I talked about earlier. LGBTQ+, not black lesbians, not black gays, not gay blacks, everyone was grouped together and no real breakdown.

Black LGBTQ+ identifying individuals said they not only experience racism and homophobia, but dealt with gossip, intimidation, discrimination, isolation, social rejection, some people even dealt with vandalism and sexual assault. Ask yourself how many of these items on this list are discussed or dealt with in your practice as an addictions or other type of counselor? How many of these issues do you come across or even talk about dealing with on a regular basis in the event that you have an individual who was black, LGBTQ, and has an addictions issue?

There is also a subculture of black men that have sex with men and women for drugs or money to purchase drugs. And those individuals do not necessarily identify with LGBTQ+, but these are the behaviors, and it sexual behavior plus the drug use. And there is a specific sort of vernacular that goes along with that. And there is a strong
distinction between men who have sex with men and men who have sex with men and women. The men who have sex with men and women do not like to be identified in the same way as the men who have sex with men. It can be confusing and compounding -- confounding. It is something that I do not understand fully myself and I am working very hard to lower my ignorance about.

And then there is the actual or perceived vices, stigma, discrimination that were causing problems when entering and completing treatment. I can take a couple questions.

>> Yes. Charity asks, can you advise strategies that can be used to promote awareness equity in advocacy in conservative rural communities in regards to black LGBTQ identifying individuals, particularly youth.

I believe that I will address that at the end when I give some recommendations. Again, if you don't take my recommendations at the spot for you, please feel free to ask that question again.

>> What is the best way to approach a new client that would be respectful when using terms? What would be a good opening question or approach?

>> It's a sort of difficult dance, and I personally believe it's inappropriate to ask someone if they are homosexual or LGBTQ+ in a sort of direct manner. But if the individual that you know or sort of hinting that it's okay to ask, then just be direct. Ask the question. Is okay that ask your sexual orientation? Or how do you like to be referred to? What is your pronoun? Be very, very direct and open. Because it's leading with respect. And if you lead with respect, letting the individual know that even if you don't have the answers you are taking them and you're trying to build a rapport and build a connection with them in opposition to maybe just guessing or not saying anything. I can take one more.

>> Let's see. Can you! The question, heterosexual who experiments with other men who don't consider themselves gay?

>> Having -- sexual orientation is greater than just what your sexual partners are. It's a mindset, it's a lifestyle. There are so many things that go into it. And just because an individual may occasionally have sex with another man, doesn't mean that that person identifies as homosexual or gay.

Having sex with -- the way you identify is based on multiple factors. And there are lots of people who have sex with women who don't identify as straight. So sexuality for me, is a
continuum. It's a spectrum. It's not these neatly defined boxes. Anything very often when we think of sexuality as very neatly defined boxes that we can check and say if you check any of these boxes, that is where you fall. But it's not quite that simple. I'm going to move on because I'm looking at the time and I want to make sure I get through everything. So Peter I will let you know when I can take more questions. >> Thanks. >> Some other issues that are present in treatment, I found that research article, by Lyons, -- about indigenous transgender individuals at what they talked about facing was stigma via social rejection and sometimes violence. And this is in treatment. An phobia that was either felt actual, or perceived by them from other individuals in treatment. Some of the other treatment issues were physical and structural barriers of segregated housing, segregated groups, which basically, it can work in two ways. Sometimes it makes people feel very safe, but sometimes I mix people feel like you're pushing me aside again. I'm not allowed to interact with other people. Which doesn't allow me to share my experience, which doesn't allow people to understand what my experience is and how is different for me. Also negative attitudes and a lack of general knowledge about black LGBTQ identifying individuals. Isolation from or internalized to stigma due to fear of experiencing stigmatization was a really big issue. Often, LGBTQ people specifically transgender people thought that just their presence was a disruption to other people in treatment. And so it forces them to limit what they shared. Forces them to limit them in completing treatment in some instances. And treatment centers igniting feelings of isolation, being unsafe, or unwelcome. So as I've been going through the peasant the PowerPoint presentation, here are some questions I want you to ask yourself equated your mind go? What were some of your automatic thoughts as I read through the previous slides? Were you thinking things like this is a big deal? Why do they need to be treated differently? It's not my responsibility to learn this information. Why don't they speak up? Were those some of your automatic thoughts? Why do you believe you had those thoughts? Is it some internalized negativity towards black people? Is it internalized negatively toward LGBT plus people or both?
And if you did have any of those thoughts, you believe that meets the beneficence and non-malfeasance standard? And if it doesn't come I want you to really think about checking those thoughts and thinking about how you can move around them. And if you don't know, I'm here to help you. Here are some possible interventions that counselors can use when dealing with LGBTQ+ identifying black individuals in their addictions treatment.

Study on your own. Human sexuality is not a requirement for certification or renewal of certification as an addictions professional. Treatment providers may not be adequately trained peer so it is important that you take the time to do some studying on your own. Learn skills for a judge nonjudgmental approach that creates a safe space for these individuals to express their needs.

Use motivational interviewing skills to help build rapport and break down barriers. The perception by black LGBTQ+ and identifying individuals of Homer negativity, stigmatization, racism, discrimination, those are possible barriers to them being able to stay in and consent can successfully complete treatment. So it's important that as the professionals break down the barriers, rebuilt the rapport so we can provide them proper assistance.

The aware of your own attitude if your attitude is negative or ambivalent, and change it. I looked at a couple of studies like this one by Washington and Brocuto, survey 350 addictions professionals in rural and urban areas and showed that nearly half still held ambivalent or negative attitudes and had limited knowledge of the needs of the LGBTQ+ population. The affirming and work from a positive regard stance. For black and other nonwhite LGBTQ individuals may need to include components of self-esteem enhancement racial identity formation and solidification. Because these are things that they struggle with. Again, very often, these people aren't dual minorities. They have to deal with not only being LGBTQ+, but in a cultural minority.

Provide equal respect. Even if you stand firm on the belief that sexual orientation is a choice, there are so many other human choices that are afforded not discriminate in protections such as religion, your job, where you live. So regardless of whether or not you believe sexual orientation is a choice or is a phenomenon of nature, provide equal respect. Because you respect other people's human choices.
Place more attention in addictions treatment on settings on strength best models, resiliency, and prevention.

Research consistently shows that prevention methods with addictions are fantastic tools. So if we could really create more systems of prevention, I think we could do it great justice.

The introspectively aware of the role that racism and Homer negativity has played in your own development and work to resolve any conscious or unconscious residual bias or prejudice that you may hold.

In that same light, introspectively identify if unconscious bias, racism or Homer negativity are influencing your care provision and if they are, work to actively change that.

Additionally, it's great if you can work with LGBTQ people from the following perspectives. Empathetic understanding. Genuineness. Openness. Flexibility. Commitment, positive regard, specifically unconditional positive regard, using appropriate self-disclosure and confidence, because that builds confidence in the relationship. Build the rapport. It breaks down barriers and creates a safe space for the individuals to really share what is at the root of their problems.

Recommendations. We are wrapping up now. Here are some universal recommendations. If you’re in a state that does not require trainings, advocate for that. States could benefit if they required formal training in cultural competency and human sexuality relevant to LGBTQ+ people and other sexual minorities. Currently less than 30% of state credentialing organizations required training in cultural diversity and human sexuality is not a requirement at all, period.

Ask yourself, do you believe this should be a requirement for licensure? Why or why not? If you do not believe so, what is blocking you from that believed? Because the more we understand about cultural competency, the more we understand about human sexuality, the more relevant it becomes in our practices and how we present our services to our communities.

And take part in personal and immersive experiences with black LGBTQ people when you possibly can. Because that's going to assist you in expanding your cultural
sensitivity and your overall understanding. Reading and research is fantastic, but the depth and breadth of personal interaction goes so far beyond.
Also as we discussed earlier, find a way to create more research on the addictive behaviors of racial, ethnic, and sexual minorities. Because it is obviously greatly needed.
And ask yourself what are some of the management which you are your colleagues can create personally immersive expenses with black LGBTQ+ individuals? Is there a community center? Is there something in your neighborhood that may be available or is there something you can create to attract these people and bring them in and help them get a safe space?
Also create empirical research relevant to that community. That something you could do? Is that something you could have happen at your place of work or with your overall institution?
And that's it. Here are some of the references that I know you're probably only pretending to care about. And we have a couple minutes for questions if we have any more, Peter. Thank you all.
>> Yes, Dr. Porter. I just want to show that a colleague just sent me a text stating that the House has passed the equality act today and has passé it to the Senate, which has always been blocked when it got to the Senate. So it is headed to the Senate at sometime in the next you days or weeks.
>> That is fantastic. I will have to read up on it.
>> Maurice, maybe you have covered this, but he states, are there any articles that has research surrounding the history of LGBTQ+ -- with chattel? I have heard that the way enslaved Blacks were treated sexually particularly in certain geographic implications may have an impact on the output of this population, particularly Caribbean population.
>> I'm not 100% sure, but I think that this is the article I think it is, check this article out. Is the Black Community More Homophobic, there are a lot of other words, it's by Marjorie Hill, and the date on this is copyright 2013. It gives a plethora of information about different books and things that are really specific to the black community and how homosexuality is viewed from a historical standpoint. And it focuses really heavy on
slavery and the Harlem Renaissance. So that may be a good resource for you to check out.

Any other questions?

>> There is a movement for LGBTQ people to establish church gatherings period your comments on that?

>> I think that has always been a movement. I think that is a large part of nondenominational churches where the focus is about the connection to God and not specifically the rigidity of religion, and the specific doctrine. And I know lots of LGBTQ people who are consistently looking for faith and a place of faith where they feel accepted. So I would say yes, that has existed movement for as long as I've been alive, probably, and maybe far before. I'm a lot younger than I look. I will just say that I'm 25. Thank you.

>> And last question, because we are about out of time, what drew you into this demographic?

>> I am a black LGBTQ+ identifying individual. So it's extremely important to me because I live a lot of this firsthand. So is very easy for me to create this presentation because it worked. And what was most interesting is the people at NAADAC wanted this presentation more than I did. I tried to sort of steer away from something that was so close to myself, they were like, no, this is great. This is what people need. And this is how it all happened. But I am this presentation.

>> Appreciate you sharing that information, Dr. Porter. And we are all out of time. Lots of great questions.

>> Yes P thank you also much.

>> I want to thank Dr. Porter for an excellent presentation.

>> Thank you. I hope y'all got my email. If you have more questions, feel free to email. It was on the PowerPoint peers.

>> Just a reminder, to return to the virtual seminar page on the NAADAC website for you access the session to find a link to the CE quiz. Instructions for your CE certificates is attached to the chat box and available on the NAADAC website.

And my last comment, I just want to talk about NAADAC and being a member. I would hope that you all will check into becoming a member as well. Because whenever I go
out, I’m a member of the Houston chapter as President, and whenever I got to speak to other professionals, I always talk about being a NAADAC member. So for me, I tell people the most rewarding experience of being a NAADAC member’s networking opportunities that have enhanced my career. Membership brings about affiliation, affiliation gives you that platform for your voice to be heard as an advocate for the people you serve as well as for addiction professions. So please join so your voice can be heard.

So this is the last session for today. We have another half day of sessions planned for tomorrow. Please join us for our first session tomorrow morning and tomorrow afternoon Integrating Music Into Substance Use Disorder, Treatment for Resilience of the African American -- our presenter is Grady Anthony Austin and facilitated by Helena Washington. It will begin promptly at 12:00 p.m. Eastern time. Make sure you know that. 12:00 p.m. Eastern time period we hope to see you all. Stay safe and had a good evening.