00:00:10:03 - 00:00:41:23
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[Shannon Winnubst]

In this module with Ronald G. Murray, you will learn a wealth of information about the particular kinds of dynamics involved in the thorny issue of substance use disorder in LGBTQ+ individuals and communities. Mr. Murray has over 16 years of experience as a service provider, community advocate and clinician in Columbus, Ohio. He has worked with Equitas Health, one of the largest LGBTQ+ and HIV AIDS serving health organizations in the country.

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As Associate Director of Health Advocacy. And he is the current Board of Trustees president of Stonewall Columbus, the largest LGBTQ+ community center and organization in Central Ohio. Mr. Murray is also involved in the house and ballroom community, which is an underground culture and community within the BIPOC, LGBTQ+ community. He is a founding father of the House of Exclusive Landon, and is the overall Godfather of the House.

00:01:17:05 - 00:02:01:01
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The work of this module is particularly important and difficult because it focuses on one of the most taboo issues of contemporary US culture. What I call the expression of pleasure. At the heart of homophobia, and arguably of transphobia as well, is the judgment and policing of how we LGBTQ+ folks experience pleasure. The history of LGBTQ+ communities and politics is full of intramural between ourselves, disagreements about how we should respectively present ourselves to the straight and cis world for acceptance. As one might imagine

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a lot of this turns on how we express our desires and pleasures. In 2003, queer theorist Lisa Dugan coined the very helpful term homonormativity to conceptualize this growing trend in Lgbtq+ communities to try to appear normal to mainstream society. According to straight and cis norms, for example, we can easily see homonormativity in the modeling of the new nuclear family by LGBTQ+ couples through monogamy, adoption and birthing of children, and home ownership.

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The friction inside LGBTQ+ communities between those who are at peace with becoming normal, and those who want to express pleasure and desire beyond the constraints of straight, cis and mainstream norms. That friction will likely never die out. But across this fiction, we can catch a glimpse of how, for LGBTQ+ individuals and communities, the expression of pleasures is the very heart of both our stigmatization and our liberation.

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Given that historical context, when Mr. Murray turns our attention to the difficult dynamics involved in substance use disorder in LGBTQ+ persons and communities, we in the community are on thin ice. I want you to consider three conditions in Mr.. That lead to Mr. Murray's presentation. These conditions sort of fall together like dominoes. First of all, as the ones who have daily lived experiences of navigating homophobia and transphobia, we in the LGBTQ+ community are already struggling with shame and anxiety about our desires and pleasures.

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Secondly, given this daily lived experience, we may be in even greater need of a panacea. And in this alcohol drenched and substance filled culture of the United States, we're likely turning towards mood altering substances at high rates. As Mr. Murray's data will confirm. So if we just put those two first conditions together in a kind of equation of queer plus substance use disorder, we see a kind of double shame emerge at the very heart of our identities as LGBTQ+ individuals

and communities.

00:04:41:18 - 00:05:32:11
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Namely, at the heart of how we practice pleasure. Even further, if we add race into it stigmas about pleasure into this toxic brew, we get a truly terrible result of what I would call a tripled shame for LGBTQ+ individuals and communities of color who are struggling with substance use disorders. Finally, the third condition, shows how crucial it is for health care practitioners to educate yourselves, just as you're doing on the specifics of caring for LGBTQ+ individuals and communities. Medical institutions and health care practices often are sites of further stigma, shame, and sometimes even violence for LGBTQ+ persons.

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Given those histories and those lived experiences, we're less likely to seek medical care for substance use disorder or, as many modules explained, for any health problem. Those three conditions falling together like dominoes, I suggest, give us a strong sense of the cycles of pleasure and shame that Mr. Murray unravels in this module. As Mr. Murray puts it, the fear of judgment can be completely isolating and paralyzing for LGBTQ+ individuals struggling with substance use disorder.

00:06:08:15 - 00:06:44:10
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Perhaps more than any other module in this certificate, Mr. Murray insists that effective health care practitioners must suspend all judgment. We have to ferret out all biases, and we have to commit to a constant kind of self-education and reflection when offering the best possible health care practices for LGBTQ+ individuals and communities. Once again, I believe that the lessons in this module will improve all forms of health care for all of your patients.

00:06:44:12 - 00:06:45:13
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Enjoy the module.

[Ronald Murray]: Hi,
my name is Ronald Murray.

I'm a licensed social worker,
licensed criminal abuse counselor.

I've been a licensed social worker and
chemical dependency counselor for almost

20 years now here in Columbus, OH.

I currently work as an associate Director
at a local LGBT Health Center here in

state of Ohio.

We are the largest.

We specialize in working on LGBTQ health
from the whole person.

From HIV/AIDS services and care and case
management to mental health chemical

dependency counseling, primary care,
services and things like that.

Nationally,

I'm a community advocate and activist
that I work specialized in mental health,

HIV/AIDS services.

I provide training and education and
cultural competence,

how they work for individuals who are
persons of color,

who are LGBTQ plus teaching other
individuals how to service those

individuals they might not have
experiences with.

We're going to talk with substance use
and substance disorder in our population.

I'mma start off with this quick quote
from SAMHSA's website.

It says: "People who identify as lesbian,

gay, bisexual, or transgender,

questioning often face social stigma,
discrimination,

and other challenges not encountered by
people who identify as heterosexual.

They also face a greater risk of
harassment and violence.

As a result of these and other stressors,
sexual minorities are at higher risk for

various behavioral health issues."

What I just read to you really means in
layman's terms is that people who are

LGBTQ+ really experience often times of
racism, homophobia,

transphobia and discrimination at higher
levels than people who are heterosexual

based off their sexuality,
based off their gender description or

non-gender description.

Those are things that we're here to learn
more about why and how that is,

how can we as people,
individuals use them to be humans to one

another and how to curtail as they're
happy in our practices.

Substance use and misuse are significant
concerns amongst the LGBTQ+ population

community.

This intersection,
the unique challenges and disparities are

really exasperating this community.

A lot of people who are not in the
community or who work with the community

actually may not know that.
These types of issues are rampant within

the LGBTQ+ community for various reasons.

They also contribute to other existing
health disparities and negatively impact

the overall health being of the
individuals.

You might not want to seek care because
the experiences you've had in the past

based off your sexuality,
based off your gender description.

So I may be an addict,
I may be suffering some of the issues.

I may not want to get any health issues
done because I've had experiences when

I've gone into care before based off of
people judging me,

based off of people not providing care
for me or services for me,

based off of how they see or how I
present.

So imagine being someone who is suffering
from substance abuse disorder and going

and having that same experience.

These are some reasons why these issues
go untreated.

Let's start with our definitions.

So every time I do trainings like this or
education about this,

we want to make sure we have the baseline
definition of what we're talking about

here.

So we're gonna start,
I'm gonna read you what I found what

addiction is,
and that anybody can do Google "addiction,

"

I think we all kind of know what that
really is.

It's defined as a "chronic relapse
relapsing disorder characterized by

compulsive drug seeking,
continued use despite harmful

consequences,
and long-lasting challenges in the brain.

It is considered both a complex brain
disorder and a mental illness.

Addiction is the most severe form of a
full spectrum of substance use disorders,

and is a medical illness caused by
repeated misuse of a substance or

substances."

"What did you just say Ron?"

Addiction is a compulsive disease that
allows you--to compels you to continue to

do something that is harmful to the other
lives and experiences of your life.

So addiction overrules things that you
find important.

It overrules how you care about your
family, overrules about you going to work,

overrules how you care about how you look,
how you function,

things like that because this disease
needs to be fed.

Then we talk about substance use and
misuse.

What does that mean?

Substance use the consumption of
psychoactive substances,

including alcohol and drug.

The definition officially of drug misuse
refers to "use of a substance or for a

purpose that is not consistent with its
legal and medical guidelines,

most often a prescription medication,
drugs."

For instance,
everyone has a grandmother or auntie who

had a toothache and she didn't take all
of her Percocets and she kept it in a

pill box and you come and say "Grandma,
auntie, I have an ouchie!"

"Oh baby, go get my codeine."

I then take one of them.

That's technically drug misuse--

talking about that--that's technically
drug misuse,

because the other part about addictions,
addictions is also when your drug misuse

gets out of control and out of control is
that compulsion that you can't control,

which makes your other life skills become
unimportant because that addiction

disease is taking over.

So often the questions we get often times
is: "is substance use disorder defined

the same way as addiction?"

Yes, from the DSM-IV to DSM-V,
substance use disorder and addiction

became the same definition,
they don't think they use addiction in

DSM-V anymore.

And those who are not familiar with DSM-V,

The Diagnostic and Statistic Manual is
how globally individuals diagnose

different types of diagnoses is when
you're clinically like social workers,

psychiatrists--psychiatrists, psychology,
even sometimes medical doctors just give

you diagnosis,
mental health and substitutions for

diagnosis out of this book.

And so there's a criteria numbers that
they give you globally, international,

there's a group of smart people get
together and say, "Hey,

these are the numbers.

These are how we're going to define them."

And so the reason they had this book so
that anywhere you go across the world,

if I say, for instance, 314.9,
which is I hope it still is an adult

deficit hyperactive--ADHD,
which is probably ADD right now.

But so that's why we do DSM-IV and V.

So addiction is now called substance use
disorder.

So you might hear people say "SUD" or
"addiction,"

those are the same things.

DSM-V classify someone as having a
substance use disorder when the recurrent

use of alcohol or drugs cause a
significant impairment.

Again,
when it causes the inability to function

in these certain fields of their lives.

This can include health issues,
disability,

failure to meet work responsibilities,
difficulties at school and home.

The most commonly used,
misused or abused drugs within the LGBTQ+

community are alcohol, tobacco, marijuana,
methamphetamine, cocaine, and opioids.

So for the next portions that we'll talk
about a little bit,

there was a study done in 2019 from
SAMHSA,

the National Survey of Substance Disorder,
a little bit about the study and we'll

talk about some of its limitations in the
study as well.

They just started LGB--lesbian,
gay and bisexual men and women--persons

towards cisgender.

That's important to note now,
that are 18+.

And we'll talk a little bit further more
about why "T" is only a transgender

person's,
a person identified as transgender.

And I also don't think that anybody who
would identify it as gender non-conformer

or non-binary is less than this as well
because I don't see them in this study

piece there.

And in this particular study,
the first talks a little bit about opioid

marijuana, methamphetamine use.

They told us that there was a 37.
6% increase of use of marijuana,

opioids and methamphetamines from 2018 to
2019 amongst the LGB population adults.

And that's 18 plus.

That's a significant increase from in one
year.

And now with marijuana use,
there was a 16% increase of

psychotherapeutic drugs,

that means individuals who were
prescribed medications through the

psychologist or psychiatrist,
there was a 16% increase in those 2.

3 million,
those people who took the study.

Another thing to note here is that
there's similar,

there's a rise in marijuana use in the
LGBTQ+ community over the past five years.

And that's what's me looking at some
other information in the past five years

means that 2024 to back to 2019 since
that last study was done,

a lot of can be the social change or
legal changes.

A lot of states of legalizing marijuana,
There's a lot that've destigmatized THC.

An increasing number of States and
countries moving towards

decriminalization and legalization of
marijuana for medical,

recreational purposes.

Society's perception of cannabis has
shifted.

There's a lot to saying that individuals
are now firing their way to profit off

cannabis and marijuana instead of
criminalizing it.

And so we know that when it becomes
profitable,

those of us who are sexual minorities or
minority groups again who were once being

criminalized for are now being sought
after to be more of the people who are

purchasing it as opposed to those who are
being sought to be convicted of it.

It's essential to recognize though that
though it's being criminalized and

destigmatized,
efforts may play to role increase use of

marijuana.

Factors also change social norms,
peer influences and mental health issues

also exasperate even though they have the
marijuana use.

We have some wonderful benefits that we
know from having THC use and candies that

a lot of people speak to.

However,
that still doesn't address the other

multi-factor things that individuals
suffer from with just drug use alone.

So using marijuana alone,
there's an answer to some of the other

things that individuals face in this
community.

Another thing we talked about in this
study that I referenced before is

subscription pain reliever misuse and
heroin use of my LGB.

So when we talk about prescription pain
reliever misuse,

so that means using more than its
intention.

So that means if you, again,
had a tooth pulled at the dentist,

for example,
and they said take one pill every eight

hours per pain and you took 5 pills every
eight hours--I'm exaggerating--

and they gave you 14,
it lasts you 2 weeks and a 14 only lasts

you three days, thats misuse.

And also the other thing we have to note
here is that often times as I said before,

that misuse kind of comes into addiction
in all or most cases of substance

disorder.

So often times a lot of individuals for
instance,

will start with using opioid--prescribed
opioid and then run turned into using the

heroin use because opioid and heroin hit
the same brain receptor,

so,
and it's cheaper to get heroin than it is

to continue to get the painkillers
prescribed through the most legal ways

that people are doing it.

So what we do find here,
one of the charts that I looked at and

there was an increase of pain reliever
misuse from 2016 to 2019.

It went from 1.
1 million in the individuals that were in

the research in 2016 to 1.
3 million in 2019.

Pain reliever use disorders,
those any of us who were diagnosed with

it were 181,000 and 2016 and 220,
000 in 2019.

Those individuals who are so to be
diagnosed with it,

that means they had to have treatment.

So that's what the that's why the two
numbers are just starkly different.

So it doesn't mean that because 1.
3 million in 2019 and only 220 K in 2019

are vastly different numbers.

It just means that only 220 thousand of
them actually went into care and got

treatment for them somehow or other,
whether they were arrested,

whether they went to the doctor where
they got some type of diagnosis.

Because the only way to get diagnosed
with pain reliever use disorder is

someone had to diagnose you with a DSM 5,
as we talked about earlier.

And there's also pain reliever misuse
initiates,

which means individuals who are on pain
reliever initiates means those

individuals started medical assistance
treatment,

which is medications that help to start
the withdrawal fight,

the use of medical assistance treatment,
the effects of opioid use disorder.

There were 205 K those raised up on 2019
from 196 K in 2016.

And also, I'll note here also too,

that in the number of individuals who

used heroin from 2016 to 2019 raised,
as well as those who were diagnosed with

heroin use wasn't a lot different to 2016
to 2019 with the diagnosis from 77,

000 to 90,000.

It's still a lot of people,
but it just wasn't a large increase as we

saw with the misuse prevalence rates
among LGBT individuals.

Research indicates there are higher rates
of substitutes and misuse compared to

junk population.

There's higher rates of individuals who
are LGBTQ plus amongst this population

diagnosed some misuse and disorder than
there are over the heterosexual

population.

Why is that?

It could be because there's smaller
individuals who are being diagnosed.

Who identifies the population?

So if you have a smaller dense population
who are going in for treatment,

who identify as this population and
they'll have a higher rates of those

individuals who are small population who
have been diagnosed,

they're going to have a higher rate than
you have a larger population of

individuals who have less diagnosis of it,
if that makes sense.

Just statistically,
it's going to be a small amount.

However,
we do know that there are more people who

there seems to be a lot more people of
those individuals who are in treatment

who have a lot more diagnosis,
several diagnosis than those who are

heterosexual.

[Ronald Murray]: So we can't talk about substance abuse disorder unless you go to

talk about mental health because we-they kind of run hand to hand,

when I mean they kind of actually do like what comes first,

the chicken and the egg?

We do know that your substance abuse disorder or substance abuse can also

exacerbate your mental health problems.

They can carry a negative spiral to addiction, emotional damage.

Often times when I've done treatment, when I've worked with individuals who

battled both of them together, coexisting disorders,

it's a struggle throughout.

Which one came first?

Was it the mental health or did the mental health bring all the substance

abuse issues?

Or did the substance abuse bring on their mental health?

Especially when they're having a crisis or a relapse,

you're not as sure which one brought it on.

Often times you have to wait until the individual,

especially in the middle of a drug episode,

come down because when they're in the drug episode,

it can mirror a lot of mental health

diagnosis.

And vice versa,
when they're in a mental health crisis,

it can we mirror a lot of drug- like it
can look like they're on episode with

drugs.

So often times that's why it's important
sometimes for those of us who in law or

law enforcements or those of us who in
community mental health agencies or even

just in the community,
it's not always what it seemed just

'cause it walks like a duck and quack
like a duck, sometimes it's not a duck.

There's other stuff that's happened that
we maybe have to be aware for and prepare

ourselves to educate ourselves as much as
possible.

Now when we talk about serious mental
health,

those are things like schizophrenia,
depression, things like that.

We're not talking about things like mild
things like ADHD and things like that.

When we talk about serious mental health,
things that are high end that kind of

enable you from functioning day-to-day,
psychotic features,

things with psychotic features,
things that enable you, you,

you're hearing voices,
you have auditory hallucinations,

you're seeing things that are not there,

those are serious mental health things
that we're talking about here.

According to the research,
we did see an increase of 24.

2% of individuals who are 18-25.

It's important to know that they're in
serious mental health.

That's kind of where it usually comes out
whenever just have those psychotic

features or diagnosis of serious mental
health that comes between those age years.

And what's important out here is that 38%
of those individuals who identified as

having SMI or serious mental illness and
that age group in this research, 38%,

they got didn't get any treatment.

And getting any treatment means they did
not go to the doctor getting get on

psychotrival drugs.

And many of them turn to using drugs,

street drugs, for lack of a better word.

The other piece to talk about is the
co-occurring issues.

And that means the individuals who are
diagnosed with substance abuse and mental

health.

And so we again, we know,
know what came first,

the chicken or the egg.

And so to actually have co-occurring,
someone had to officially diagnose you

saying you have this and this.

Same thing,
it's like when you have HIV and you have

AIDS diagnosis,
individuals who have AIDS diagnosis,

you don't have until the doctor says you
have that diagnosis.

So it's kind of same thing,

They do have a mental health and
substance disorder.

A list of drug use at 66.
2% from 2016 to 2019.

But there's an increase of individuals
who had serious mental health illness, 1.

7 million from 4.1 million.

That's a significant increase.

That's a 66.2% increase.

There was a slight increase in marijuana
use in the past year with this research

done 2019.

By 2018-2019,
there was a increase at opioid use,

binge drinking, alcohol and cigarette use.

But the really thing to really focus on
for this research that I looked at was to

with the increase of illicit drugs from
2018 to 2019, which was 65.2%.

Locations where people get treatment at.

And then this is kind of where we,
the-the train starts rolling.

These individuals in the research itself,
there were 2.

6 million of them who were diagnosed with
substance disorder and they talked about

where they got treated at in the last
year.

287,
000 of them said they went to self help

groups.

That might have been AA, Al. Anon,

all those other groups, church groups,
those were all self help groups.

Self group groups are usually groups who
are peer led.

Those are groups for individuals that
most people from arranged groups are peer

led.

They're not clinicians, things like that,
but they are people who are suffering

from some of the same conditions who have
been in recovery or-or have not have long

term sobriety and they are helping other
member communities to get to where

they're at.

209,000 of them went to the private,
their private doctor's office.

A lot of people choose to get treatment
in privacy with their doctor and that

might mean some of them got medical
assisted treatment.

Again, medical assisted treatment,
things like methadone, suboxone, vivitrol,

supplicate,
where you give medications to help fight

the withdrawal or the effects of opioid
addiction.

A lot of them got outpatient mental
health treatment.

It was 190k of those outpatient
rehabilitation treatment,

but you have inpatient rehabilitation
treatment, 144k of those.

So the difference in significance and

understanding what that is,

is that when you're doing substance use
disorder treatment,

it's four level actually where you go
detox to residential,

then you go to inpatient or which is
residential, intensive and outpatient.

So you kind of step it down a little bit.

And so people outpatient are less
adjusted then an intensive outpatient.

So if we're doing outpatient treatment,
that would be they're getting treatment

or counceling twice a week or maybe once
a week.

Whereas at intensive it's like 3 times a
week or 9 hours a week.

If they're doing the hospitalizations,
especially when they come from detox,

that means that they are actually fully
seeking treatment.

They are sequestered from the community.

They're embedded in treatment all day
long with nurses and doctors at medical

rehab and things like that.

And so a lot of those are getting
treatment.

The other part about that is a lot of
them are getting treatment in the

emergency room,
They're getting diagnosed in the

emergency room.

The emergency room is providing
withdrawal medication to them and they're

releasing about some of them might be
getting started getting initiated on the

in medical assisted treatment there,
getting a link to saying, "Hey,

go to the streaming program here."

We don't know if they're accessing them
for the the research didn't tell us that

they follow up after that and there's 16,
000 that are getting treatment in prison.

and I'm going to talk a little bit about
prison and why that's important to talk

about here for mental health purposes for
our population.

Now,
even though we talk about how prison

serves as a way of rehabilitation and
things like that,

it also serves as a place of trauma and
stress for many LGBT people.

Many people have illnesses and treatment
problems inside of prisons,

though with LGBT and other,
the criminalization of substances and the

lack of access to appropriate treatment
in the community can result into these

individuals being in prison.

You have a large number of individuals
who are in prison for nonviolent crimes

because they're addicts.

Often times from the 80s,
we had the crack-the crack era,

we had those individuals who were
suffering heroin and opioid addiction,

individuals who were found with drug
paraphernalia or found with certain large

amounts of drugs on them.

And they were had several charges for
these same things.

And instead of they were charged,
instead of seeking treatment externally,

they were in prison for years and years
and years.

So you also have these individuals
dealing with that, dealing with stress,

dealing with trauma,
dealing with all types of abuse, violence,

I'm not sure,

I've never been in prison, these things

I've heard from clients that are
happening there.

Imagine that and also imagine being
LGBTQ+ inside the prison walls.

Individuals who are LGBTQ+,
particularly those who are transgender

and gender non conforming often
disreportedly experience different types

of experiences in prisons.

Especially for those who then those who
are LGB and cisgender identifying.

This also as accentuating circumstances
to their to their concerns and issues

where many prisoners don't identify their
trans- their transness,

they're who they are authentically.

So that offers another piece of stress
and trauma on their issues there as well.

So information about mental health from
this research and mental health and

co-occurring issues with the United
States in 2019 from the research,

serious mental health among LGBT

populations between the ages of 18-25 and

26 to 49 increased compared to 2016.

Major depression episodes with severe
impairment between the young adults,

significantly increased compared to 2016
and major depression episodes increased

amongst the same age group in 2018.

There's a huge treatment gap for
treatment among mental health substance

use disorders in the LGBT population.

Substance use disorder significantly
increased suicidality amongst LGBT

population amongst age 18 and older
increased in that population.

During this research,
self help groups ranked higher as an

outpatient then outpatient rehabilitation
facilities for these locations with

substance treatment was received.

Now this is important to note that self
help groups ranked higher and outpatient

rehabilitation facilities for research
that was done in 2019.

It was important to note that in 2019 I
was before the pandemic of March 2020.

So I'm curious to see what this follow up
would be,

because keep in mind it said "self help
groups rank higher."

So I told you if self help groups result
were peer-led,

so that means I needed to be around my
peers or be around my people.

So then we went into an isolation for
almost two years.

So how do you think

these numbers look now?

This same research was done and after
March 2020 where I couldn't get out of

the spaces that I was-that was causing my
trauma.

And I've talked to you a little bit about
the limitations of the research that was

done.

There was no research.

Just when I keep looking for research
specific about transgender individuals,

persons of trans experience and substance
use, it's limited information.

There's research currently being done,
but none the results are out yet.

And I'm also certain that there's some
research being done,

especially after the pandemic as well too.

So I do apologize that I don't have any
specific data regarding the T of LGBT.

Those are things that we're looking at
nationally.

Those are things that the researchers are
looking at.

Hopefully they're looking,
and I know that we're looking at HIV from

the HIV world as well.

There's always a gap when it comes to
those things because we're still learning

and we're also doing a deficit to that T
part of our population,

those very significant individuals there.

And we see how they're not being
represented in the research.

And we're assuming that there's things
about them that we're making assumptions

about,
but we're not bringing them to the table

to ask them what their needs are and part
as part of having them in research and

finding out how do we meet those needs.

[Ronald Murray]: There are factors that
increase to the increase of use of

substance in the LGBT community.

I talked a little bit about them earlier.

Trauma is a big thing in this population.

Think about growing up as a young gay boy,
gay girl, trans person,

not understanding who you are and live in
a family that understand who you are and

doesn't identify with who you are
scribing to be and the abuse you may have

experienced at home and the community to
bullying, early childhood trauma.

We do know that things that happened to
us as a child stays with us as an adult.

LGBT youth are at a high risk of being
victims of sexual abuse during childhood

and their heterosexual counterparts
because they can't tell anybody their

truth.

They don't believe everybody's going to
believe them and they're also threatened.

They're scared.

The people who are most in charge to
protect them or are in charge to protect

them are the same ones who are abusing
them in a lot of cases,

LGB adults are also high risk for
traumatic experiences and their partner

violence is never goes reported.

Sexual assault that never goes reported.

Gay bashing happens a lot.

Things that happened to a lot of LGBTQ in

the community that never go reported.

It happens on a daily,
whether it's workplace violence,

workplace microaggressions,
workplace trauma,

stuff that happens in your doctor's
office.

These are traumatic experiences.

And so we wonder why individuals don't
get treatment because they've had these

experiences before they came into our
doors.

So I remember had a client that would
come to us on the bus and I would have to

tell our front desk is that: imagine what
they've gone through.

They rode the bus for three hours.

That means they've gone through three or
four community neighborhoods.

And this individual has,
we don't know what they've gone through

this traumatic experience being on this
bus,

being who they are authentically and they
come to us.

We have to present them in a pleasant
manner because the trauma they experience

and get here,
we can't further compound that trauma to

come to us for care and treatment.

Isolation is another experience that LGBT
community experiences.

And again,
think about what we just came out of,

this big pandemic.

We couldn't touch anybody.

We couldn't hold anybody.

We had to put on the mats.

We couldn't have smiles.

Everything was virtual.

Everybody was 'Zoom me this,
' 'Teams me this', 'webinar me this',

however, go outside air hugs.

But if we're a community of people that
that thrive on human touch,

this LGBT community does that 10 times.

If the LGBT community has a higher level
of incident rates of drug and alcohol use,

I'm sure it's a higher incident rates
that need to be hugged and touched

because they didn't have it growing up
because that's part of what the traumatic

experiences is.

The lack of having a support network
through family and friends can make

someone feel isolated and lonely.

One of the biggest fears of a lot of gay
individuals is being,

I see from their families

they were so connected to.
A lot of gay individuals, grandmama boys,

mama babies and,
and a lot of them don't come out because

they don't want to experience or have
that separation from that,

that connection that they have.

And a lot of times that fear of them

being isolated from that family structure

is so great that they can't authenticate
who they are.

That's traumatizing itself.

That's depression.

When you can't live your life as you are,
that exasperates.

While I'm using my dress because I'm
hiding that pain, I'm pushing it down.

Isolation experiences by this community
stem from a lot of things:

discrimination at home,
discrimination at school, work,

places where you have unique factors for
your addiction.

Studies conducted in-for the CDC tell us
that lesbian,

gay and bisexual transgender youth have
increased numbers of violence and

bullying at school.

The place where you're supposed to find
out who you are,

learn your voice is the place where most
of them find the worst,

heinous crimes atrocious to them.

We see it everyday the news,
individuals can't use the restroom that

they want to use the restroom because
what people have ideas about where she'd

use the restroom.

The basic needs of us are basic human
functioning of argument about where I

could use the restroom,
individuals scared to use the restroom,

and if you have people busting indoors
saying you're not supposed to be here

because you look like this,
that is traumatizing in itself.

Adult members of this community often
face rejection at home,

a struggle to find a community of friends.

Then we talked about barriers of
treatment.

So we talked about violence,
we talked about trauma.

Now we talked about how do we get the
treatment?

There's stigma associated by being in
treatment.

There's stigma about why am I getting
treatment?

Does it mean I'm crazy?
Does it mean I need help?

Does it mean I'm an addict?
Does it mean that the person who's

working with me might not understand me?

Are you going to judge me?

The fear of judgment and discrimination
in this population is really large.

Do you understand how to overt this
population?

Lack of culture competency is a big fear.

That's one of the big barriers,
getting my pronouns correct.

For any many individuals,
their pronouns are correct is just like

understanding what my race is,
that's just as important.

For me personally, for instance,

my name is Ronald or Ron.

However,
I don't allow you to call me Ron unless

you dress me as Ronald 1st and ask my
permission.

That's important to me because my mother
and father named me Ronald for a reason.

And if you want to shorten,
you should have my permission.

That is my identity as well as my gender
and my pronouns.

So those are things,
small things about getting noticed and

that's part of my culture.

That's part of learning my cultural
competence.

Many treatment providers may lack
understanding on trainings or need

training LGBTQS populations because they
don't provide adequate and appropriate

care.

The one-size-fits-all model doesn't work
with this population.

There's legal and policy barriers that
prevent from treating this population

properly.

Discrimination laws and policies may
hinder access to healthcare, housing.

Here in Ohio,
we have law-we're now thinking a

legislation fighting against treating
trans youth with gender affirming

medication now,

all these House bills things there.

So those are the treatments, the barriers.

You have trans youth who can't get the
gender affirming medication now because

it's now their parents,

the right for the parents,
parents or child how they want to is now

being just in legislation.

Those are things that are bears to care.

People are scared just come in to get
care.

Not just the person himself,
but the loved ones that circle around

them.

Economic inequality,
socio-economic access kind of is

inhibited to getting treatment to care.

I may not have insurance,

I don't know that I might qualify for
Medicaid,

I may not know that I might qualify for
Ryan White, things like that.

There's also sting my associated with
treatment in addition in addition

treatment.

This population is either excluded
entirely from programs and services or

grouped together and sexual monitored
groups instead of being put into a

dedicated category.

Bad experiences in healthcare settings
may also change how their outcomes in the

healthcare will be.

If the individuals are not able to make

it past other obstacles to find treatment

options,
there may not be any further concerns

about their care,

they're not going to come back.

Often times when treatment centers are
seeking care with LGB populations,

are making programs,
they don't have the LGBTQ+ population in

mind.

We're making this treatment population
for the population because they're often

not at the table.

So how can you say we have an inclusive
program,

but you didn't ask to include all the
inclusivity of these people?

How do I want,
how do you want us to treat you?

You don't know that I'm allergic to
peanut butter,

but you keep serving as peanut butter
& jelly salads,

but your lunch is "all inclusive."

Doesn't make sense.

But then when we come in and I have a
bite back, I'll give an example.

Many, many years ago,
I was working at a center and it was a

woman's facility,
primary woman's treatment center.

And there was a trans woman who was in
this the group.

It was a women's group.

Trans woman came into the group and all
of the other women in the group everyday

didn't have any issues but one woman did.

And everyday,
the one woman would stare at the trans

woman and make comments,

she would misgender her, stare at her,
making uncomfortable for her.

And the facilitator and the program
director let it happen day in and day out,

day in and day out,
and it came up at a meeting.

and the facilitated group said: "Ron,
how do I deal with this?

Because she keeps looking at her and she
keeps making comments and I don't know

what to do" and blah, blah, blah.

Do I put the trans woman out to make
everyone uncomfortable?

And I said, well,
if we look at it as race and the trans

woman was a black woman and the person
who was making her comfortable was a

white woman, what would you do?

I would put the white woman out because
that is-that's not appropriate.

So then why is this any different?

What happens is we have to check our
biases;

what I said to her: "You don't want to
put her out because you kind of agree

with her,
but you don't want to say it out loud."

It's the same process and it was an "a-ha!

" moment for her.

She said it's that simple.

It's that simple.

You treat everybody that you would treat
anybody else like a human.

I have a just the right to be here no
matter what my gender is,

and no one else has the right to me feel
uncomfortable.

I have a right for you to create
programming around me and my sexuality,

just as you did with everybody else with
me in mind.

Violence is a big thing in our community,
LGBTQ+ community.

This population is more than likely to be
targeted for crimes other than any other

minority group.

We talk about Orlando,

that happened in Orlando a few years back.

We talked about a couple,

even recently, a couple of months ago,
there was a shooting and another gay club.

We see increased violence during gay
pride,

especially here in Columbus during that
we have like a third-second or third

largest gay pride in Columbus,

and we have an increased number of police
here,

presence here during the pride festival
because we have an increased number of

threats,
so many more threats than the community

even knows about.

And I'm kind of privy to it because of
I'm on a board of one of the pride

committees here,

and so what that tells me is that
people's mirror being authentic with who

they are impacts other people so much
that they want to hurt somebody.

Think about that level of stress that you
deal with every day is you haven't

bothered anybody else and you're just
existing who you are.

You might be a rainbow one,
you might be ascribed to a different

gender,
but that impacts somebody so badly they

want to cause violence you and take your
life.

That stress alone,
knowing that you can't go outside without

having to watch your back.

You can't eat dinner at a counter without
wonder if somebody's going to come up

behind you and attack you is enough to
make you want to sit at home and not seek

treatment.

Homelessness,
the homelessness rates in this community

contribute to a lot of substance use.

A lot of people are still discriminating
people with housing because you can't get

a job if you're discriminating against
get a job or you can't get a house if you

don't have an income and you can't pay

your rent.

There's a trickle down effect there.

We talked about Abraham Maslow "Hierarchy of Needs," safety, security, housing.

Those things aren't happening.

If I don't have any safety,
I don't have any security,

I'm not going to have any housing.

Those are things that we're dealing with daily, daily.

Doing drugs for a lot of individuals takes them out of the reality numbs that

pain for a minute.

Survival sex is really big in its population.

Survival sex really means like for instance,

individuals who are having sex to stay in someone's house,

individuals who are being targeted,
individuals who are having sex to pay the

rent, having sex to keep their job,
having sex to get a job,

being forced to have sex.

These are all under survival sex,

and there's a whole gambit of reasons why this is bad and for some people-and some

people don't realize they're in these spaces here there until they're out of it.

Drugs are heavily done here.

A lot of people are having sex,
getting into drugs because the partners

that they're having sex with want them to be high.

The part of having sex with,
especially in this population get them

addicted to crystal methamphetamines.

For instance,
if we're talking 'bout gay men,

give them addicted to crystal
methamphetamines,

get them addicted to cocaine,
the partners that they're having sex with

provided drugs for them and they won't
have sex with them unless they're high

with them as well.

That leads to the misuse of abuse in
terms into the addiction,

because now they can't have sex,
regular sex without being under influence

of these drugs.

That's where the addiction comes into
play and the compulsion kicks in.

Health disparities,
which means-and this population receives

has a large-larger number of diagnosis of
these health conditions as opposed to the

mainstream population of everyone else.

There's a disproportionate rate of
substance use disorder,

that means there's a higher rate of
substance abuse disorder amongst this

population than others in the-in the
community.

Substitutes can increase risky-from risky
behaviors,

barrier-less sex leading to higher rates
of HIV and other sexually transmitted

diseases within the LGBT+ community.

Gonna talk about that a little bit with
survival sex.

And I kind of don't like to link those
two together often times,

but we kind of can't keep them together.

I often caution myself when talking about
HIV specifically only when we're talking

about LGBTQ+ because anybody can get
diagnosed with HIV and contract HIV.

I also think here too,
and this is going to be my disclaimer,

barrier-less sex in discussion about HIV.

We have the adaptive sex positive mind.

Sex positive means that when individuals
come to you as a clinician and talk about

the way they're having sex,
it is not to judge them.

This is one of the other reasons people
aren't getting treatment, feeling judged.

If you don't ask them and if you don't
want to know the answer to the question,

don't ask it.

However, as a clinician,
as a medical provider,

whoever it is you are in that community,
that person,

you want to create an environment where
it's OK for them to discuss it.

So you can't help them to help themselves
to get out of it.

If you're not willing to have that job,
have that discussion with them.

So it's best for you to have a discussion
and if it makes you uncomfortable,

process it after you're done meeting with
them with somebody else.

[Ronald Murray]: So how do we treat these
individuals?

What do we provide for them?

We start with creating inclusive spaces.

Traditional treatment modalities has some
limitations.

These modalities and treatments--options
were not created with LGBTQ individuals

in mind.

Traditional modalities such as 12 step
programs,

due to the lack of inclusivity and
relatives to unique experience of LGBTQ+

persons oftentimes don't work and 'less
they have-unless those made or created by

individuals who are in the same community,

individuals aren't comfortable.

I can't say how many times I've asked you
to ask, do I know,

is there any specific gay men 12 step
program,

any specific lesbian women treatment
programs that I can go to that just-with

just lesbian women or just gay men or
just trans individuals?

These programs often emphasize complete
abstinence and may not adequately address

the complex intersection to identity
discrimination trauma experienced by

LGBTQ plus individuals.

I'll say that again,
these programs often emphasize complete

abstinence.

So all the programs we talked about
earlier when they talked about detox,

hospitalization, residential,
intensive outpatient, outpatient,

all are zero tolerance, abstinence,
especially if they're based on the

traditional models.
For individuals who are LGBTQ+ abstinence

only may not work.

And we'll talk about it right now.

Harm reduction seems to be a better model
for a lot of individuals.

Harm reduction,
I'll read you what it is and we'll talk

about it a little bit better.

Harm reduction philosophy,
it approaches that recognize that all

individuals are not ready or able to
commit to complete abstinence and focus

on minimizing negative consequences.

So that means it doesn't say completely
stop, it just says stop gradually.

And as you're stopping gradually,
what you're doing is replacing what you

would normally do is your habit or your
abuse with something else like counseling,

other healthier habits,
going those places as you're gradually

coming down from that habit or that use
that you were doing.

This approach actually works well for
LGBTQ+ individuals because this has

become their way of coping.

So if I RIP this away from them coping,
it also starts triggering my trauma.

It's just triggering it.

I don't know what else I have to hold on
to because again,

we talked about isolation,
we talked about violence,

we talked about all the stuff that I'm
experiencing and this drug,

whatever it was, helped me down.

Now you're telling me I can't have it
anymore and I need to latch onto you.

I have fear of isolation.

I have fear of a,
-of attached reactive-reactive attachment

therapy.

I have fear of making connection to other
people because I'm being judged.

I'm scared to be in treatment.

Now I can't do my drug,

what am I going to do?

I further decompress in this mental
health state.

If we incorporate a space of harm
reduction.

And when I say keep using it,
what we're saying is: do less of it,

because the model of it talks about doing
less over a gradual period of time.

You'll eventually be off of it into a
space of sobriety.

Counseling is great.

It's another barrier to treatment,
depending on the counselor and the

person's relationship.

I can tell you how many times I've worked
for individuals who were further damaged

by the counselor based on the council's
homophobia, transphobia, religiosity,

their own personal opinions,
their biases against the individual,

what they thought this person should do
instead of listening,

what that individual's needs are and
understanding that because they're in

front of you,
being gay is not the reason they're in

front of you, being trans.

is not the reason they're in front of you.

If you are their drug and alcohol,
counselor, you're there for mental health.

We are identifying the whole person.

Oftentimes we focus on that one thing
that's front of us because we're

uncomfortable exploring who we are as an
individual outside of that,

our own biases of the individual.

Sometimes we lose the messenger because
of the message and we become just as

harmful to our clients as the drugs that
we're trying to help them get off of.

Sometimes we don't check our privilege at
the door when our clients are coming to

the door.

And we talk about privilege a lot.

I know,

and after 2020 and in my lifetime,
we talk a lot about privilege of a white

men privilege.

Privilege is unearned access and
advantage in certain situations.

But we also have a heterosexual privilege.

We have gender privilege,
cisgender privilege.

When we're in these spaces that we're in,
our clients see us as authoritarian or

figures of authority.

That's a privilege in itself.

Oftentimes if they're with us unwillingly
there because of probation, parole,

child-child protective agency,
things like that,

or because they're under the grasp of
this disease,

and we come in with this privilege and
think that we know everything what's best

for them.

Heterosexual privilege says that I'm
judging you and basing everything that

you are off of what heterosexual that I
know-heterosexual norms of life.

"Well,
you shouldn't be in here if you had a

girlfriend" if there's a gay man.

So those are things that we have to
really understand.

And often time again,
the message is often lost because of the

messenger and we become just as
problematic,

just as destructive to our clients lives
as the drugs we're trying to help them

get off of.

How do we support this community in
treatment services?

"Understanding."

It's not just a catchword,
understanding that they are the experts

of their experience.

They might not be the expert on how their
drugs affects their brain chemically and

things like that and the receptors and
all those things and transmitters and

neurotransmitter things like that.

But they are the experts of the life they
go through when they leave our offices

and how they got there.

Keep that in mind when we're talking to
them.

Understanding as a clinician that there
is a duality that exists there and that

struggles what you deal with every day.

It is important for non gay individual,
non members of LGBTQ+ to understand that

LGBTQ+ people exist in a duality in
society.

There is a heteronormative way of
functioning society and the LGBT + way of

a of society.

We're often raised under the
heteronormative where our duality exists,

who we are.

Once we ascribe to that,
we conflict with that daily.

We have to figure out how to balance that.

For many of us who are privileged,
who are allowed to do that,

who are stronger enough, brave enough,
we're able to combat that and just exist

who we are authentically.

But it's a larger number of the
individual who cannot.

That is where that trauma,
struggle and conflict happens.

And when you tell them "don't be gay,
don't be XYZ, you must act like this,

" that is where you lose them.

We haven't acknowledged who they are as a
whole person or their intersectionality.

Intersectionality is-is being alternative
to their needs in order to link

individuals, institutional,
and structural levels of power in a given

sociohistorical context for advancing
health equity and social justice in

relationship to building effective and
impactful and substantive partnerships.

What does that mean?

A whole person.

We're not monolithic.

I present everything that you in front of
me and everything that you don't know I

exist in.

So just because you see in front of you a
cisgender African American male does not

mean that that's who I am.

I came from somewhere.

I live somewhere out to school somewhere.

I'm somebody's child.

I'm my mother somebody,
my father somebody.

These things go into who I am.

I like cartoons, I like this.

I like spaghetti.

I like-these parts of who creates who I
am.

If you don't function on the entire
person, only focus on one thing,

you're going to lose the individual in
front of you.

Intersection at LGBTQ+ identity with race,
ethnicity, and socioeconomic status.

LGBTQ+ individuals encompass a diverse
special identities, including race,

ethnicity, and socioeconomic status.

However, when these identities intersect,
they can compound discrimination and

marginalization,
leading to unique challenges in accessing

resources and support.

So understanding that when everyone
presents who they are as a whole person,

it presents challenges for the
individuals in treatment centers.

Why?

Because they're only used to dealing with
you just as a gay person,

not as the person who come in-who's come
from a different social and economic

status, not as a gay person who's black,
a gay person who's Latinx,

a gay person who's from this neighborhood,

when these come together,

and he was prepared to handle that piece
of it.

Understanding that not all gay black men,
for example, hang out with other gay men,

they might hang out with some of the
heterosexual gay men.

That blows a lot of people's mind,
but why is he over there?

Are they gay as well?

That irrational assumption puts a
dampering harm and how actually provide

services and functioning in care.

There's also a unique function.

We're talking about LGBTQ+ people of
color and their intersectionality,

the culture barrier.

So now we just have,

wee have, and I'll use myself as that,

we have the gay man, a Black gay man.
Culture barriers,

expressing ideas that openly accessing
the firm and support systems where their

communities is a new way or has not ever
encouraged it.

It is difficult for individuals and
community of color who have never been

taught to express who they are in their
sexuality to come out and do that.

Give an example.

"You should come out to your parents.

That's going to make your life a lot
easier

when you're counseling.

I mean what I mean,
you're struggling with it.

Just go out and tell your parents" in
certain cultures and communities that's

going to be isolation.

We talked about that earlier.

I'm going to be excommunicated with,
I'm a grandmama's baby.

She's never going to talk to me once she
finds this out.

I know this for a fact 'cause she did it
to my cousin Leroy.

Fear of deportation.

Limited access to healthcare and social
services, increased vulnerability,

exploitation, discrimination,

language barriers.

Now,
the fun thing that we always talk about

language barriers,
always talk about English as second

language.

However,
English to English is another thing.

Understanding the language that exists in
culturally in LGBTQ+ peer population,

specifically in the LGBTQ people of color,
it's a different language that we speak

sometimes as well too,
when we're talking about the house and

ballroom community,
it's a totally different verbage and

language that we're using.

And oftentimes you might think it's
offensive for you,

but this is how we show our appreciation
when we say certain words and things like

that.

That is different in this community.

There are also structural barriers
represent from this population,

especially those communities of color,
like access to healthcare.

How to do that?

We also magically assume because a
suddenly a certain age that they should

know how to go to a doctor's appointment,
how to fill out a Medicaid application,

how to read the script,
how to read their aftercare appointment

notes from a doctor.

They don't. Why?

Because their grandmother or their mother,
their father usually did it for them.

That individual is no longer around COVID
to got a lot of our parents,

a lot of our grandparents,
a lot of our caregivers.

We're now struggling with how to make up
those things there.

However,
we don't we don't understand how to read

doctor's orders.

We don't know that we have to update our
Medicaid every so often and so and we're

coming and we don't have care anymore.

But you're not taking the time to tell us
because you only give us 30 minutes to

talk to the doctor and nurse.

And we don't have a case manager because
our Medicaid is not active or Ryan Weis

and I got to be putting this out.

Those are barriers to care.

And we get frustrated and our-our
frustration comes out in our anger and

our passion and we're escorted out
because we're angry.

Then we get micro aggressed, violence,
isolation, thrown away.

That trauma cycle starts again.

Why when I didn't care?

The impact on substance abuse patterns on
treatment outcomes.

Cultural, social,
economic factors intersect to influence

substance use patterns and treatment
outcomes among LGBTQ population of color.

Discrimination, minority stress,
and social economic disparities can

contribute to high risk and substitution
and related health problems,

while limited access to cultural complex
services and support networks may hinder

recovery efforts.

Recognizing the intersectionality of
LGBTQ+ persons of color and understanding

the in unique interconnectedness of the
account of these factors can contribute

to a healthier and more productive
treatment relationship established with

this population.

[Ronald Murray]: How some strategies may
alienate LGBTQ+ persons.

So this is kind of like some do's and
don'ts.

Most of our treatment programs that we're
in, unless they're based in LGBT centers,

we're not creative LGBTQ persons in mind,
most of our programmers don't-are lacking

cultural competency.

What does that mean?

That means they were not created with us
in mind,

and then they are not evaluated with us,
with us in mind.

And they're also not asking us what we
need while we're in these treatment

centers.

We're being forced to operate under
heteronormative assumptions,

which is to my next one.

They're made off of binary gender models.

There's false equivalencies.

"Oh, you're doing this and this,
This is why this is happening."

But you're not looking at me as a whole
person.

You're ignoring my intersectionality.

The language is outdated,
it's often offensive.

The focus on traditional styles and
family structures, for instance,

and in this community,
I may have someone I call mother and

father,
but it may not be my biological mother

and father.

I may have someone I call sister and it
may be a cisgender male.

I may someone call someone daughter and
it may be a six foot five cisgender male.

The one thing that I always say and
treatment standard,

especially with this population,
watch your face,

watch your medical communication,
watch your tone.

The eye rolls.

We see them at the side of our eye,

we just don't say anything because we're,
we,

we don't want to say anything because if
we get into it with you or have an

altercation of verbal,
we know we're going to be escorted out.

And the meaning in our defense mechanism
comes up when we see the eye rolls and we

hear the [audible exaggerated sigh],
and we hear the-the pin slash and we hear

the phone and we hear the whispers we're
walking through.

You may not even be talking about us,
but these are things that we've

experienced already.

Making sure it's a safe environment for
me and limit all those things.

Common effective treatment models for and
interventions for LGBT populations.

Medical system treatment,

we talked about what that was,
treatments that help individuals who are

suffering opioid addiction,

Common behaviors, there's a great one,
motivational interviews,

one that's has proven to be helpful with
this population.

Creating or finding tailored treatment
models.

Finding therapy support groups
specifically tailored to the needs of

this population can provide a safe and
supportive environment for exploring

substance use issues,
addressing mental health and concerns of

building and resilience.

Asking individuals who are part of
population who are suffering these

conditions--help us create a support
group.

What do you need to feel safe while
you're in treatment?

And let's create a model around that.

Providing cultural competent care.
Healthcare providers who understand the

unique challenges faced with this
population and provide a firmly non

disruptive care extends for effective
treatment and support.

Understanding what my body is and how my
body function and teaching me how to

express what that is,

allowing me to talk to you about all of
my proclivity sexually and all my body

parts that I used during that sex as well
as my drug use.

Well it's culturally competent,
no matter how uncomfortable it may make

you.

This is how we build a relationship.
Harm reduction,

we talked about that earlier,

we understand that harm reduction is
getting does not give him permission to

do drugs.

It's saying that there is a "Linus
blanket;" a comfort blanket there,

and use it.

If I wrap it up,
their trauma response is going to put

them back out there.

They're not going to be successful
absenence only,

that everyone doesn't respond to that.
Finding the best tailor program for that

individual,
not one that fixes all and not one that's

based on binary heteronormative values.

This approach are particularly beneficial
because it may address all the barriers

that are accessing treatment and
maintaining sobriety to minority stress

discrimination, trauma.

Minority stress are stresses that express
individuals who are not in the majority.

Individuals in certain minority groups
such as micro-aggressions,

such as specific trauma values that we've

talked about earlier,

other minority groups experiences as well.

Avoiding policing anyone's gender
presentation personality.

"Maybe you shouldn't dress like a girl
next time you come in here."

"Maybe you should dress a little bit more
feminine."

That's not your place to do that.

I didn't come to ask you about how I
dress.

I came to get my treatment for my-my
substance use.

Those things let me know that you're not
here with my best intentions in mind,

and in your mind you may be,
but that has now just turned me off to

you and treatment.

We haven't built that rapport yet and I
didn't ask you about how I dress.

That means you're not accepted who I am
as a whole individual.

There's a resilience and protective
factor with this population.

Building and supporting

a community around this population can
provide essential support,

accepting them for affirmation,
promoting resilience, reducing method,

likelihood of substance use.

Finding individuals in your workspace who
reflect the population you are serving.

Access to affirmative care,
culturing the competent healthcare

provides LGBT persons can improve
treatment outcomes and support recovery

Despite facing significant challenges,

this community can demonstrate remarkable
resilience and strength of navigating

substance use and any issues when seeking
help,

when they have the protective factors in
place,

when they are in protective treatment,
and when they are also surrounded by

providers and support systems that
encourages this type of health and

healing.

Training for healthcare providers is
imperative.

Provide training for your providers of
cultural competency.

Include the language and the best
practices for providing LGBTQ purposes.

Cultural competence ensures that the
healthcare setting--

that means when I walk into the building,
do I have just gender specific restroom?

Do I have gender neutral restrooms?

Do I immediately ask the person checks in?

"What are your pronouns?"

"What is your gender?"

"How-what do you prefer?"

"What do you want me to call you?"

These are ways to tell me that I'm asking
you.

I'm affirming you.

And the other thing is oftentimes
individuals who are not part of this

community don't actually actually know
what those things are.

I've worked with a lot of clients,
heterosexual and part of the community,

and I've asked a lot of my clients that
question, "what are your pronouns?"

A lot of heterosexual individuals will
say "what-what I look like" and I have-

and that's the moment for me to educate
them.

So even if you deal with individual,
not its population,

when you ask those questions, they'll say,
I'll say "are you heterosexual?

homosexual? blah, blah, blah,
whatever straight means."

Then I just apart from to educate them
about what each of these mean.

So now only are you educating an
individual who is not part of community

about what pronouns and why it's
important to identify what your pronouns

are,

but then when you have a difference in
this population,

you also show that you are affirming who
they are from the time they come into the

door, making them comfortable.

We're creating inclusive spaces.

That's what the training comes into play
at.

We're creating affirmative spaces.

We're providing affirmative therapy.

We're hiring clinicians who are affirming
that individual as who they are.

There is a overload of people who are
looking for individuals who are black,

gay, professional counselors.

We're looking for LGBTQ specific
counselors in the city.

They are like a unicorn because it's
difficult to find someone who knows who

you are who specializes in who you are as
a whole person.

Do we ask the right questions when
they're not in front of us?

Is your literal language affirming?

When I walk into your building,
do I see a rainbow flag that says "OK,

this is a safe space to be in."

When I look at the magazines on the table,
are they saying that's something that

reached to me?

Is your assessment clear?

Are you asking the clear question
assessment about their gender again,

identity, sexuality?

Are you able to explain what they are?

If they ask you,
"what do you mean by that?"

Are you having gender specific policies
and procedures in place and you're

welcoming back in your client packet?

There's a talk about non gender
discrimination laws,

LGBT specific things that makes them feel

uncomfortable while they're there?

Is your agency required gender specific
sensitivity training for all your staff

regularly,
not just a one hour every five years LGBT

training?

Do you offer equal and fair access to all
programs regardless of gender or gender

neutrality?

Meaning if I am a trans woman,
can I go to the women's programming?

If I'm a trans man,
can I go to the men's programming?

Am I able to list my gender opposite of
how I was assigned at birth on your paper

legally because I cite that on my birth
certificate?

00:00:09:22 - 00:00:39:05
Unknown
[Shannon Winnubst]

Hello! That was a jam packed module. We're very grateful to Mr. Murray for sharing his expertise and his wealth of experience with LGBTQ+ individuals, and this difficult issue of substance use disorder. He gave you a lot of data and a treasure trove of tools to improve your mental health and substance use. Clinical practices. Here's a quick overview of his major interventions.

00:00:39:07 - 00:01:12:05
Unknown
Number one, LGBTQ+ communities face disproportionate struggles with mental health and substance use disorder. And yet, there's still very little research and data on this huge health disparity. This is especially problematic post Covid pandemic and the lockdown, when the general population's mental health declined and substance use increased. We should assume that this happened and even more significant margins for LGBTQ+ persons and communities.

00:01:12:07 - 00:01:43:21
Unknown
We need more data on these crucial health struggles, especially since mental health symptoms mirror those of substance use disorder, and they're crucial to distinguish these for effective care. Finally, this data is also crucial to address the overincarceration of LGBTQ+ communities that that incarceration the rest are often triggered by a mental health or a substance use disorder episode.

00:01:43:23 - 00:02:21:15
Unknown
Secondly, number two, the cycle of trauma often causes LGBTQ+ persons to develop substance use disorder and not to seek medical care for it. All too often, stigma and judgment are central to LGBTQ+ identity formation in the United States. Mr. Murray really underscores how this creates a culture of fear for LGBTQ+ individuals and communities. And this fear extends fully in the medical environment where we expect readily to encounter discrimination, biases and even harassment.

00:02:21:17 - 00:02:53:21
Unknown
The cycle of trauma can be directly triggered by healthcare practitioners if they exhibit even the slightest sense of judgment. A facial expression, and a shrug of the shoulders, and certainly an eyeroll about anything. An LGBTQ+ person is relaying to you can shut down effective communication immediately. And this is especially true around substance use disorder, because, as Mr. Murray shows, these behaviors are so often tied with sexual practices.

00:02:53:23 - 00:03:32:07
Unknown
Mr. Murray is very clear about the need to work on one's own biases about drug use, about sexual practices, about gender expressions before, during, and after one's care for LGBTQ+ individuals and communities. If not, you're likely to trigger the trauma that sent the person into the cycles of substance use disorder. Number three, harm reduction and not abstinence only, must be the approach to LGBTQ+ individuals struggling with substance use disorder.

00:03:32:09 - 00:03:51:05
Unknown
Remember, pleasure and how we practice pleasure are the sites of our stigmatizing as LGBTQ+ persons in this culture. Mr. Murray makes it clear that an abstinence only approach to substance use disorder will trigger the trauma that causes the disorder.

00:03:51:05 - 00:04:10:20
Unknown

As he elaborates, the failure of abstinence only approaches, I want to add that 12 step programs are also often bound up with religious orientations. And sadly, religion has often been a site of judgment and stigma for LGBTQ+ individuals and communities.

00:04:10:22 - 00:04:51:00
Unknown
Harm reduction, which is grounded in non-judgmental pleasure, positive positions and stances, should be the guiding principle for these healthcare practices. With LGBTQ+ persons and all persons. Number four violence in the streets, within the home and from the state are all very, very high for LGBTQ+ communities. Those who become outcast by their families or feel stifled by being in the closet often look for safe havens inclusive of non heteronormative of gender and sexual identities.

00:04:51:02 - 00:05:21:12
Unknown
For example, consider the historical and contemporary importance of LGBTQ+ bars as oases for finding jobs, finding romantic partners, and just hanging out with your friends and developing networks of care. While a haven for queer pleasure and community, those same environments can also breed substance use disorders. due to the increased prevalence of alcohol and party drugs associated with bar nightlife.

00:05:21:14 - 00:06:03:14
Unknown
Considering the dearth of, say, that of safe public spaces that promote the discussion or expression of gender affirming or sexual pleasure, we must remember the intense, everyday stress that LGBTQ+ persons carry with them into your clinics. Therefore, echoing several of our modules, it's essential to check one's biases, create a non-judgmental and inclusive environment, engage ongoing education trainings, and listen directly to your LGBTQ+ patients and clients about their needs and desires for effective care.

00:06:03:16 - 00:06:24:02
Unknown
I hope this module gives you many fresh ways to undertake this multi-pronged education of yourselves, your colleagues, and your practices. Thank you so much for your commitment to providing the best possible healthcare to LGBTQ+ individuals and communities. No matter the social stigma attached.