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ENGAGING LGBTQ+ PEOPLE WHO USE DRUGS: CULTURAL RESPONSIVENESS AND BEYOND

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[video transcript]

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are Dr. Derek Blevins, an Assistant Professor of Clinical psychiatry at Columbia University, a research psychiatrist at the New York state psychiatric institute and a psychiatrist in private practice in Manhattan. He completed his psychiatric residency at the University of Virginia where he served as chief resident and also completed a combined clinical and NIDA funded t 32. Research, fellowship and addiction psychiatry at Columbia University. Dr. Blevins is the clinical implementation coach and technical assistance for the New York site of the NIDA healing communities study, which aims to reduce opioid overdose deaths by 40%. He is also interested in the application of repetitive transcranial magnetic stimulation, and pharmacotherapies for the treatment of stimulant use disorder. In his clinical practice, Dr. Blevins focuses on the treatment of substance use disorders with a special interest in LGBTQ plus individuals, which is why we are very pleased to have you here today. Derek, over to you.

01:13

Thanks so much, Lauren, and thanks to CEI, for the invitation. Yeah, so I guess let's just go into it and get started. So as Lauren said, I don't have any financial disclosures. I do want to take a moment to acknowledge a couple of people who have influenced the way I think about and maybe present on this topic, my peer and good friend Jeremy Kidd, and Petros Lagunas, who many will know as an upcoming president of APA. So learning objectives for today. So first, we'll review some of the basics of gender and sexuality. We'll talk about LGBTQ plus alcohol and drug history and culture. discuss some of the epidemiology of substance use substance use disorders and psychiatric comorbidity. Then move on to some of the key principles of providing culturally informed and responsive treatment to LGBTQ plus individuals with substance use disorders. And then last review some examples of clinically relevant evidence for treating this population with substance use disorders. So first, just to start with a clinical case, and we will, you know, just have this case in mind as we go through the presentation and we'll come back to this patient again at the end. So Ali is a 27 year old person sex assigned female at birth, identifies as genderqueer perverse prefers presenting as masculine. Also self identifies as gay and uses he him or they them pronouns. Ally has a cisgender male partner who identifies as gay, and a non binary partner who has sex assigned male at birth, who identifies as queer ally lives alone and department has minimal interaction with their family. Because they do not support their lifestyle. They present for outpatient treatment for problems related to drinking after ongoing difficulty despite attending Smart Recovery virtual meetings, they've been drinking on average five standard drinks per day for the last year. In addition to alcohol, they smoke cannabis every weekend and use Mali which they test with their dance safe kit. once every six months at Circuit parties. They were stabilized on testosterone by their provider in the United States by an endocrinologist. And since then, I've been purchasing it from a friend who buys it from Mexico so continuing on the same dose. So on the first encounter, the clinic where they're coming for help treating alcohol issues, the patient notices that all the flyers in the waiting room are of heterosexual couples. That front desk staff uses she her pronouns based off of the legal name that they see. The nurse repeatedly calls them their legal name Alice, the physician focuses on the risks of potential fentanyl laced MDMA. The physician asked which one of their

partners is their real boyfriends physician insists on doing a pregnancy test before starting now. Trek's own and the physician refuses to prescribe any meds including naltrexone because of their testosterone that is coming from Mexico. So probably not a great way for Ali to start out her treatment for alcohol use issues. And we'll again think about this case as we go through and we'll come back at the end and think about some other ways that this could have turned out. So we generally think of gender sections and sexuality as being discrete, but related concepts. We know it's a lot more complicated than that, though. You know, sex is arguably the most simple to understand as it relies on anatomy and physiology. Gender, though includes one's gender identity, so how they think about themselves and their gender expression or how they present within their environment. And that may change depending on the environment. And then sexuality includes both sexual and emotional attraction as well as sexual behavior. And those things may or may not align. So while that, you know, the previous slide showed the kind of three overlapping kind of concepts here, we see it as much more complicated than that. This is an A nice illustration for how to conceptualize sex, gender, and sexuality and how they may or may not relate to each other. So really, if you think about each of them existing on a spectrum that may change over time for a person, or it may be more fluid, you know, on a day to day, week to week, month to month basis. And just to point out that as healthcare professionals, the importance of biological sex or sex assigned at birth, it might be relevant to us, but it may also be a real source of shame or hatred for the person that we're treating. So it's just important that we are aware of that, especially if we want to provide the best care to our patients. So just to go over some definitions, and term comes a gender. So gender is defined as either of two sexes, male and female, when considering the social and cultural differences, rather than the biological one, so more focused on the social and cultural differences. So it is all and it can also use more be more broadly used to denote a range of identities that may not correspond to establish ideas of male and female. And in terms of different terms that are used to describe gender, these are probably the more common ones, although there are others. And you know, it's really most important to ask the patient for the term that they prefer to use, rather than think about this as being sort of a diagnosis and that you're assigning a term based off of some factors that you've determined. So these terms is just cisgender and transgender being that the gender either matches or doesn't match the sex assigned at birth. gender queer person usually doesn't identify strongly with either gender or has more fluidity between the two age gender is not identifying as either by gender identifying as both gender fluid being less fixed, non binary, again non identifying as either gender or maybe outside of gender roles. And then gender expansive, may be again wider, more flexible, or this person may be still exploring their gender identity. So on the other hand, we have this the definition of sex, which is again either of two main categories male and female, but much more focused on the individual's reproductive reproductive functionings. So sex is really a biological term. Typically, the sex assigned at birth is based on external anatomy, internal anatomy and physiology as well as genetics. So 2x chromosomes are an X and Y chromosome, and also be used to define a person's sex. But this certainly more easily fits into two categories. But it is important to remember that there are intersex individuals that may have some combination of what are typically male and female anatomy or physiology. So transitioning, the next term I want to define. So transitioning is a series of processes that some transgender people may undergo to live their life more fully as their true gender. And this can include a number of things including social transition, medical transition, legal transition, and trans people may choose to undergo some all or none of these

processes. And that does, you know, obviously does not affect their ability to identify as, as a particular gender. Transitioning can be very important. It can also be very sensitive. Someone may want to transition but not have the resources, whether it's financial or support or even access to those services. Mental health providers are almost always included in the evaluation process, particularly when someone is looking at a medical transition that may involve surgery, and sometimes also for hormone therapy. Substance use is not an absolute contraindication to any of these parts of transitioning, including medical, but there are some considerations around surgical risks. Even you know, when it comes to tobacco use, and these individuals when they're thinking about surgery. So, in sort of contrast, some overlap with gender identity, is the concept of gender dysphoria. So gender dysphoria is a diagnostic term that In the DSM five is described as psychological distress that results from an incongruence between one's sex assigned at birth and one's gender identity. So not all transgender individuals will experience gender dysphoria, or gender dysphoria that may exist earlier may improve when people receive treatment.

10:22

These are the symptoms that are listed in the DSM five, the person needs to or more over the course of six months or longer and it has to include some significant distress or impairment. I'm not going to read through the list but you see lots of language around desires to have the second primary secondary sex characteristics of the other gender or to get rid of the primary or secondary sex characteristics of the gender of the sex assigned at birth. Treatments for gender dysphoria sort of range across what I mentioned in the definition of transitioning social, legal, medical or medical surgical, medical surgical. So social affirmations like pronouns and names, legal affirmations, changing government IDs, to include their name or their gender, medical affirmations like pubertal suppression, particularly when youth are going through or are about to go through puberty, hormone therapy like estrogen or testosterone, and then surgical affirmations that include a vaginal plasti phalloplasty chest or top surgery, facial feminization, tracheal, cartilage shave and voice surgery. And then psychotherapy can play an important role, you know, the type of psychotherapy tends to be more open ended exploration of feelings and experiences. And this is certainly in contrast to conversion therapy, which is considered to be unethical by most or all professional medical professional organizations and has negative outcomes, whereas these other types of affirmations, and an exploration of feelings and experiences can have positive outcomes. So moving from gender, then we'll talk some about sexual orientation. So sexual orientation is a person's identity again, that word being important in relation to genders, gender, or other genders to which they're sexually attracted. So as heterosexual, homosexual. Some of the other terms that you know, are more commonly used straight, gay, lesbian, queer, and then perhaps less common asexual and pansexual. Identity is really only one aspect of sexuality. attraction can also be emotional and physical. They don't have to necessarily align. And then the behavior itself, what is the sexual behavior. So these are the three main components of sexual orientation, just to think about how some of these components may not entirely align. So you know, a man may identify as straight and have had same sex experiences before. A transgender woman may have previously only had sexual experiences with women when identifying or presenting as a man and consider herself straight at that time. And then after transitioning, may only have an attraction to men and still consider herself straight. So you can't necessarily align or you can't align gender identity with sexual

orientation, or you can't assume anyway. Now to move on to think about some of the cultural aspects, you know, historical cultural aspects of substance use in the LGBTQ plus population. You know, I think that providers may be perceived as disconnected from their patients, you know, when someone is coming in with a substance use concern, without some understanding of the alcohol and drug culture in that community. So pre war there, there were lots of anti LGBTQ laws and sentiments in the United States, and this really increased the need for safe spaces. Bars kind of filled that space. So in New York City and San Francisco, as well as other large cities and the states. Bar bars were considered safe gathering grounds and also a venue for community organizing, and then in your city. The Stonewall riots began on June 28 1969, and lasted for about a week. This is when the police raided the Stonewall Inn, which is a bar and in the village in New York City. And there were protests and lots of of anti gay and anti trans brutality in that time period, sort of seen as the beginning of the modern LGBT Q movement, or rights movement rather. This was a story in the advocate. I just included the title here so you can see how intimately related these two things are. This, the history of gay bars is also a tale of LGBTQ liberation. This is a picture of Stonewall and when it became a national monument, it wasn't designated as such by President Obama, as far as I know, is the only bar that is a national monument. It also includes the adjacent park and streets. It's not just the bar itself. But this was the first national monument honoring LGBTQ rights. So the cultural evolution of LGBTQ and substance use the relationship has expanded to include large venues where gay men particularly congregate, and sometimes plan their entire year their vacations, vacation time around attending circuit parties or things like gay specific cruises, and club drugs like MDMA, which is methylene dioxide, methamphetamine, GH B, or gamma hydroxy, butyrate. And ketamine have become almost synonymous with gay nightlife in these venues in particular, so ecstasy, MDMA, and Molly, all words for the same thing, although, you know, people may debate you on one being more pure than the other, probably more of a marketing scheme than than truth. But essentially this the same chemical. This study showed that gay men who used MDMA were much it was associated with being more out. And I think that that's an important thing to consider, you know, why, why does someone who uses substance, MDMA as an in pathogen, so it increases sense of connectedness, and then a community that may not have had that, that sense, you know, in youth or young adulthood, that feeling can be quite rewarding. ghsp B, or G, as you may hear called, this was a study looked at why gay men use G and some of the reasons were it's short duration of action, giving an energy boost helping with sleep, I realize sounds are is contradictory, increasing libido and then the limited after effects. So being working through the GABA system has similar effects as alcohol but does not cause the same hangover the next day. So this is what this limited after effect is referring to. And then ketamine, you know, is something that's been around for a while and it seems to be making kind of a resurgence in the LGBTQ nightlife as well. I think we think about ketamine now as a treatment for treating depression and looking at it for many other things. But it certainly is still abused substance, or a substance that is used to get high. And then more recently, in the evolution of this culture is the presence of gay specific dating or hookup apps like Grindr being a, you know, probably the best known example, but there are others. And these may have provided some safe space for people who aren't out to explore their sexuality. But they also provide spaces for to find others who are engaging in drugs, or other types of sexual behaviors. It's fairly common to see profiles that mentioned specifically methamphetamine. And this image here, which was a pride ad from Los Angeles. You can see all these capitalized T's and that is

an indication of, of someone who is using or selling methamphetamine or Tina, the T. and methamphetamine jHP. Again, thought to be sex, sex enhancers reduce inhibitions around sexual activity. This is a quote from one of my own patients saying he only gets on Grindr when he wants to use ue methamphetamine. So not looking for a date not even necessarily looking to have a sexual experience, but looking to use methamphetamine. So with each of these, you know, there are unique patterns of substance use unique substances used unique risks. And at the same time, all of these spaces does or maybe did provide some sense of safety and security to LGBTQ people. So the relationship is really complicated. There are a number of factors that may result in these spaces shifting from safe to toxic or toxic to safe, and you know, that shift doesn't have to be a permanent one. It can shift to a toxic space one weekend and back to safe space the next weekend or or one night to the next. But these are some of the things to consider anyway, the physiology of the drug and the person using mental health issues physical health, friendships, families and social connections, romantic relationships, employment status, financial status, all things that may sort of mediate this transition back and forth between safe and toxic space.

19:54
So now I'll talk a little about epidemiology. This this data that I'm going to show is for From the 2016 or 2015, MS DOS published in 2016. And there has been in his distance then, but they haven't yet analyzed the LGBTQ specific data. So we don't have these nice visualizations, and not a lot has changed between, from one visit to the next, we see trends, certainly, but not dramatic changes one to the next. So of the sample 4.3% of the sample identified as a sexual minority. And just to also point out that this doesn't ask about gender identity or didn't at the time, so these individuals may or may not be captured by the question about sexuality. So that's why the on these slides, it'll say LGB, instead of LGBT 1.8% of this, so of the total sample identified as lesbian or gay, and then two and a half percent identified as bisexual. And what you see is really dramatic differences with illicit substance use. So this is drug use, specifically among LGB adults overall, and then also between men and women. So statistically significant across all categories. And I don't think that that is necessarily to say that when you see the difference between the size of the bars, but it is statistically significant also. So generally, illicit substance use is two to three times that of heterosexual individuals, or what they call the sexual majority, with notable exceptions, one being inhalants, which is 12 times higher in the sexual minority group. And the second being methamphetamine, which is almost four times higher than the sexual minority group. There are no illicit drugs that are reported as less than the sexual majority group. So they're all more generally two to three times as much, but these two in particular are quite a bit more. So I want to talk about them separately, just since we are seeing these much higher numbers. So inhalants, as a class is a pretty broad and diverse class of drugs. So on one side, we have these substances that we know are quite toxic, like Halloween, for example. And these are what people generally think of when they think of inhalants. So people, you know, huffing, sniffing glue us using aerosolized cans to get high. And then things like gases like nitrous oxide, which is what Whippets are, and that's the you know what to use a dentist office. You can also buy cans of nitrous oxide at a bodega. That's what people usually when they refer to Whippets are talking about those cans. On the other hand, we also have this substance nitrites that are included as inhalants. These are Amel or butyl nitrites. They're sold also because as video head cleaner, leather cleaner or room deodara Room odor iser bodegas

and sex shops to common places to find nitrites very different though than this other class doesn't have direct central nervous system activity. Unlike Tallinn and nitrous oxide. The way it works is by dilating blood vessels and relaxing muscles. So people do feel some kind of rush feeling. But it's not because there's this increase of dopamine, like with these other substances tell you a nitrous oxide. And they're used as sexual enhancers, particularly among men who have sex with men and may facilitate the sexual activity. This was a statement that was released by the FDA about a year ago about nitrides specifically, saying that they had seen an increase in hospitalizations and deaths related to nitrites. The there was some controversy about the FDA even releasing the statement, they didn't talk about the numbers of people that have been reported, you know, whether it's three or 300, that we have no idea from the report anyway. And some people in the community did perceive this as being overly reactive to kind of a widely used, what we think of as a non addictive substances, again, doesn't cause that rush of dopamine, and that community, and of course, released in pride month of 2021. Also, so probably wasn't the best timing. Now, there are substances that I wanted to mention specifically is methamphetamine. I mentioned this as sexualized drugs, sometimes referred as to as Chem sex more specifically, it's more British term, but sometimes you'll hear it in the United States. This was a study that asked men white gay men why they use methamphetamine and they said that it prolongs or heightened sexual experiences and changes their attitudes or beliefs about sex. Typical pattern for methamphetamine use is vendor or vendor patterns, especially over weekends. It can be smoked using nasally intravenously, which I didn't include on the slide or this term I just included because it sometimes comes up used directly. So it can be dissolved in water liquids or The powder itself can be inserted directly. It can be really difficult and men who have sex with men and begin using methamphetamine to kind of uncouple those two behaviors. So the meth use and the sex, especially if it starts at a younger age. And you know, it's consistent over time can be very difficult to separate the two very challenging and in psychotherapy. In this study, they showed that persistent methamphetamine use is a major risk factor for HIV seroconversion. So about five times the percentage zero converted in this 12 month time period in this sample, and persistent users accounted for about a third of zero conversions and the sample. So talks to him about drugs and then went to just mention also alcohol. So again, the in EI LGB, so not including trans individuals, so significantly greater past month alcohol use compared to the sexual majority 64 versus 56%. What you're seeing here is the graph on this slide is the proportion or percentage of binge drinking, which is defined as four or more drinks for females are five or more for males on one occasion, significantly greater, especially in lesbian or bisexual females mean that you can see from this graph, there's no significant difference in the male group, but the female group is so high that that it makes the total sexual minority population significantly greater than sexual majority. And then similar heavy drinking except again, among lesbian or bisexual females, it was about twice as high. Just one other two other things to point out was one is keeping in mind that telescoping effects of alcohol women, that their use escalates to addiction much more quickly than in men. And then second, the potential physiologic consequences of alcohol are much greater on women for a variety of reasons the way that women metabolize alcohol. Second thing to note is that there was a recent study that looked at screening anyway for transgender or gender expansive individuals, and found that this using five or more as a cutoff was held for screening. And that's a little bit different that we're talking about on this slide. But just to point out that these numbers do track for transgender, gender expansive individuals. Looking at substance use disorder now, so

again, what you might expect compared to the earlier slides, when we looked at substance use that STDs are two to three times greater among gay or bisexual adults. You know, the silver lining here, I guess, is that they're more likely to seek treatment than sexual majority adults. Although when you look at both of those numbers, it is quite low 15.3% sexual minority adults versus 10.6% of sexual majority of adults seek treatment specialty treatment for addiction or substance use disorder. And this data is more specific for trans individuals. This was a pretty large sample, though not as large as and as and as claims data, which is really different than this, which is where they go in and interview people. But this looked at claims data, and showed that our claim commercial or Medicare Advantage claims in 2017 showed that drugs alcohol applies, substance use and nicotine are all much higher in trans adults than cisgender adults. The highest was cannabis at 2.1%. Again, this is a substance use disorder, opioids next at 1.3. And cocaine is 0.5. And you just can see that that's much lower than the rates of substance use disorder among non are cisgender individuals. Switching a little bit to thinking about psychiatric comorbidity, so this is also known as the data. We know that about two thirds or more than two thirds of gender minority individuals have some past year mental illness. It's more than twice that of straight or heterosexual adults. Serious Mental illness is 3.6 times greater than sexual majority are heterosexual adults, major depression three times greater. But again, silver lining I guess, is that individuals in the sexual minority are more likely to receive mental health treatment than sexual majority.

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Along the same lines as psychiatric comorbidity, thinking more specifically about trauma. This study looked at LGB individuals and compared to heterosexual with same sex sorry, LGBT individuals and heterosexual is with same sex partners and showed that they had a greater risk of childhood maltreatment, interpersonal violence, trauma to a close friend, unexpected death of someone close and then with all those things not so rousingly More a greater risk of PTSD, trauma and the trans population. So this was a study that looked at reasons for discrimination among trans adults, it was about 400 adults 63% of those were trans men, that 83% said that they had been discriminated against due to their gender identity or expression about 80% because of their appearance, 68% for sexual orientation, about 60% due to their sex and 40% 44% due to their age. In this study, higher everyday discrimination scores and greater number of attributed reasons were independently associated with PTSD symptoms. And I just wanted to mention that comorbidity, psychiatric comorbidity and trauma because we know that those individuals are also at higher risk of developing substance use disorders. And just to take a minute to recognize that, you know, 2020 21 was the deadliest year on record in the United States, for transgender and gender non conforming people. And I believe the last the last figures and said about 47 individuals died in 2021.

31:21

So switching gears a little bit now, so we've talked about some of the cultural, cultural issues or cultural context, the epidemiology where we see much higher rates of substance use across the board, but especially certain substances, higher rates of psychiatric morbidity and trauma. And then now let's think about why, why this exists. Why, why are these numbers increased among LGBTQ individuals, so three kind of broad categories or fields ways of thinking about this, one is managing same sex feelings, another is minority stress model. And then the third is pure

substance use farms. And we'll go through each of these in some detail. So managing same sex feelings, this was a model that was developed by Drescher and bine, published back in 2009, and then republished and 2012. And it you know, you can see in this kind of transitions between being closeted to being self aware to identifying as lesbian, gay or bisexual or identifying as non gay, you could understand where alcohol or other substances may play a role or a part and these transitions in particular, or when people sort of achieve or, you know, establish these different stages. This was a really interesting book, from a psychologist Alan Downes, who primarily works with gay men with borderline personality disorder. He talks about stages that a gay man may go through to discover authenticity. Shame he describes as being born from parents or a parent's, an individual's parents, or society's lack of authentic validation for the individual. So they seek out validation for things outside of their authentic self things like Sports, education, relationships, or sex or drugs. And I would just argue that substances can play a major role in each of these stages. Even once someone has discovered authenticity, which he describes as sort of as being the goal. I guess the hope of everyone would be that substance to play less of a role or certainly a safer role at that stage than in an earlier ones. So moving to the minority stress model, so Elan Meyer at Columbia created this theoretical model that's been used to understand the role of different types of stressors on minority groups. The model shows that the stressors that a majority group would experience and then the additional stressors that minoritized group would experience both by their status and their identity. And then it talks about distal which I would think about is external stressors or proximal so kind of internal processes, and how these results affect different mental health outcomes. This has also been kind of revamped to show the impacts of minority stress on physical health outcomes like cardiovascular risk. And, you know, I, for me, I think it's helpful to point out that the role that we as healthcare providers can and hopefully will play is this role of being, you know, helping with coping and social support being part of the community or being an ally of the community. But the other alternative is that this can be us, you know, we can induce more distal stress upon individuals that we see in our clinical practice. And then the last of the three kind of theories or reasons why people might have more substance use or psychiatric comorbidity is pure or substance use norms. So, this study showed that social norms mediated an alcohol increase and LGB men so lesbian gay bisexual men are gay or bisexual men. Social norms and positive alcohol expectancies mediate mediated the alcohol increase in women of the same group, you really see this dramatic increase from high school to freshman spring semester for men, and much higher in women that stays more stable, it doesn't increase as much but still stays quite high and higher than the heterosexual peers. They have used a composite score assessing, combining both quantity and frequency of drinking to determine this, the baseline and then the increases at these different stages. This was another study that was done after the Pulse nightclub shooting in Orlando that surveyed about 300 individuals a month after the shooting, and LGB peers were perceived as likely to have coped using alcohol. So 68% thought people use alcohol or drugs 41%. And this is in comparison to actually small proportions that did report coping with alcohol or drugs. So 26 and 7%. So dramatic differences and what people perceive versus what people did to cope with this shooting afterward. And it showed that there were 15 times greater odds to cope with alcohol, and nine times greater odds of cope with drugs, drugs among the people that had that social norm perception. So among those that thought it was higher, are much, much more likely to actually cope with alcohol or drugs, just showing the importance of, of substance use norms and how it may influence substance use or developing

substance use disorder. So moving on to the next section, thinking about some principles of LGBTQ plus treatment, our LGBTQ plus substance use disorder treatment, and I'll talk about kind of four general categories. So first referral, the referral process forms, you know, the administrative stuff when someone comes into a clinic, and the environment when they first come in, talk about some issues around disclosure and confidentiality, the clinical interview itself, and then some Finally, some treatment considerations that may be more specific to this population. So thinking about referral resources, so it can be very helpful to collaborate with LGBTQ specific organizations. or specify that you have LGBTQ friendly providers, you know, on your website on other sources, referral sources. Intake Forms can be a make or break sometimes when people come into an office or they receive the forms, you know, by email or by mail, fill them out online. And the way the wording the language and a form can result in potentially a treatment fracture before treatment even begins. So being more having more options for inclusivity. Some examples here, saying relationship status instead of marital status, having transgender or other as an option for the gender checkbox, if that's what it is, having a line where someone can specify their pronouns that they use, specifying between legal and preferred name. And then similarly, thinking about what gender versus legal gender means on a form, I'll show you an example of a basic example of the form that I use. And then the next stage you know, if they have passed the test of intake forms coming to the clinic. You know, who they encounter when they walk in the door and what they see can be very impactful. So educating our training front desk and other staff on issues around sensitivity, displaying LGBTQ plus specific services on brochures or flyers, having you know, symbols in the waiting room I included the picture of the trans and, and gay pride flags here just as examples, having unisex bathrooms. And these things may lead to someone disclosing more openly or hiding more from the healthcare provider. If they walk in and they feel like this is not an open welcoming environment for them. They may be less likely to share information that can be very clinically helpful and can be very helpful to developing rapport in an ongoing way. So this is just a screenshot of the way that my form is worded and not that it that it's perfect by any means. I don't think any are. I prefer to use legal gender since this is what a pharmacy might require or an insurance billing issues. And then discussions about gender identity can occur during the clinical interview, I don't necessarily need that to exist on a form, where they're not sitting in front of me and can we can have a discussion. And you know, after we've developed some rapport with each other, so that's just an example. And I included here also legal gender, male, female and New York. Now, x or other genders is also an option. The next of those four categories that I was going to talk a little about is disclosure and confidentiality, it's really important to recognize that coming out for LGBTQ plus individuals is an iterative process, it is not quite as simple as you know, coming out of the closet door, it can be variable across different people in someone's life. So family members, friends, coworkers, and then, you know, as related to us, their psychiatrist or therapist or other health providers, so they may be at different stages of, you know, how out they are with each of these. Each of these individuals are people. And an individual really reserves their own right, to disclosing their identity and how they do it.

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You can and should emphasize confidentiality, confidentiality and privacy and their treatment. And this should be regardless of who is involved or who's paying. You can be supportive while

allowing the patient to decide if or when you have a role in the coming out process. And you make depending on depending on the report and what this person's needs are thinking about the clinical interviews, so creating an affirmative environment for the interview itself, so it's very likely that LGBTQ plus persons had some sort of prior traumatic experience with a healthcare professional, you know, whether that simply using the wrong term, or, you know, much more complex than that. And this may result in it taking longer for the individual to gain or to gain the individuals trust. You can express lack of inexperience particularly well, just across the board, but I think that where this typically comes up is working with transgender individuals. But they also don't expect that the patient is going to educate you. You know, I think that it's our job to do the work of educating ourselves of how to talk and hopefully one of the reasons why we're here today. Talking about genitals or physical appearance can be very sensitive and stressful, especially in an initial encounter where you may not have gained their trust, understandably. So developing rapport can be very helpful before asking those more sensitive questions, especially if it's not relevant, you know, at in that moment for that assessment. Being open ended with questions in the clinical interview, allowing the patient to self disclose and identify just an example of how you might ask that is can you tell me more about your gender identity? Or can you tell me more about your sexual orientation? Rather than giving the options for close ended questions? Explain why you're asking and avoid any unrelated probing, especially around anatomy, like they mentioned before. And just an example of that would be so I understand. So I can understand the potential impact of medications can you tell me any history that you have with hormone use? And then normalizing things? You know, if you're going to ask a question about methamphetamine for example, you can say some people engage in sex by using certain drugs you know, and then go on to ask questions about other substance use and sex and potentially related sexual behaviors. So not making assumptions so use gender neutral language and mimic what the patient how the patient uses terms or refers to someone using partner I think is a very easy one rather than referring to husband or wife unless they have used that term. Similarly, avoid salutations the Mr. or Mrs. and Mrs. Miss until the patient preference is known. If they identify their sexuality as queer, I didn't. You can also call it queer and at the same time, you can clarify what type of specific sexual behavior they might be engaging in. If the term is not helpful for you to understand that. Remembering that their current behavior or body physical appearance may not indicate their indicate their identity or history. So gay men have children with a current male partner or a prior female partner. masculine or feminine appearance does not define gender identity and gender of current partner does So not define sexual orientation. using appropriate terminology, asking the patient to clarify if needed, repeating your understanding of the terms meaning as a way of clarifying it. Recognizing and apologizing for mistakes, also, again, going back to not their job to educate you, but make sure you understand the way that they define something. Labeling the medical record is a, you know, easy, practical tip, you know, writing names and pronouns out, you can include their sex assigned at birth versus their legal gender versus their gender identity, you know, right on the front of the record, or the top of the page of their medical record, I use parentheses to to use someone's preferred name just as an example. These are other things that may come up during a clinical interview, and can be complicated, but topics that may come up around trauma, family dynamics, violence experiences, discrimination, things around sexually transmitted diseases PrEP, which is pre exposure prophylaxis for HIV, they may have experienced issues accessing or being traumatized by accessing health care in the past. So these are all things just kind of to

be aware of that may come up in initial meetings. So when thinking about various specific substance use disorder treatment considerations, one is the kind of some differentiation of treatment and harm reduction although the reason I put this asterisk is that treatment or harm reduction is treatments, you can provide harm reduction across the entire continuum of care. And that can be treatment itself. Use motivational interviewing, like patient, that patient centered language and questioning to explore thoughts and impacts related to specific substances without overgeneralizing. Focusing treatment aspects. So again, different difficult to differentiate with harm reduction. But if we're going to differentiate it, focus treatment on higher impact substances like methamphetamine or ghp, which come with more risks, and maybe harm reduction strategies on lower impact substances like and frequent use of MDMA or poppers just as examples. There are some LGBTQ plus specific treatments that have been studied and that are available. So peer support, crystal meth anonymous, and LGBTQ AAA or NA meetings, if you if you go to 12, the 12 step website, you can typically filter out the LGBTQ plus meetings, culturally tailored behavioral treatments like pagana behavioral therapy, and then there's some evidence for medication for as for substance use disorders, and I'll talk a little bit more about a couple of these. I do want to say that over emphasizing the role of substances like poppers that are used for sex, or MDMA that's used once a year at a circuit party, that does have the potential of having a negative impact on the therapeutic alliance. The provider may be perceived as not understanding the community for reasons that I've talked about. If it's appropriate, that provider may ask permission to share information or education like the FDA, notice on poppers or like about risk of adulterated MDMA, MDMA pills, there have been reports of fentanyl adulterated MDMA pills. But often the patient may be more educated than that provider regarding some of the more specific risks. And I think we can all learn from our patients experiences also. Peer support can be challenging, especially in residential programs that may offer generalized or sometimes same gender 12 step meetings. So, you know, I think that we need to rethink some of the way we approach groups and those types of settings too. So this was a study I'm done by my friend Jeremy, I mentioned at the beginning. And Jeremy kid, that was a scoping review, looked at all LGBTQ plus associated treatments that that were available in the literature. They found 71 different publications, most of them were psychotherapy, treatments for alcohol, tobacco, or meth problems for sexual minorities or gay or bisexual men. They did not find any of that compared groups based on gender and identity. So there are lots of gaps, a lot of work to be done. And even here on these tables just showing there were really no published studies until what 2004 Unfortunately, seeing an increase up to 71 since then, and up to 2020. Anyway, but really very little On, on those on transgender or gender non conforming individuals. So a few specific treatments that have been shown to be helpful medication wise for substances. So mirtazapine, or Remeron is the brand name that you may hear 30 milligrams was shown that in combination with substance use counseling to reduce methamphetamine use and some HIV risk behavior behaviors among cisgender men and transgender women who have sex with men. One thing to consider about mirtazapine is weight gain, there are certainly potential impacts on body image, we go back to thinking about some of the, the Alan Downes theories of kind of this different stages of development toward authenticity and the impacts of this may have you know, with impacting body image, the study authors, though have reported that patients were not rejecting of the treatment because of this, but you know, it is a consideration in the real world.

51:06
This was a study that was done and published recently last year that looked at combining Bupropion extended release 450 milligrams will now track zone XR, injectable for methamphetamine use disorder. This was general populations, they didn't they didn't specify, you know, gender, sexuality. They took all comers basically. And they showed a significant difference in response, although both were quite low. In methamphetamine use disorder treatment, this was, you know, a major outcome but 13.6% response compared to 2.5% with placebo. They didn't in the original study, differentiate the or analyze by sexual orientation, but there is a secondary analysis that is being planned and I think is that analysis is done and it looks like there may be some differences depending on sexual behaviors, but we'll have to wait and see what the results say or what the publication says. There has been a gay specific CBT that was developed by Steve Shaw and Kathy Rebeck. I believe there is UCLA. This was shown to have significantly reduced sexual risk behaviors compared to CBT CBT that had comparable or showed comparable reductions and methamphetamine use. This is the manual which you can access free online. And I just show it here. So you can see some of the differences that you might not see in kind of the traditional CBT meet Auntie Tina, I mentioned Tina's another term used for methamphetamine and other more specific things around sex and identity that may not exist in kind of a standard manualized CBT. So we're turning back to our clinical case as we wrap up. So let's think about that ally coming in for treatment for alcohol use, you know, she's tried some smart or they've tried to smart recovery meetings, and have not been unsuccessful, and had a bad experience when they first showed up. So now they've come back and noticed flyer with same sex couples and another with an individual waving a pride flag. The staff refers to ally as she which the patient corrected once did they politely and they apologize and use they pronouns and you know, road on the chart alley. They slash them. That physician focuses on related concerns, explores some of the potential impacts of cannabis and actually validated the harm reduction strategies regarding MDMA. So remember, Ali was testing their MDMA with dance safe kit to make sure that it was pure, pure MDMA and didn't have any adulterants. And then the physician discusses some of the potential risks related to non FDA regulated testosterone and prescribes psychiatric medications including naltrexone for alcohol use disorder as there would be no contraindication between by prescribing and attracts on if someone is on testosterone. So much better clinical experience for ally when they returned. In summary, substance use and substance use disorders are higher in the LGBTQ plus population. Mental health and trauma are also higher in this population. substances and spaces where substances are consumed may provide or have provided safety and comfort. treatment engagement may be perceived as a threat to identity because of that safety and comfort that those spaces are used provided before and treating LGBTQ plus individuals may require a heightened awareness and sensitivity to develop rapport and improve outcomes. And then there are some specific tailored evidence based treatments that we can consider when it's possible, and some free resources online like the manual that I mentioned. And here are some references for today's talk. Some additional resources. So the Gay and Lesbian Medical Association has a nice guideline for caring for LGBT patients. CDC also has kind of a brief website with some pointers to LGBT casebook is very helpful. There's also a pocket guide to LGBTQ mental health. And then the APA is also has a best practice highlights available online. And then finally, just to say thank you, and happy Pride Month, and these are some pictures that I took a few years ago, prior to the pandemic. Anyway.

56:08
Thanks so much, Dr. Blevins. We've got a few good questions in the chat. So I'm just gonna dive right in. The first is how would you define sexual curiosity?

56:19
How would I define sexual curiosity? So I think that I would probably ask the person how they define that. But what I would probably expect if someone is saying they're sexually curious that they haven't formalized or decided what their sexual orientation is, so whether they're gay, straight, or bisexual. And that may take, you know, weeks months, or they may never, they always have some sexual curiosity. They may never, you know, formalize the identity. But I would say that sexual curiosity is someone who is exploring their relationship, both emotional and physical with individuals of both genders.

57:03
Great, What recommendations would you offer for clients who wants to obtain gender affirming surgery and may have challenges with drug use? How would harm reduction assist?

57:17
Yeah, so I think that the first, the first part of that is they should see someone who provides the medical and surgical care regardless of where they are, and their, the severity of their substance use the you know, what stage of change they might be in for, for substance use, how engaged they are with treatment, it can be helpful for them to understand what the real risks are, you know, whether it's related to smoking, you know, and if they need to stop smoking a certain number of weeks before they can have the surgery for wound healing purposes, it can be helpful for a surgeon to explain some of that to to the individual, and that may change their level of interest in either reducing or stopping using the substance or it may change their level of interest in having surgery. You know, I think that it really just comes down to, you know, risks and benefits and the discussion of what's important to the patient. Harm Reduction can definitely play a role. You know, one thing that I'm might think about in that space being harm reduction is a period of abstinence, or a period of significant reduction, even if they don't intend to maintain that in a, you know, long term ongoing way or don't identify a particular substance as being problematic or having had, you know, cause problems before.

58:47
Follow up question that just came in. I've had folks claim the use of inhalants as a harm reduction measure. They say the muscle relaxing effect lowers the risk of tech based fissures and can lessen cross fluid. What do you know if there's any veracity to this? Or should this person gently correct their patient?

59:08
Yeah, you know, as far this is one of those studies, it's very difficult to do for a number of reasons. You know, it, there is some, I think, physiologic reality that that may be true. You know, I'm not, not to get into too much detail, but I'm not sure that just thinking about fissures and muscle relaxation, that those two things are as related as things like lubrication. So, you know,

think that there's some gray area there. I guess the question I would have is how helpful it would be to correct the, whatever that belief is, as opposed to thinking about what some of the potential risks may be. And allowing them to you know, if they do feel Like there is, I mean, maybe they've experienced that right? Maybe they've experienced a reduction in pain or fissures when using poppers or nitrites versus not. So it'd be hard to dispute that right, if they've had that experience. So rather than getting in that, that argument with them, it might be easier to think about, right? Pros and cons. And is that enough of a pro to outweigh some of the potential cons, you know, especially in light of the FDA statement, and some of the concerns about, about hospitalization and death and, and death? Again, knowing that we don't actually know what those numbers are.

1:00:45
I'm gonna pose one final question. And for the attendees who are still with us today, if you didn't see your question answered, I will follow up by email, we want to make sure that Dr. Blevins has a chance to respond to each of you. But given the time, I'm going to cut it off with this this last one. What recommendations would you offer for health care providers to address their own implicit biases towards clients who identify as LGBTQ A plus? And who may use drugs or may also participate in sex work?

1:01:16
Hmm. Yeah, that's a great question. I feel like it could probably, well, I can write a book, I feel like someone could write a book on that. If they haven't already. You know, I think that the place to begin is from a place of not understanding, right and insight around that, and educating yourself ourselves as much as we can, when it comes to whatever that space is, right? If it is that we're totally comfortable and have no, at least perceived implicit biases toward gay individuals, but toward trans individuals that feels different, right? That as much reading as you can, and speaking with people, maybe in a non clinical context, about their experiences, especially their experiences with discrimination and bias. I think that gives a good foundational understanding. And then it's sort of from there, like after every experience that you have with the client to really reflect back on that afterward, right? Like have that like five or 10 minutes where you sit and think about what that indirect interaction felt like, where their time periods where you would have done something differently. Sometimes there are going to be time periods where you wouldn't have done something differently and the client or patient is still going to have a negative reaction because of the previous traumatic experience that they've had before to. Right it's not it's not so black and white. It's not just if the client patient gets upset that you did something wrong or have some misunderstanding, I think really reflecting on that. And you know, the fact that that someone would ask that question is a really great start to that and, and being aware that we have those biases and the openness to reflect on them, I think goes further than lots of reading and you know, getting a PhD and something Well, thanks again. Dr. Blevins, these guys.

[End Transcript]