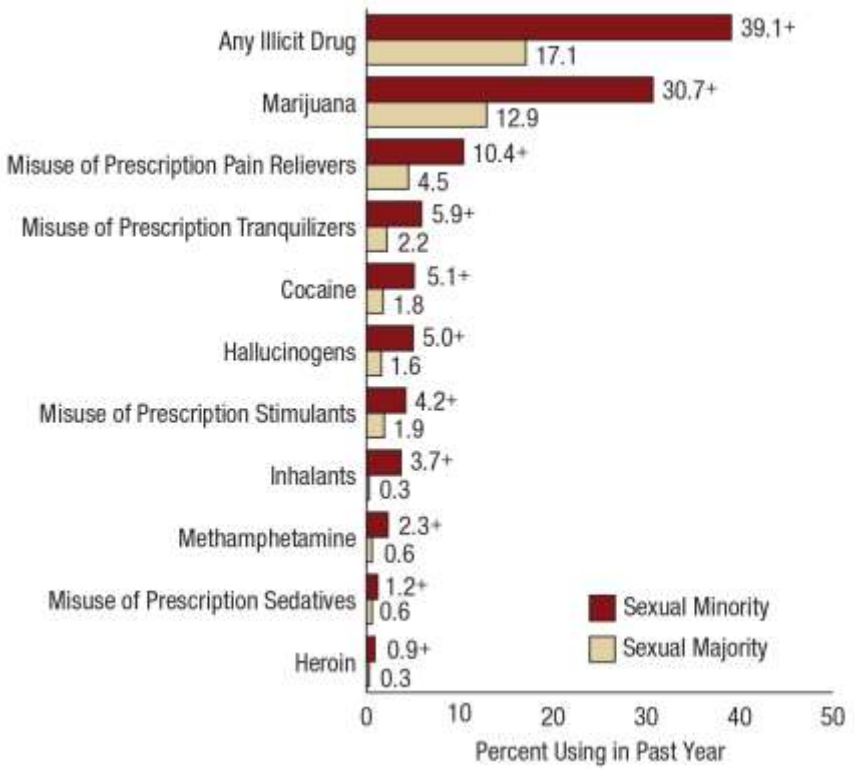
Faith G. Harper, PhD, LPC-S, ACS, CAN
info@faithgharper.com

General Statistics

NSDUH is an annual survey of the civilian, noninstitutionalized population of the United States aged 12 years old or older.10 The survey is sponsored by SAMHSA within HHS. *Adding the sexual attraction and sexual identity questions was part of the 2015 NSDUH partial redesign.* The survey covers residents of households and individuals in noninstitutional group quarters (e.g., shelters, boarding houses, college dormitories, migratory workers' camps, halfway houses). *The survey excludes people with no fixed address (e.g., homeless people not in shelters), military personnel on active duty, and residents of institutional group quarters, such as jails, nursing homes, mental institutions, and long-term care hospitals.*

In 2015, sexual minority adults were more likely than sexual majority adults to be past year users of any illicit drug and to be past year users of each of the 10 categories of illicit drugs in NSDUH. Among sexual minority adults, 39.1 percent used illicit drugs in the past year, or nearly 2 out of 5. Nearly one third of sexual minority adults (30.7 percent) used marijuana in the past year, and about 1 in 10 (10.4 percent) misused prescription pain relievers. In comparison, among sexual majority adults, 17.1 percent used illicit drugs in the past year, 12.9 percent used marijuana, and 4.5 percent misused prescription pain relievers (SAMHSA, 2016).



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Data Flaws

Gender

Please note that while SAMHSA is now curating date on sexual minorities, this survey only asks about sexuality, not gender variance. The questions focused on sexual attraction and sexual identity. Therefore, an individual who is transgender, gender variant, genderqueer, agender, or has an intersex condition is not being represented within this survey. A transgender woman who likes men, will properly identify as a straight woman. And data relating to possible issues surrounding gender identity that have led to drug misuse and abuse went uncaptured.

Funding For Research on LGBT Substance Use

In a 2014 article published in Social Work Today, Jeremy Goldbach, PhD, LMSW (an assistant professor at the University of Southern California School of Social Work noted: "Less than half a percent of all [National Institutes of Health] funding went to LGBT issues, and within that half a percent, 82% was focused on sexual risk and HIV. So if it's not about sexual risk or HIV—and primarily in adult gay men ... we basically have no idea" [what the impact of substance use on LGBT individuals really is] (Redding, 2014).

Issues In Standardization of Reporting

Additionally, we need to remember that there is no standardized system for reporting drug related deaths in the United States which can affect our determination if a death is related to a prescription drug or illicit drug. As an example, state reporting procedures make it difficult to explicate whether a death is heroin or morphine related, as many medical examiners are hesitant to label a death as heroin related unless there is the presence of 6-MAM, a metabolite that is unique to heroin. However, 6-MAM quickly metabolizes into morphine within the human body (DEA Strategic Intelligence Section, 2015).

Prescription Drugs, Child Abuse, and Gateway Outcomes Among LGBT Youth

National research (Marshal et al., 2009) has shown that substance abuse is twice as prevalent in LGBT youths compared with their peers. While correlation is not causality, it is important to note that there are also significantly higher rates of emotional, physical, and sexual abuse reported by LGBT youth (Kecojevic, et al., 2012).

When looking specifically at prescription drug misuse (defined as taking prescription drugs "when they were not prescribed for you or that you took only for the experience or feeling it caused") among LGBT youth, one finding stands out. While LGBT youth and their heterosexual, cisgender counterparts are all more likely to misuse prescription drugs if they suffer sexual abuse, early prescription drug misuse was far higher in LGBT youth that reported *emotional* abuse than in their heterosexual, cisgender peers (Kecojevic, et al., 2012). Possible causes, could be the content of the emotional abuse, or the lack of other supports allowing for healthy identity formation. Additionally, prescription drug misuse has been noted as having a significant

correlation with later illicit opioid drug abuse. Nearly half of the youth who inject heroin, started by abusing prescription medications. (Partnership for Drug Free Kids, 2017).

Factors Associated With Higher Usage Rates

Minority Stress. There are significant negative effects associated with the adverse social conditions experienced by individuals of a marginalized social group. Stressors include employment discrimination, housing discrimination, health care discrimination, relationship recognition discrimination, and generalized social prejudice (Hunt, 2012).

Lack of Cultural Competency. There are significant negative experiences associated with health care access (or lack of culturally competent health care) for individuals within the LGBT population. Therefore, many individuals either avoid or delay treatment, or choose not to disclose information about themselves, which can be of detriment to their care outcomes (Hunt, 2012).

Socialization and Targeted Marketing. Bars, clubs, and restaurants have historically been safspace for LGBT individuals, where there is a higher likelihood of greater use of both legal and illicit substances (Hunt, 2012). Additionally, programs such as Subculture Urban Marketing (SCUM; Kulke, 2015) has been used by drug and alcohol companies for decades to target gay and transgender social networks.

Creating Safe Space:
Suggestions for Inclusive Practice and Support

On Intake Forms:

- Ask about relationship status as well as marital status (this is helpful for EVERYONE, not just the LGBT population).
- Ask about legal name and preferred name (instead of “nicknames”)
- Ask about different sexual (gay, lesbian, bisexual, pansexual, etc.) and gender identities (transgender MTF, transgender FTM, genderqueer) and separate out gender identity from sexual identity.
- Have space on intake forms for legal name and preferred name. Name and gender marker changes can be a huge barrier for a multitude of reasons, their legal name may not match their identity.
- Have space for the individual to identify their preferred pronouns (he, she, ze, singular they, etc.)

In Interaction:

- Don’t presume individuals are cisgender or heterosexual. Ask about relationships, partners, spouses instead of girlfriends, boyfriends, husbands, and wives.
- If someone is out with you, do not presume they are out to everyone else. Discuss these issues, how they want their privacy protected, and safety plans if their sexual orientation or gender puts that at risk in their home or community.

- Allow for discussion on how homophobia, monosexism, and/or cissexism is affecting their daily lives and recovery. These experiences may be present in their surrounding community AND/OR internalized.
- Allow for space to work on accepting gender identity or sexual orientation as an integral part of recovery.
- However, do not pressure individuals into a self-acceptance they are not yet ready for. Religious faith and other cultural considerations can act as an intersectional identity crisis that needs to be navigated carefully and strategically (TALGBTIC, 2014).

Within Program Structure:

- Create policies and standard operating procedures that are part of your regular human resources training that protect the rights, safety, and privacy of LGBT clients. How will people be called upon in the waiting room? Referred to in their charts, etc?
- Create policies and standard operating procedures to protect and support LGBT staff members and volunteers. For example, are partners as well as spouses eligible for insurance coverage? Are you looking for plans that cover gender confirmation procedures (Cheatsheet.com maintains a list of providers). For employees that transition on the job, have a policy that supports their transition (the Transgender Law Center has an excellent model policy).
- Build competence at all levels of program development. This includes not just clinical and peer supports, but also front line staff and administrative team members. Trainings such as Safe Zone (offered by The Center – Pride Center of San Antonio, for example) were designed for universal participation.
- Have appropriate community resources for individuals. To include Lambda AA meetings, LGBT support groups, and culturally competent providers. Have these resources available through your website and social media so individuals not affiliated with your organization that are seeking resources can still have access to the information you have collected.
- Signal that you provide safe, culturally competent space on your fliers, handouts, brochures, as well as in your offices (safe zone stickers, rainbow stickers, flags, etc.) …even if it's small people will be looking for a sign you are someone they can talk to. They will see it, I promise!
- Review treatment materials for inclusive language and cultural competence. Materials that do not reflect individual experience are far less likely to be beneficial. Tailored interventions are far more effective than cookie cutter treatment for *everyone.*
- Consider hosting programming that is LGBT specific within the context of your greater programming. Find ways to do so that don't increase a sense of isolation, difference, and otherness, but allows individuals more options. For example, Alamo Area Youth Move would offer a second meeting space during each meeting event where LGBT youth, could break off after the first hour of group to discuss LGBT specific issues among their peers if they so desired.