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Substance Use Treatment and Providers for Sexual and Gender Minority Populations in a Texas-Mexico Border City

Diana Laura Barraza
University of Texas at El Paso

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SUBSTANCE USE TREATMENT AND PROVIDERS FOR SEXUAL AND GENDER
MINORITY POPULATIONS IN A TEXAS-MEXICO BORDER CITY

DIANA LAURA BARRAZA

Master's Program in Public Health

APPROVED:

Oralia Loza, Ph.D., Chair

Jeannie B Concha, MPH, Ph.D.

Joao Ferreira-Pinto, Ph.D.

Stephen L. Crites, Jr., Ph.D.
Dean of the Graduate School

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Dedication

I dedicate this achievement to my loving parents, Roberto and Graciela, who with love and effort provided all necessary tools and resources for me to thrive and succeed in my educational journey. A special dedication to the memory of my loving mother, who was, and continues to be my source of inspiration and strength. To my loving husband, who has always been my support in the difficulties and the fan of my achievements. To my siblings, Leticia and Roberto, who have accompanied me in every stage of my life providing me with their unconditional support and encouragement. To my beloved dog Apollo, who has been my biggest admirer, lovingly watching over me and providing me with motivation to endure long sleepless nights.

I also dedicate this thesis project to all of my family members, close friends, cohort members, and professors in the Public Health and Psychology Departments. Their support, encouragement and guidance was instrumental throughout my academic journey.

SUBSTANCE USE TREATMENT AND PROVIDERS FOR SEXUAL AND GENDER
MINORITY POPULATION IN A TEXAS-MEXICO BORDER CITY

by

DIANA LAURA BARRAZA, B.A.

THESIS

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Abstract

Sexual and gender minority (SGM) is an umbrella term that refers to lesbian, gay, bisexual, transgender, and gender-diverse populations. These populations face challenges and barriers when accessing health services that further lead to negative health outcomes and an increase in health disparities. For example, rates of substance use are higher among SGM communities compared to heterosexual/cisgender people. Risk factors for substance use problems include lack of social support, Adverse Childhood Experiences (ACEs), rejection and discrimination, and solitary drug use. Various efforts in Texas and the U.S.-Mexico border region have been made to close the gap in health inequalities. In El Paso, Texas, the Purple Pages of El Paso (PPoEP), were established in 2017 as an online resource to connect SGM communities and providers in the Paso del Norte region with high-quality, culturally sensitive health care and social services. The goals for this project were to: (1) expand the PPoEP; (2) update the PPoEP; (3) improve the delivery of mental health/substance use treatment services through informational videos; and (4) identify substance use intervention funding opportunities. As a result, 10 new providers were added and the information of 21 providers was updated to the PPoEP. The “Safe and Welcoming Environments” video had 12 views, the “Correct Terminology” video had eight views, and the “Health Disparities” video had eight views within the first 10 days of sharing with target providers. Three substance use intervention grant opportunities were identified.

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Introduction

Sexual and gender minority (SGM) is an umbrella term that refers to lesbian, gay, bisexual, and transgender and gender diverse populations, including those whose sexual orientation, gender identity, and expressions, or reproductive development is characterized by non-binary constructs of sexual orientation, gender, and/or sex (National Institute of Mental Health, 2020; National Institutes of Health, 2022). SGM populations face stark challenges in achieving and maintaining health, receiving equal rights and equal opportunities, as well as facing social and systemic effects of oppression and discrimination (Smalley, 2017).

Traditionally, the health of SGM individuals has been focused primarily on risk, that is, higher levels of engagement in risk-taking behaviors and disparities in health outcomes when compared to non-SGM populations, perpetuating a continuum of discrimination, victimization, and harassment towards this population as a result from homophobia/transphobia (Smalley, 2017). It is important to also point out that homosexuality was considered a diagnosable illness in the United States until the late 1970s. As to date in 2022, in the United States, only 22 states and DC have state antidiscrimination laws protecting the provision of public services (including health care), employment, and housing regardless of sexual orientation and gender (Movement Advancement Project, 2022a). Nonetheless, only two states (New Mexico and Wisconsin) have laws that address discrimination against students based on sexual orientation, and only Alaska has laws that protect students based on sexual orientation and gender identity (Human Rights Campaign, 2022a).

There is federal protection against discrimination based on gender identity, which was included in the Affordable Care Act (Section 1557), however, this protection only applies to providers and organizations that receive federal funding (Kates et al., 2018). Moreover, in

addition to considering the needs of SGM individuals in programs designed to improve the health of the community, there is also a critical need for culturally competent medical care and prevention services that are specific to these populations and their unique needs (Centers for Disease Control and Prevention, 2022a). One specific group within SGM populations is the Latinx community. This population in the United States has its own needs and characteristics within SGMs. The Latinx LGBTQ+ population in the United States has been growing in previous years. As of 2021, there are approximately 2.3 million Latinx LGBTQ+ adults living in the United States (Williams Institute, 2021). About 65% of Latinx LGBTQ+ adults are under the age of 35 compared to 45% of Latinx non-LGBTQ+ adults under 35 in the country (Williams Institute, 2021). In terms of social and health inequalities, 10% of these adults are unemployed, 35% have been diagnosed with depression, and 42% have experienced physical assault and threats (Wilson et al., 2021). According to a report by UCLA published in 2021, Latinx LGBTQ+ adults in the U.S. prefer to live in the West than in other regions; 38% live in the West, 33% live in the South, 18% in the Northeast, and 10% in the Midwest (Conron & Goldberg, 2020). In terms of health outcomes, Latinx LGBTQ+ adults had greater odds of being diagnosed with serious health conditions, including asthma, diabetes, cancer, high blood pressure, and high cholesterol (Conron & Goldberg, 2020). As will be explored in further detail later in this paper, the Latinx LGBTQ+ populations face higher levels of discrimination and victimization, as well as various barriers to care. There is a gap in the published literature about risk factors for substance abuse among SGM, with some literature on risk factors for drug use among men who have sex with men (MSM), and substance abuse treatment and recovery that is tailored and adapted to this population's specific needs and vulnerabilities. The focus of this project is to summarize the health needs of SGMs, the barriers to care that this population faces, the little

availability of substance abuse treatments that are culturally tailored to the LGBTQ+ population, and the presence in statistics of SGMs in the Paso Del Norte region.

Background

HEALTH DISPARITIES AMONG SEXUAL AND GENDER MINORITIES

According to the Centers for Disease Control and Prevention (CDC), health disparities are “preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations” (Centers for Disease Control and Prevention, 2021). Research has indicated that SGM individuals experience health disparities that are associated to stigmatization, discrimination, and denial of their agency and their rights (Centers for Disease Control and Prevention, 2022b). Discrimination against this population has been associated with high rates of psychiatric disorders, substance use, and suicide. Experiences of violence and victimization are frequent for LGBTQ+ individuals, and these have long-lasting effects on the individual and the community. The personal, family and social acceptance of sexual orientation and gender identity affects the mental health and personal safety of SGM individuals (Thompson, 2020). In 2016, the NIH formally designated sexual and gender minorities as health disparity populations alongside racial/ethnic minorities, socioeconomically disadvantaged populations, and underserved rural populations (National Institute of Mental Health, 2020).

According to the SAMHSA’s National Survey on Drug Use and Health (NSDUH) report from 2015, sexual and gender minority adults were more likely to be past-year users of any illicit drug in comparison to their heterosexual counterparts (Substance Abuse and Mental Health Services Administration, 2016). An estimated 36.3% of SGM males and 41.1% of SGM females used illicit drugs in the past year, in comparison to 20.4% of non-SGM males and 13.9% of non-SGM females (Substance Abuse and Mental Health Services Administration, 2016). According to the National Survey on Drug Use and Health from 2018, SGM individuals reported higher

rates of alcohol consumption (64.3%) in comparison to the overall United States population (55.1%) (Substance Abuse and Mental Health Services Administration, 2019).

Research is consistent in showing that LGBTQ+ individuals experienced negative events that are linked to poorer mental health outcomes, elevated substance use, and sexual risk behaviors. For example, in a national survey among 62,302 participants in 2013-2014, all sexual, gender, and racial minority groups except for white gay men and non-white bisexual men, self-reported worse health when compared to non-SGM and non-minority males ($p < 0.05$) (Hsieh & Ruther, 2016). This trend has also been observed outside the United States. For example, in a cross-sectional study among 18,416 twins in the United Kingdom between 2017 and 2019, after accounting for sociodemographic factors, being a sexual minority was associated with increased psychosocial adversity, substance use, and the number of lifetime sexual partners (Oginni et al., 2021). However, worldwide, not all national reports include or are specific to sexual and gender minorities. For example, Mexico reports the rates of drug use through the National Survey of Drugs, Alcohol, and Tobacco Use by age and sex but does not include results by sexual and gender minorities who are known to be vulnerable populations to drug use (Secretaria de Salud, 2017).

Two national studies in the U.S. indicate that after adjusting for sociodemographic characteristics, SGMs have higher odds of substance use disorder compared to heterosexual people. The first report from the National Epidemiologic Survey on Alcohol and Related Conditions among 36,309 participants from 2012 to 2013, indicates the odds for any substance use disorder were significantly higher for gay/lesbian participants (AOR: 1.8; 95% CI: 1.43, 2.21) and bisexual participants (AOR: 2.00; 95% CI: 1.50, 2.57) compared to heterosexual individuals (Kerridge et al., 2017). The other report is from the National Survey on Drug Use

and Health among 126,463 participants, including 8241 LGBTQ+ adults, between 2015 and 2017, which indicates that compared to heterosexual people, SGM had increased odds of substance use disorder among men (AOR: 1.92; 95% CI: 1.38, 2.68) and women (AOR: 1.73; 95% CI: 1.21, 2.48) (Schuler & Collins, 2020). No data or rates of substance use were found for the state of Texas for SGM.

However, this trend of elevated substance usage among SGM is visible in other states as well, such as the state of California. The following articles describe health disparities and drug use among SGM when compared to heterosexual people. Health disparities in substance abuse are reported in two surveys among SGM youth. The first report from the California Healthy Kids Survey from 2013 and 2015 among 634,454 participants indicated that sexual and gender minority boys and girls had elevated rates of alcohol use (26.90% of SGM boys, 35.07% of SGM girls) compared with their heterosexual peers (15.21% for non-SGM boys and 17.53% for non-SGM girls) (Fish et al., 2021). In another report of an online survey from California among 147 participants between 2017 and 2018, after adjusting for sociodemographic characteristics SGM participants had significantly greater odds of use of cigarettes and cannabis when compared to non-SGM participants (AOR: 2.05, 95% CI: 1.04, 4.01) (Nguyen et al., 2021). Health disparities also exist within the SGM community, two studies indicated age and racial/ethnic disparities among LGBTQ participants. In a 2016-17 generational study among age cohorts of sexual minorities born 1956-1963, 1974-1981, and 1990-1997 in the United States, members of the younger cohort reported higher levels of distress than both the middle and older cohorts (Meyer et al., 2021). The other report is from a cross-sectional study among 107 LGBTQ+ individuals with potentially traumatic events (PTEs) exposure recruited from online groups, listservs, and forums in 2017, results indicated that rates of PTE exposure, shame, loneliness, substance use,

and sexual risk behavior were higher among LGBTQ+ of color (44.4%) compared to white LGBTQ+ people (55.6%) (Scheer & Antebi-Gruszka, 2019).

Barriers to Care

Individuals from the LGBTQ+ community often face challenges and barriers when accessing health services that further lead to negative health outcomes and an increase in health disparities. The challenges that LGBTQ+ people live in the health care system are mainly stigma, discrimination, rejection, and violence. Among the barriers to care, they experience inequality in the workplace and health insurance sectors, provision of unadopted care, and even denial of health due to the provider's lack of competency (Kates et al., 2018).

SGMs can have the same needs as people in the general population but also have unique health challenges and concerns and are more likely to experience challenges when obtaining health care. Research has suggested that SGM often experience fear of seeking medical attention due to fear of discrimination, insensitivity, incompetency, and lack of appropriate treatment options. Similarly, in secondary data analysis of a national survey among 486 LGBTQ+ adults in 2017, 39% of participants reported avoiding doctors due to discrimination concerns. This was significantly more notable among older participants as being over the age of 30 increased the odds of avoiding the doctor due to discrimination concerns (OR: 0.31; 95% CI: 0.11, 0.92) (Casey et al., 2019). A large portion of SGM individuals has been subject to incompetent and discriminatory care. In the next article among 40 self-identified LGBTQ adults in New York City in 2015, these challenges were reported as system-level issues, and 72% of participants identified incompetent, insensitive, or discriminatory providers, and high service costs as barriers to access health care services (Romanelli & Hudson, 2017). Moreover, many SGMs have

described difficulty finding sexual and reproductive services from culturally competent providers locally. Specifically, healthcare workers who provide sexual and reproductive health care, and who lack cultural competency relevant to the wants and needs of SGM females were also considered a barrier to care. A report from a qualitative study among 39 individuals who were assigned female at birth who identified as lesbian, bisexual, queer, and/or genderqueer in California between 2016 and 2017, indicated that the primary challenges to accessing reproductive healthcare were provider's primary focus on fertility, provider's lack of LGBTQ health competency relevant to reproductive health priorities and treatment options, and provider's discriminatory comments during a clinic visit (Wingo et al., 2018).

Barriers to care are not a problem unique to SGMs in the United States, this trend is visible in other countries as well. For example, a focus group study among six European Union member states in 2016 that included both LGBTQ+ community members (n=52) and healthcare professional participants who also identify as LGBTQ+ (n=51), showed that participants see the provider's default assumption that the patient is cisgender and heterosexual as a barrier to healthcare (McGlynn et al., 2020).

Furthermore, when SGM individuals can find quality care that attends to their unique needs and vulnerabilities, they face better health outcomes, as is shown in a cross-sectional study among 101 male-to-female transgender persons from 3 community health centers in New York City in 2007, being under a physician's care was associated with increased smoking cessation ($p=0.004$) and increased utilization of clean needles provided by a licensed physician ($p=0.002$) (Sanchez et al., 2009). This article demonstrates that just having access to care improves people's health outcomes. Likewise, barriers to care can be reduced or eliminated by training physicians in how to care for different populations. This can be achieved by providing providers

and staff members with pieces of training such as safe zone, sensitivity, cultural sensitivity, and diversity pieces of training. However, health disparities among SGM populations continue to be a reality. These challenges and barriers to care are a growing problem in the United States as the gap in health outcomes widens. As result, fewer data are available on the long-term benefits of culturally competent and properly adapted treatment options for SGM populations.

SUBSTANCE USE AND ADDICTION

The National Institute on Drug Abuse (NIDA) defines drug addiction as a chronic, relapsing disorder that is characterized by substance seeking compulsively, causing a long-lasting change in the brain (National Institute on Drug Abuse, 2018). Addiction is a medical illness referred to as Substance Use Disorder (SUD) in the fifth edition of *The Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, and it is caused by repeated and compulsive misuse of one or more substances (National Institute on Drug Abuse, 2018).

Rates of Substance Use

According to the National Center for Drug Abuse Statistics, in 2018, if alcohol and tobacco are included, 165 million (60.2%) Americans aged 12 years or older currently abuse drugs (i.e., used within the last 30 days) (National Center for Drug Abuse Statistics, 2021). As of 2021, in the United States 139.8 million Americans 12 years old and older drink alcohol, 14.8 million (10.6%) have an alcohol use disorder, 58.8 million people use tobacco, 31.9 million use illegal drugs, and about 8.1 million (25.4%) of illegal drug users have a drug use disorder (National Center for Drug Abuse Statistics, 2021). According to the National Center for Drug Abuse Statistics, in 2018 6.3 million LGBTQ+ adults had a substance or mental abuse disorder

or both, 7% of LGBTQ+ adults struggled with illegal drugs, 2% of LGBTQ+ adults struggled with alcohol abuse, and 8% of LGBTQ+ adults struggled with both illegal drugs and alcohol abuse (National Center for Drug Abuse Statistics, 2021). Research is consistent with these statistics across the nation and in specific zones, such as El Paso, Texas. Results from the National Adult Tobacco Survey among 57,994 participants between 2012 and 2013, the rates for smoking was higher among SGM adults (27.4%) than non-SGM adults (17.3%) ($p < 0.001$) (Johnson et al., 2016). In the same study, the prevalence of current cigarette smoking was 22.2% for women who identify as lesbian or gay, 36.0% for women who identify as bisexual, and 14.3% for women who identify as straight (Johnson et al., 2016). However, the rates for alcohol consumption and use of illicit drugs were higher in El Paso, when compared to the state of Texas and the U.S. The rate of alcohol consumption was higher in El Paso in 2011-2012 (73.1%) compared to Texas (56.6%) and the United States (60.5%) for individuals between the ages of 18 and 25 (Loza et al., 2017). This trend was also present for the use of any illicit drug in El Paso (5.5%) in comparison to the state of Texas (4.9%) but not when compared to the United States (6.7%) for individuals older than 26 years old (Loza et al., 2017).

Risk Factors for Addiction

Research is consistent in showing that lower social and community support are risk factors for substance use. Research also has shown that rates of substance use are higher among sexual and gender minority communities compared to heterosexual or cisgender groups. The use of substances was associated with a lack of social support. The results from a systematic review of the literature on social support effects on mental health in the LGBTQ adolescent population between 2008 and 2016, showed that 40% of the studies indicated lower social support was

associated with higher levels of depression, anxiety, and alcohol and drug misuse (McDonald, 2018). Contrary to these findings, results from a cross-sectional study among 2,454 LGBTQ+ students from Minnesota between 2013 and 2014, community support was significantly associated with decreased odds of high-frequency alcohol use (OR: 0.59; $p < 0.01$) (Eisenberg et al., 2020).

Lack of social support continues to be a problem since the beginning of the COVID-19 pandemic. In terms of substance use, low social support can lead to solitary use, which is a risk factor for subsequent substance abuse problems. This issue was examined in a national study among 212 sexual and gender minorities assigned female at birth who use alcohol and/or cannabis, between 2020 and 2021, and results found that an increase in solitary substance use was a robust risk factor for concurrent and prospective increases in substance use during the COVID-19 pandemic (Dyar et al., 2021).

Risk factors for substance abuse are also present within the LGBTQ+ community in their unique experiences. For example, in a survey among 2,590 SGM men in 2015 and 2016, drug use and rates for STIs were significantly associated with having a history of being primary or secondary victims of violence (Bertolino et al., 2020). The presence of these trends within the LGBTQ+ community indicates a health disparity in substance abuse among this population. This can translate as being a sexual and gender minority can be a risk factor for substance misuse. Two national studies indicate that after adjusting for sociodemographic characteristics, SGMs have higher odds of substance use disorder compared to heterosexual people. One study from the National Adult Tobacco Survey among 57,994 participants between 2012 and 2013, found that smoking prevalence was higher among sexual and gender minority adults (27.4%) than straight adults (17.3%) ($p < 0.001$) (Johnson et al., 2016). In the same study, the prevalence of current

cigarette smoking was 22.2% for women who identify as lesbian or gay, 36.0% for women who identify as bisexual, and 14.3% for women who identify as straight (Johnson et al., 2016). The following national studies refer to specific populations within the SGM community. A National Survey on Drug Use and Health among 126,463 participants, including 8241 LGBTQ+ adults, between 2015 and 2017, after adjusting for sociodemographic characteristics, reported that compared to heterosexual women, lesbian/gay women had significantly higher odds of cigarette smoking (AOR: 1.55; 95% CI: 1.23, 1.95), marijuana use (AOR: 2.04; 95% CI: 1.61, 2.59) and substance use disorder (AOR: 1.73; 95% CI: 1.21, 2.48). In the same study, compared to heterosexual men, gay men had significantly higher odds for illicit drug use (AOR: 1.98; 95% CI: 1.58, 2.50) and substance use disorder (AOR: 1.92; 95% CI: 1.38, 2.68) (Schuler & Collins, 2020).

There was a gap in the literature about risks associated with substance abuse that referred to the state of Texas in this specific population. However, data from this population and substance use patterns were available from the state of California. In this cross-sectional study among 335 transgender and 31,737 youth who were not transgender from California between 2013 and 2015, after adjusting for demographic characteristics, results showed that transgender participants had higher odds of lifetime alcohol use (AOR: 1.62; 95% CI: 1.24, 2.12), cigarette use (AOR: 2.25; 95% CI: 1.65, 3.08) and marijuana use (AOR: 1.84; 95% CI: 1.38, 2.46) compared to other participants (Day et al., 2017).

Generational Trauma

Another risk factor associated with substance abuse is the presence of generational trauma. Generational trauma is the term used to describe the trauma that passes from one

generation to the next (Gillespie, 2020). Trauma can affect genetic processes, leading to traumatic reactivity being heightened in populations who experienced a great deal of trauma (Gillespie, 2020). Families with a history of unresolved trauma, depression, anxiety, and addiction may continue to pass maladaptive coping mechanisms and distrustful views of their environment onto future generations (Dixon, 2021). Trauma itself can contribute to poverty, compromised parenting, diminished attachment, chronic stress, negative health outcomes, and unstable living conditions (Dixon, 2021).

The available literature on generational trauma also referred to as historical trauma, refers to the realities of those individuals dealing with trauma, how it affects their life, and certain health outcomes. Authors in the literature also point out a pathway model to better understand the context of a person who is impacted by generational trauma and its effects on health. In this comprehensive critical review of the literature on theories of historical trauma published between 2003 and 2013, public and personal reminders of historical trauma (e.g., structural inequalities, perceived discrimination) influence how salient a narrative or experience is to a person or group which in turn influences whether the narrative will have health implications such as predisposition to psychological distress, PTSD, anxiety, and depression (Mohatt et al., 2014). The authors also describe how generational trauma is manifested among affected individuals. Historical trauma is a cumulative trauma over both the life span and across generations that results from significant traumatic events and manifests itself in depression, self-destructive behavior, substance abuse, identification with ancestral pain, fixation to trauma, somatic symptoms, anxiety, guilt, and chronic bereavement (Heart, 1999). In the next article, generational trauma is explored through the experiences of Mexican and Mexican American individuals living in the United States. Authors argue that psychosocial stressors (e.g., anti-

Mexican sentiment, discrimination, and racism), as well as limited access to health care, are linked to an increased rate of substance abuse, hypertension, metabolic syndrome, anti-social personality disorders, and Type II diabetes among the Mexican and Mexican American populations (Estrada, 2009). Generational trauma from the experiences of SGM bears similarities to those of Mexican and Mexican American people. In a longitudinal study among 216 LGBTQ+ older adults in the United States in 2014, results showed that the oldest generation (those born in 1934 or earlier) reported significant risk related to social relationships ($p < 0.01$) and the lowest levels of openly disclosing their sexual identity ($p < 0.001$) compared to the other two generations (those born 1935-1949 and 1950-1964, respectively) due to generational trauma (Fredriksen-Goldsen et al., 2020). Likewise, in a qualitative analysis of the identity formation among nine gay men from a local chapter of Services and Advocacy for Gay, Lesbian, Bisexual, and Transgender Elders in Georgia Between 2017 and 2018, participants described being relegated to silence and invisibility of their sexual identity for most of their lives (Bower et al., 2021).

Conching and Thayer (2019) in their article, present a model that describes the impact of generational trauma on the health of present-day generations; (1) personal exposure to trauma or stressors can induce epigenetic modifications that can contribute to the development of poor health, (2) poor health can occur through intergenerational epigenetic modifications in response to parental and grandparental trauma or stressor exposures (Conching & Thayer, 2019). The role of epigenetic changes also serves as a scope to better understand the long-lasting changes in gene expression and substance abuse problems among affected individuals.

Epigenetic Changes

According to the CDC, epigenetics is the study of how a person's behaviors and environment can cause changes that affect how genes work (Centers for Disease Control and Prevention, 2020). Epigenetic changes are reversible and do not change the DNA sequence, however, they can change how the brain read a DNA sequence (Centers for Disease Control and Prevention, 2020). Epigenetic changes can be associated with substance abuse and subsequent dependence on drugs among individuals who consume drugs or with a family history of drug consumption. Drug dependability involves potentially life-long behavioral abnormalities, and these behavioral changes suggest that long-lasting changes in gene expression may contribute to the addiction phenotype (Nestler, 2014). On a novel mechanism for nicotine- and cocaine-induced epigenetic changes where neuroblastoma cell lines (SH-SY5Y cells) were incubated along with either nicotine or cocaine. Seventy-one percent of the genes exposed to nicotine developed significant nucleosome distribution changes, while twenty-six percent of the genes exposed to cocaine showed remodeling (Brown et al., 2015). This idea has also been tested in research with animal models using various drugs for addiction. In this animal model experimental study, male rats treated with liquid ethanol undergoing withdrawal exhibited depression-like behavior and had increased deacetylase 2 (HDAC2) levels causing an altered epigenetic state in the hippocampus (Chen et al., 2019). Similarly, in a simulation of nicotine withdrawal, nicotine-treated zebrafish during the day but not at night obtained the highest conditioned place preference score, compared to those continuously exposed concluding that repetitive abstinence periods are risk factors for nicotine use and vulnerability when in nicotine environments (Pisera-Fuster et al., 2020).

Other Factors Associated with Substance Use

Contributing factors for substance use continue to be studied in the general population but also specifically to SGM populations and their unique experiences and vulnerabilities to substance use. The research was consistent in stating that unwanted sexual contact, peer pressure, and cognitive dissociation were associated as risk factors for substance use. Results from a survey administered to 595 gay men attending Pride Festival in Atlanta, Georgia in 1999 indicated that crack cocaine and nitrite inhalant use were significantly associated with a history of unwanted sexual contact (Kalichman et al., 2001). In addition to the lack of community support, peer pressure is also a risk factor associated with substance use among adolescents and young adults. This trend was present in a cross-sectional study among 443 teenagers in six Rhode Island middle schools between 2015 and 2016, compared with other participants, sexual and gender minority students (26.6%) were more likely to report willingness to use cigarettes ($M=0.21$ vs. $M=0.42$; $p<0.05$) and marijuana ($M=0.55$ vs. $M=1.03$; $p<0.01$) due to peer pressure (Gamarel et al., 2018). Vulnerability for SGM groups might also have to do to engage in certain behaviors and activities to survive (e.g., sex work) or in social contexts, to connect with other people (e.g., sex parties). This trend was analyzed in a cross-sectional study among 774 gay and bisexual men and other men who have sex with men in Vancouver between 2012 and 2015, results indicated that cognitive escape (i.e., disengagement based on Cognitive Escape Scale) was significantly associated with street drug use and sexualized drug use (Card et al., 2020).

SCREENING TOOLS

Health researchers, health benefit carriers (i.e., health insurance companies), and epidemiologists strongly recommend the use of clinical screening tools to identify individuals

with undiagnosed substance use disorders, monitor ongoing symptom severity, assess the best approach for treatment, and recovery practices, and to assess outcomes after treatment. The most common screening tool used to assess substance abuse problems among different drugs is the Screening, Brief Intervention, and Referral to Treatment (SBIRT) tool. Another tool that has become widely used to identify risk factors for substance abuse is the Adverse Childhood Experiences (ACEs) tool.

Screening, Brief Intervention, and Referral to Treatment

The Screening, Brief Intervention, and Referral to Treatment (SBIRT) screening tool is an instrument that is used to diagnosed individuals with a SUD or those who are at risk of developing and SUD, as well as to refer them to the most appropriate treatment option (Substance Abuse and Mental Health Services Administration, 2020). SAMHSA's Center for Substance Abuse Treatment (CSAT) initiated the SBIRT program in 2003 to respond to the need for a coordinated effort to screen, provide intervention, and referral to individuals in need of such services and to eventually promote the adoption of SBIRT in the United States (Babor et al., 2017). The SBIRT components are screening to identify unhealthy use of alcohol and other drugs, brief intervention that provides feedback and information about unhealthy substance use, and referral to treatment to facilitate access to addiction assessment and treatment. SBIRT has been found to decrease the frequency and severity of drug and alcohol use, decrease emergency department visits and hospital days, and demonstrate net-cost savings (Madras et al., 2009).

Besides alcohol, the SBIRT is used to screen for other drugs as well such as tobacco, cannabis, solvents (e.g., paint thinner), tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens, and narcotics (e.g., heroin) (Department of Human

Health and Services, 2020). For alcohol, the test that is used is the Alcohol Use Disorders Identification Test (AUDIT) and the screening categories go from low risk (I) to severe (IV) and the follow-up actions depend on what is the individual's score. For example, in the low-risk zone (I), individuals will receive a positive health message and drinking guidelines, in the risky zone (II) a brief intervention is used to reduce use, in the harmful zone (III) individuals receive a brief treatment to reduce or abstain and a specific follow-up appointment, lastly, in the severe zone (IV) individuals are referred to specialized treatment for a full assessment (Madras et al., 2009). For other drugs, the Drug Abuse Screening Test (DAST-10) is used. The DAST-10 does not include alcoholic beverages. Also, in the DAST-10, the term drug abuse refers to the use of prescribed medications or over-the-counter drugs above directions, and any nonmedical use of drugs (Department of Human Health and Services, 2020). There are other tests for screening such as the CRAFFT 2.1, the NIAAA, the BASTAD, and the S2BI, that are used for different populations (e.g., adolescents. It is estimated that 75-85% of patients will screen negative for risk and about 5% of people screened will be referred to specialized treatment (Department of Public Health, 2012). The sensitivity and specificity of the AUDIT test were analyzed in a cross-sectional study among 286 primary care patients screened for unhealthy alcohol use, the results showed that the AUDIT screen test was 73.9% sensitive (4.3; 95% CI: 3.1, 6.0) and 83% specific (0.3; 95% CI: 0.2, 0.4) for the detection of unhealthy alcohol use and it was slightly more sensitive (88%) (3.2; 95% CI: 2.5, 4.0) and less specific(72%) (0.2; 95% CI: 0.1, 0.4) for the detection of a current alcohol use disorder (Smith et al., 2009).

Research has shown positive results of SBIRT in identifying individuals at higher risk levels for substance and alcohol abuse. The application of SBIRT programs has also shown positive results in decreasing substance use and in providing quality access to treatment (e.g.,

providing individuals with the best treatment options and combination of treatments for their unique needs), and providing equal access to services by adapting the testing tools to different populations. The following study was a cross-site evaluation of two cohorts of SAMHSA's 5-year grant recipients in 2003 and 2008, and SBIRT implementation was associated with improvements in treatment system equity (e.g., equal access to services), efficiency (e.g., providing the best combination and quality of services from meeting population needs) and economy (e.g., use of valuable resources to minimize the cost of SUDs for populations) (Babor et al., 2017). Similarly, SBIRT implementation has been effective in reducing alcohol use as was shown in the results from a pre-post comparison design of SBIRT's cohort 1 among 171,921 participants who screened positive for hazardous or harmful use between 2004 and 2010, the probability of using any alcohol in the past 30 days decreased by 35.6% for all patients; the proportions of patients reporting heavy drinking dropped by 43.4% for all patients, also, the prevalence of illicit drug use dropped 75.8% (Aldridge et al., 2017). The screening test used by SBIRT implementations has also been culturally adapted for minority populations, specifically those from racial and ethnic minority groups. One example of an adapted screening test is the AUDIT. As mentioned above, AUDIT is a screening tool that is used by healthcare professionals to implement SBIRT in individuals with problematic alcohol use (Substance Abuse and Mental Health Services Administration, 2022a). In a review of the literature on the SBIRT approach with racial and ethnic subgroups in the United States between 1995 and 2005, the AUDIT has been examined with the greatest number of racial and ethnic groups and is recommended as a screening measure in primary care settings, It was also found that culturally adapted motivational interviewing showed significant decreases in drinking days, heavy drinking days, and consequences of alcohol use, also that themes such as mistrust of the healthcare system and

stigma associated with seeking mental health and/or substance treatment should be taken into consideration by providers when tailoring brief interventions to Latinxs (Manuel et al., 2015).

Adverse Childhood Experiences

Adverse childhood experiences (ACEs) refer to potentially traumatic experiences that occur in a child's life. ACEs refer to specific types of trauma such as physical, sexual, and emotional abuse, neglect, losing a parent or experiencing parents' divorce, exposure to domestic violence, mental illness, and substance abuse, and having a parent who has been in jail (American Society for the Positive Care of Children, 2021). The ACEs quiz score is based on ten types of childhood trauma measured in the ACE study, five being personal items and the other five being related to family members (American Society for the Positive Care of Children, 2021). Research has shown that a score higher than 4 on an ACEs quiz is linked to an increased risk of developing chronic diseases and behavioral challenges, including obesity, autoimmune disease, diabetes, heart disease, poor mental health, alcoholism, and even reduced life expectancy by as much as 20 years (Padilla, 2021). Research on different racial and age populations has supported the associations between high ACEs scores and substance abuse and mental health problems. In a cross-sectional study among 7,148 college students in California and Minnesota in 2015, accumulated ACEs scores were associated with alcohol use (AOR: 1.19; 95% CI: 1.09, 1.22), binge drinking (AOR: 1.13; 95% CI: 1.08, 1.19), marijuana use (AOR: 1.38; 95% CI: 1.30, 1.45), tobacco use (AOR: 1.28; 95% CI: 1.42, 1.67), and illicit substance use (AOR: 1.54; 95% CI: 1.42, 1.67) after adjusting for demographic characteristics (Forster et al., 2019). In another cross-sectional study among 417 Spanish-speaking Latino caregivers in Texas in 2017, results

suggested that high ACE scores are positively associated with mental health issues ($p < 0.001$) and substance use ($p < 0.001$) (LaBrenz et al., 2020).

SUBSTANCE USE TREATMENTS

When it comes to substance use treatment, there is no one-size-fits-all. There is a variety of different substance abuse treatments that are used either by themselves or in a combination of other treatments, depending on the needs of the individual seeking help. The type of intervention used for substance abuse relies upon the stage of action such as preventative measures, treatment for ongoing use, or recovery and recovery support. There is a wide range of treatments that are evidence-based such as harm reduction approaches, cognitive-behavioral approaches, and trauma-informed approaches (Miller, 2022). There are also treatment options that are not considered evidence-based such as the 12-step programs. However, there is an existing gap in knowledge about substance use treatments and minority populations as not all treatment approaches have been adapted to all groups such as the Latinx or LGBTQ+ populations. Moreover, further research is needed to culturally adapt treatment approaches to the population of interest, in this case, Latinx SGM populations. These topics will be discussed in further detail for each of the proposed treatment approaches according to what was found in the published literature and what was missing.

EVIDENCE-BASED SUBSTANCE USE TREATMENTS

Evidence-based treatment refers to the type of treatment that has scientific evidence supporting the effectiveness of the treatment and the goal is to encourage the use of safe and effective options to enhance the achievement of results and lessen the use of unsafe treatments

(Society of Clinical Child & Adolescent Psychology, 2017). There is extensive data in the literature on evidence-based treatment approaches that support the effectiveness of these treatment options when used among SGM and Latinx populations. These psychological evidence-based treatment options are effective when treating individuals with substance abuse problems and other mental health issues. This is shown in a systematic review of the literature published between 2001 and 2013 on the effectiveness of psychological interventions in substance use disorders, such as Cognitive Behavioral Therapy (CBT), Motivational Interviewing (MI), and Relapse Intervention (RI), which concluded that the integration of these interventions yields to better treatment outcomes across many drugs of abuse compared to not having psychological treatment. The results also showed that psychological treatment is more effective when combined with medication compared to psychological treatment alone (Jhanjee, 2014). In contrast, there is also supporting evidence of the lack of appropriate treatment measures for substance abuse. Another systematic review of the literature published between 2001 and 2017 on the principles of care related to substance use disorder (SUD) treatment in young adults showed that SUD treatment was commonly marked by poor outcomes, loss of follow-up, and low quality when evidence-based treatment was not incorporated (Hadland et al., 2021).

Cognitive-Behavioral Therapy

Cognitive-behavioral therapy (CBT) is a form of psychological treatment that consists of efforts to change thinking and behavioral patterns (American Psychology Association, 2017). CBT has been demonstrated to be effective for a range of problems including substance use problems, depression, anxiety disorders, and severe mental illness (American Psychology

Association, 2017). CBT helps the patient become aware of inaccurate or negative thinking so that they can view challenging or difficult situations more clearly and be able to respond to them more healthily and efficiently (Mayo Clinic, 2020).

Research has suggested that CBT is a well-suited treatment option for patients dealing with substance use problems, as well as patients dealing with other mental health problems that can be categorized as risk factors for substance abuse such as minority stress, PTSD, and sexual risk behaviors. In two randomized controlled trials, CBT showed positive outcomes in reducing the frequency of drug use among participants. In the first study among 221 participants in Vermont and New Hampshire between 2010 and 2013, the group receiving integrated cognitive behavioral therapy produced more favorable outcomes in reducing drug use compared to standard care alone and individual addiction counseling alone (McGovern et al., 2015). Similarly, in the second randomized controlled trial among 92 participants also seeking treatment for substance abuse in Connecticut between 2014 and 2017, compared to participants receiving treatment as usual those receiving cognitive-behavioral therapy had a significant reduction in the frequency of primary substance use over time ($p=0.01$) (Paris et al., 2018). CBT shows beneficial outcomes in treating other mental health problems that are associated with substance use. In the following study, among 114 participants with PTSD in trauma-focused cognitive-behavioral therapy in Philadelphia between 2013 and 2016, it was significantly associated with improving participants' PTSD symptom severity ($p=0.02$), PTSD functional impairment ($p=0.02$), and overall mental health problem severity ($p=0.04$) (Rudd et al., 2019).

In the literature, it also has been documented that CBT is beneficial when treating sexual and gender minority populations. CBT has been practiced to train participants on how to cope with minority stress, another risk factor for substance abuse. In a study, CBT was found to be

well suited to coping with minority stress among sexual minority individuals because they take their social context into account, it can provide skills to help individuals cope with minority stress and reevaluation beliefs on internalized stigma (Flentje, 2020). Similarly, in a cross-sectional study among 10 sexual minority men living with HIV who had co-occurrence of substance use disorder in California between 2018 and 2019, participants received a 9-session cognitive-behavioral intervention targeting stress as a driver for substance misuse; participants identified they gained cognitive-behavioral skills to cope with intersectional minority stress and described stigmatization and integration of identities (Flentje, 2020). CBT use has also been documented in sexual and gender minorities to target sexual behavioral changes. For example, in a randomized controlled trial among 43 HIV-negative men who have sex with men, cognitive behavioral therapy for trauma and self-care (CBT-TSC) was significantly associated with a decrease in the odds of condomless sex acts ($p=0.03$; OR: 1.59; 95% CI: 1.37, 1.96) compared to the control group receiving HIV-voluntary counseling and testing (VCT) only (O'Cleirigh et al., 2019).

Eye Movement Desensitization and Reprocessing Therapy

During Eye Movement Desensitization and Reprocessing (EMDR) therapy, the participant is asked to recall an image that inflicts trauma, negative emotions, and or related physical sensations about the traumatic experience. While doing this, the patient is instructed to move their eyes quickly back and forth following the therapist's fingers (Wilson et al., 1995). The initial report by Dr. Francine Shapiro in 1989 indicated that EMDR significantly reduced anxiety associated with a traumatic memory as well as increased the perceived validity of positive cognitions (Shapiro, 1989).

EMDR therapy has yielded positive treatment outcomes for treating PTSD, depressive, and anxiety symptoms, positive behavioral changes, and a decrease in addiction severity. Two studies used EMDR to treat patients' PTSD and depressive symptoms. The first study is a randomized controlled trial comparing EMDR therapy to PTSD treatment as usual (e.g., psychiatric and psychological treatment) among 46 adult individuals who suffer from PTSD in May 2018, and it showed that EMDR was more efficient in reducing PTSD symptoms in these individuals (Every-Palmer et al., 2019). In another study, researchers took a step further and used EMDR therapy to treat patients with comorbidities, in this case, was a dual diagnosis of substance use disorder and PTSD. This study was conducted among 15 women from an outpatient treatment facility in 2016, in which EMDR therapy was strongly associated with reducing PTSD ($p=0.001$), addiction severity ($p=0.001$), and depression ($p=0.001$) (Tapia et al., 2018). Furthermore, in a randomized controlled trial among 80 participants receiving either EMDR therapy or delayed treatment in Colorado in 1994, participants receiving EMDR treatment showed a significant decrease in anxiety symptoms ($p=0.005$) compared to participants in the delayed-treatment group ($p=0.34$) (Wilson et al., 1995). Lastly, the next study showed positive life and perspective changes among participants receiving treatment for substance abuse. In a phenomenological study among ten women from an extended-care treatment facility for substance abuse treatment in the urban Midwest in 2009, participants reported positive perspective shifts, as well as behavioral changes as a result of the EMDR therapy (Marich, 2010).

Motivational Interviewing

Motivational interviewing (MI), as in its name, is a motivational type of therapy approach that focuses its practices on attempting to change the patient's perceptions and behaviors (Miller & Rollnick, 2019). The purpose of MI is to strengthen personal motivation for and commitment to a specific goal and is designed to empower people to change by their means (Miller & Rollnick, 2019). MI was first developed by William R. Miller in 1983 and is now widely used as an evidence-based practice in the treatment of individuals with substance use disorders and other problems related to their substance abuse (University of Massachusetts Amherst, 2018).

Published research has supported the use of MI among participants with substance use problems as these results have yielded positive outcomes. This was shown in the following article. The results from a systematic review of the literature between 1983 and 2010 concluded that MI was significantly more effective in reducing substance use (OR: 0.79; 95% CI: 0.48, 1.09) among participants compared to the control group (Smedslund et al., 2011). These results were consistent with subsequent randomized controlled trials (RCT). In one RCT among 294 participants in Pennsylvania between 2013 and 2015, participants receiving MI treatment reported significantly less peer use of alcohol ($p < 0.0001$) and marijuana ($p = 0.01$) at 3 months compared to participants receiving treatment as usual (D'Amico et al., 2018). The other article shows the importance of adapting treatment approaches to the specific needs of the target population. An RCT was conducted among 57 Hispanic participants in Rhode Island between 2011 and 2012, results show that participants in the culturally adapted MI intervention showed significantly higher reductions in days of drinking ($p = 0.009$) compared to those in the MI intervention that has not been adapted (Lee et al., 2013). However, no published studies were found on culturally adapted MI treatment for sexual and gender minority populations.

Relapse Prevention

Relapse prevention is a skills-based, cognitive-behavioral approach that requires patients and their therapists to identify the situations or cues that place the patient at a greater risk for relapse (Recovery Research Institute, 2019). Once the patient and their therapist have identified these specific situations, they then work together to develop strategies (both cognitive and behavioral) to address these situations and practice coping skills (Recovery Research Institute, 2019). The literature on relapse prevention and mindfulness-based relapse prevention approaches have shown desirable results in the prevention of relapse among individuals seeking treatment for substance abuse.

The following articles show positive outcomes in the use of relapse prevention among individuals participating in RCT. The first one conducted among 318 low-income women in substance use disorder treatment in Boston, Massachusetts between 2003 and 2006, indicates that those who received more sessions (5-9 sessions) of relapse prevention treatment reported significantly higher declines in their Addiction Severity Index (ASI) drug scores at 6 months ($p < 0.01$) compared to participants who received fewer sessions (1-4 sessions) (Amaro et al., 2014). Similarly, in a randomized controlled trial among 168 individuals with SUDs from an outpatient facility in 2007, participants from the Mindfulness-Based Relapse Prevention group reported fewer substance use days while experiencing high levels of depressive symptoms ($p = 0.01$; OR: 0.23; 95% CI: 0.08, 0.40) compared to those in the group receiving treatment as usual ($p = 0.05$; OR: -0.05; 95% CI: -0.02, -0.09) (Witkiewitz & Bowen, 2010). These results demonstrate the benefits of relapse prevention in the practice of coping mechanisms. The next RCT was conducted among 79 participants in a treatment facility for substance abuse between 2015 and 2016, results showed that the group receiving Mindfulness-Based Relapse Prevention

in addition to treatment, as usual, had decreased their drug use (d competition: -0.58 ; 95% CI: $-0.91, -0.26$), craving (d competition: -0.58 ; 95% CI: $-1.0, -0.14$), and stress (d competition: -0.77 ; 95% CI: $-1.2, -0.30$) compared to the group receiving treatment as usual alone (Davis et al., 2018). In the literature, there is a gap in culturally adapted relapse prevention treatment for LGBTQ+ or Latinx populations. However, this can be attributed to the nature of this treatment method in which the clinician and the patient work on a one-on-one basis to their unique individual needs.

Harm Reduction Approaches

Harm reduction is a set of practical strategies that are aimed at reducing the negative consequences associated with substance use (National Harm Reduction Coalition, 2021). Harm reduction approaches incorporate various strategies that include safer use, managed use, and abstinence, among others that are critical for keeping people who use drugs as safe as possible (National Harm Reduction Coalition, 2021). This approach aims to reduce the negative personal and public health impacts of drug use. This form of prevention has been shown to prevent death, injury, disease, and overdose, as well as prevent substance misuse, and is cost-beneficial (Substance Abuse and Mental Health Services Administration, 2022b).

The literature indicates that the use of harm-reduction approaches was beneficial in trying to reduce the negative consequences of drug use. Reduction in the negative consequences of drug use (e.g., injury, disease, and overdose) were more significant when a harm reduction approach was implemented that was specifically relevant to the needs and characteristics of the population of interest and their social and environmental contexts. For example, in an ethnographic study among 86 participants in Canada between 2012 and 2014, participants described different

strategies for harm reduction in substance use in relation to their geographical, social, and cultural contexts yielding to the importance of employing harm reduction approaches that are contextually relevant and responsive to the experiences of the community (Jenkins et al., 2017). There have been various national programs that use harm reduction principles that have been implemented in the United States. The following review of the literature explores the impact of two national programs. A systematic review of the literature between 1997 and 2007 on harm reduction programs such as the Alcohol Misuse Prevention Study and the School Health and Alcohol Harm Reduction Project, showed that these programs were successfully implemented and evaluated based on a harm reduction philosophy when applied to adolescents (Leslie et al., 2008). There are more specific harm reduction approaches that target specific behaviors on drug use. In a phenomenological study among 40 e-cigarette users in the United Kingdom between 2016 and 2017, participants reported that e-cigarettes were a relevant harm reduction method for smoking relapse prevention (Notley et al., 2018).

There are a wide variety of different harm reduction activities for different needs. For example, Naloxone is a drug used to prevent death by overdose caused by opioids. Another harm reduction approach is syringe service programs that are used to reduce deaths related to drug use as well as to prevent the spread of sexually transmitted and other blood-borne infections, educational packages, and counseling are used to reduce substance usage, among others (Substance Abuse and Mental Health Services Administration, 2022b). Nonetheless, harm reduction programs are not widely used in the country, and services are limited to specific areas. For example, the state of Texas is the only state in the country where needle exchange programs are illegal (Martin, 2017). Furthermore, it was recently reported that in the city of El Paso, Texas, the availability of Naloxone was limited in the city's police department (Kladzyk, 2022).

Authors from El Paso Matters argue that despite new federal funds, barriers remain to improved access to Naloxone at the El Paso Police Department, and point to the importance of the matter since police officers are often the first to respond to a crisis (in this case, an overdose crisis) and that due to the lack of availability of Naloxone, police officers are forced to wait for other emergency responders (e.g., medical staff) losing valuable time in saving a person's life (Kladzyk, 2022).

Trauma-Informed Treatment

Trauma occurs as a result of violence, abuse, neglect, loss, disaster, war, and other harmful experiences (Substance Abuse and Mental Health Services Administration, 2014).

Trauma-informed treatment is an approach that recognizes that an individual is more likely than not to have a history of trauma, and it acknowledges the presence of trauma symptoms and the role that trauma plays in an individual's life (Buffalo Center for Social Research, 2020). Trauma-informed care considers the extensive nature of trauma during the recovery process and it promotes environments of healing instead of using practices that might fall into re-traumatize the patient (Buffalo Center for Social Research, 2020).

Trauma-informed care offers participants the opportunity to engage fully in their recovery process, develop a trusting relationship with their therapists, and have better health outcomes. These combined yield better treatment results and better retention among participants. This trend was shown in a cross-sectional study among 114 participants with PTSD in trauma-focused cognitive-behavioral therapy in Philadelphia between 2013 and 2016, in which trauma-focused cognitive-behavioral therapy was significantly associated with improving participants' PTSD symptom severity ($p=0.02$), PTSD functional impairment ($p=0.02$), and overall mental

health problem severity ($p=0.04$) (Rudd et al., 2019). Similarly, in a study among 461 women in Massachusetts and California in 2005, participants who were treated with trauma-informed care were less likely to withdrawal from the residential treatment facility compared to participants receiving standard care only (Amaro et al., 2007). By understanding the unique needs and vulnerabilities of the patients in the context of trauma, care providers can improve their quality of service and help build better relationships with their patients. For example, an agency performed a self-assessment between 2010 and 2011 to evaluate the impact of integrating trauma-informed care into their ongoing evidence-based and sensitive treatment services. The assessment tools they used were the Network for the Improvement of Addiction Treatment (NIATx) and the Plan-Do-Study-Act (PDSA). The results of their self-assessment indicated that clients that provide substance abuse treatment that incorporates trauma-informed care and walk-through protocols such as NIATx and PDSA were more competent, aware, and sensitive to issues of trauma and less likely to frighten patients seeking services (Brown et al., 2013).

It is important to acknowledge that the symptoms and consequences of trauma affect each individual differently. How a person responds to trauma depends on various factors that represent their social and environmental contexts. It is important to understand the individual's needs to provide adequate care, acknowledging they might be specific needs among sexual and gender minorities. The National Child Traumatic Stress Network established the *Concepts for Understanding Traumatic Stress Responses in Children and Families* to address the traumatic experiences and responses of LGBTQ youth. This framework consists of family rejection as a predictor of risky behaviors and mental illness, secondary adversities and traumatic stress, posttraumatic adversities, and risky behaviors, addressing danger and fostering safety,

environmental factors and family support, social and academic support networks, and collaboration and mutuality (McCormick et al., 2018).

Adapted Treatments for LGBTQ+ Populations

The published literature for specialized or adapted treatment options for SGM populations was limited. As of the time of the search, the results were almost entirely descriptive. In other words, the published literature on the subject pointed out the importance of culturally adapting healthcare treatments to the LGBTQ+ population and provided suggestions on how to implement adapted approaches. The literature available on substance use treatments described the limited number of providers that have LGBTQ+-specific programs. This was reported in secondary data analysis from three U.S. surveys conducted in 2016, in which 12.6% of mental health and 17.6% of substance abuse facilities reported LGBTQ-specific programs (Williams & Fish, 2020). Similarly, in a phenomenological study among ten directors from substance use treatment programs in California between 2016 and 2017, directors shared the importance of adapting their program strategies to sexual minority individuals receiving treatment such as adapting the physical environment, providing training to staff, working with LGBTQ+ friendly providers for referrals, and create a safe space (Mericle et al., 2018). The literature also supports these results by reporting from the perspectives of SGM individuals seeking medical help for substance abuse. For example, in a focus group among seven gay or bisexual men enrolled in a substance use recovery program in Austin, Texas from 2016 to 2017, participants highlighted the need for providers that are culturally competent in gay and bisexual experiences in recovery (Mericle et al., 2020). The lack of interventions adapted to SGMs only reinforces the importance

of continuing research on this population's needs to improve the quality of care that SGM groups have access to.

U.S.-MEXICO BORDER REGION

The U.S.-Mexico border region is located at the north and south regions of the international boundary between these two countries. The border region is approximately 2000 miles and covers the states of Texas, New Mexico, Arizona, and California from the U.S. territory and Tamaulipas, Nuevo Leon, Coahuila, Chihuahua, Sonora, and Baja California from Mexico (U.S. Department of Health & Human Services, 2017). The combined population of the states in the U.S. border region is 70,850,713 and in the Mexico border region is 19,894,418 (U.S. Department of Health & Human Services, 2017). El Paso is located on the southwest side of the State of Texas and bordering Ciudad Juarez, Mexico. These two cities form the El Paso-Juarez metropolitan area and it is the second-largest binational metro area along the U.S.-Mexico border after San Diego-Tijuana (Environmental Protection Agency, 2022). El Paso is the sixth-largest city in the state of Texas with a population of 687,287 as of 2020 (United States Census Bureau, 2021). Meanwhile, Ciudad Juarez is the most populated city in the state of Chihuahua, Mexico with a population of 1,512,450 as of 2020 (INEGI, 2021). The El Paso-Juarez border region is considered a large binational zone (Gutiérrez et al., 2021). According to a Bureau of Transportation Statistics report from 2020, in the last five years, the binational zone annual northbound border crossing average was 40,707,961 (Bureau of Transportation Statistics, 2020). Of these, 7,121,807 were pedestrians, 32,807,283 were private vehicles, and 778,871 were commercial truck crossings (Bureau of Transportation Statistics, 2020).

Hispanic and Sexual and Gender Populations in the Border Regions

The southern border region is one of the most diverse regions in the United States. A vast majority of people living in the border region are people of color, with about half identifying as Hispanic or Latinx (Southern Border, 2021). In El Paso, Texas, 80.7% of individuals self-identify as Hispanic, compared to the national average of 16.3% (Loza et al., 2018). In the state of Texas, LGBTQ+ individuals represent 4.1% of the population, 44% of these are male versus 56% female (Williams Institute, 2020). According to a Williams Institute report, in the state of Texas, the average age of LGBTQ+ individuals is 35.8 years, 26% have an income lower than \$24 thousand, and 29% of LGBTQ+ individuals have children (Williams Institute, 2020).

The U.S.-Mexico border is often characterized by high rates of substance use. This is attributed to the drug trafficking that takes place in U.S.-Mexico border cities. According to the available literature on the topic, rates of drug use are higher in the United States than in Mexico. The next cross-sectional study among 1,690 Mexican Americans from Texas and 1,293 Mexicans from Nuevo Leon and Tamaulipas between 2011 and 2013, shows that the co-occurrence of alcohol use disorder and substance use disorder was more common on the U.S. border (6.8%) than off-border (3.3%) (Borges et al., 2015). However, inferences cannot be drawn about the differences in rates of drug usage given the lack of information coming from Mexico. Nevertheless, substance use on the U.S. southern border is high. Various risk factors lead to substance use such as being part of a sexual and gender minority population, mental health illness (e.g., depression and anxiety), and having a positive diagnosis of HIV, among others. In the next two articles from two different populations and looking at different substances in El Paso, Texas, these risk factors are associated with substance abuse. The first is a cross-sectional study among 107 college students from El Paso between 2014 and 2015, results show

that compared with other participants, sexual and gender minority participants (27.4%) had higher rates of currently smoking when bored (77.8% vs. 40.0%; $p < 0.05$) and having ever been told they drink too much (21.1% vs. 16.7%; $p < 0.05$) (Loza et al., 2021). The second article is a cross-sectional study among 66 men who have sex with men on depression and/or HIV medication at a health clinic in El Paso, Texas from 2009 to 2011, results show that substance use was significantly associated with increased levels of depression (27.3%; $p = 0.011$) and PTSD (24.2%; $p = 0.037$) (Kutner et al., 2017).

Sexual and gender minorities who are part of the Latinx population often face greater discrimination and stigma due to the customs and beliefs of the Hispanic culture. Research has shown that sexual and gender minorities struggle with minority stress often coming from family members and their immediate community, as well as from the struggles individuals face when seeking medical care and gender-affirming health care. In a phenomenological study among 30 lesbian, bisexual, or queer Latinas in the Rio Grande Valley in 2017, participants reported fears of experiencing prejudice and discrimination from family members and healthcare providers as barriers to sexual and reproductive health care (R.M. Schmitz et al., 2020). Results in the available published literature show that SGM face stigma and discriminatory actions toward their gender identity from their families and communities. These results are shown in the next three articles among SGM populations in the Hispanic context. In a phenomenological study among 41 LGBTQ+ Latinx young adults in the Rio Grande Valley between 2016 and 2017, a key source of minority stress was the stigma toward mental health challenges from their families and communities. In the same study, stigmatizing actions toward their gender identity (e.g., how gender identity conflicted with broader societal norms) were formative in shaping their perceived psychological stressors (R. M. Schmitz et al., 2020).

Most studies among Latinx SGM populations are situated in cities outside of the U.S.-Mexico border region and outside of Texas. In another cross-sectional study among 643 Latino gay/bisexual men and transgender women in San Francisco and Chicago in 2011, after adjusting for the city of residence, sexual/gender identity, birthplace, age, serostatus, and education, discriminatory actions towards people living with HIV was significantly associated with HIV/AIDS personal responsibility beliefs ($p < 0.001$) and internalized homosexual stigma ($p < 0.001$) (Ramirez-Valles et al., 2013). This trend is not only visible in the border region. Hispanic populations located in other parts of the United States show the same response toward SGM individuals. For example, in an ethnographic study among 40 lesbian, bisexual, and queer Latinas in New York, New Jersey, and Connecticut between 2006 and 2008, most participants reported their families engaged in erasure strategies to force them out of dating other women (Acosta, 2010). There was a gap in the literature about the LGBTQ+ Latinx populations living in Texas and the U.S.-Mexico border region such as El Paso, TX, and Juarez, CHIH.

The ongoing struggle for sexual and gender minority populations, including the stigma and discrimination coming from the healthcare sector, leads to negative health outcomes. There have been various efforts done in the U.S. border region to try and close the gap in health inequalities. One effort in El Paso, Texas was the creation of the Purple Pages of El Paso (PPoEP) (The Purple Pages of El Paso, 2017). The PPoEP is an online resource that connects LGBTQ+ communities and providers with high-quality culturally sensitive health care and social services (Loza et al., 2018). The objective of the PPoEP is to identify LGBTQ+-friendly health care and social services providers in El Paso and Las Cruces that are willing to or are already serving LGBTQ+ individuals and connect them with other providers when they need to make referrals (Loza et al., 2018). This referral list is available online at the Purple Pages of El Paso

website (The Purple Pages of El Paso, 2017). It is also intended for use by the LGBTQ+ community when seeking care or services. The PPOEP is an attempt to address and eliminate the barriers to health care in the El Paso/Las Cruces area. Another effort to close the gap in health inequalities in the Paso Del Norte Region is the Borderland Rainbow Center (BRC) (Borderland Rainbow Center, 2020). The BRC is a non-profit, LGBTQ+ community center that is located in El Paso, Texas. This organization offers support groups, therapy, casework and referrals, educational events, and food pantries to LGBTQ+ people and allies of all ages (Borderland Rainbow Center, 2020). The BRC's model has helped the community through advocacy and training to allies in different sectors such as the educational, medical, social services, mental health, and legal fields (Borderland Rainbow Center, 2020).

Texas Policy and Legislations Targeting LGBTQ+ Communities

To date in 2022, dozens of states considered legislation related to discrimination against LGBTQ+ communities, in which state governments attempted to single out and target LGBTQ+ individuals for unfair and unequal treatment (Equality Federation, 2022). There were over 30 anti-LGBTQ+ bills filed during this session, and these include 13 direct attacks on transgender youth (Equality Federation, 2022). Although none of these bills were proposed in the state of Texas, this state has made discriminatory remarks against the LGBTQ+ community, especially against the transgender community. In March 2022, Governor Greg Abbott stated that he was looking to have gender-affirming treatment for transgender youth to be classified as child abuse, and threaten parents who seek gender-affirming care for their children and providers who offer these services to be prosecuted and Child Protective Services will get involved to investigate (Goodwyn, 2022). Similarly, in 2021, the state of Texas banned transgender girls from

participating in women's sports in public schools, then in early 2022 the "Don't Say Gay" bill from Florida made its way to Texas prompting the government to introduce a similar bill (Goodwyn, 2022).

Laws that directly target the LGBTQ+ community are referred to as negative laws (Movement Advancement Project, 2022b). In the state of Texas there are a total of 10 negative laws in areas such as name and gender correction on identity documents, healthcare laws and policies (e.g., ban on best practice medical care for transgender youth), LGBTQ+ youth laws (e.g., banning educators from discussing LGBTQ people, parental notification of LGBTQ-inclusive curricula, ban on transgender youth from participating in sports), and in religious laws and policies (Human Rights Campaign, 2022b). The presence of negative laws and the lack of protective laws in the state of Texas and other similarly conservative states, poses a risk to sexual and gender minority populations as these create environments of discrimination, rejection, and violence that as result create more negative health outcomes, wider gaps in health disparities, and social exclusion and isolation.

Graduate Project

GOALS AND ACTIVITIES

Goal 1: Expanded the Purple Pages of El Paso

1. Identified all the available mental health/substance use treatment providers in the area of El Paso/Las Cruces who are LGBTQ+ competent, but who were not already included in the PPOEP.
2. Used the BRC's social media outlets for crowdsourcing to gather information on community members' recommended providers in the mental health field.
3. Created a preliminary list with all prospective providers for contact.
4. Contacted mental health/substance use treatment providers in the area who were recommended by members of the community and/or self-identify as LGBTQ-friendly/competent, to encourage and request consent to add them to the PPOEP.
5. On the PPOEP website, created a new tab titled "Substance Use" under the existing "Mental Health" section. Added providers who gave consent to be included in this directory.

Goal 2: Updated the Purple Pages of El Paso

1. Updated the PPOEP list of providers by contacting those providers from El Paso and Las Cruces already listed under the mental health sections.
2. Contacted all 25 already listed providers from the original PPOEP list.
3. Updated providers' information such as new contact information, address, LGBTQ+ sensitivity training, years in practice, and languages that their services are delivered.

Goal 3: Improved delivery of mental health/substance use treatment services through informational videos

1. Created a series of informational videos no longer than ten (10) minutes long with evidence-based content about how to provide a welcoming and safe environment for LGBTQ+ patients seeking substance use treatment services. These videos were created for mental health/substance use treatment providers.
 - a. Conducted a literature review on how to improve the delivery of services and patient interactions at substance-use treatment facilities.
 - b. Created the scripts for the informational videos. The number of videos was subject to the length of the information found in the literature review. A series of three (3) scripts for the short videos were created.
 - c. The videos were recorded using a recording studio available at The University of Texas at El Paso (UTEP) and edited using iMovie and GarageBand software (Apple Inc., 1999, 2004). To ensure representation of the LGBTQ+ population, three members of the community appeared in the informational videos.
 - d. The BRC published the three videos on their YouTube account. To estimate the number of mental health providers who watched the videos, access to the YouTube links was limited to the mental health providers invited to view them. This privacy feature was kept for two weeks.
 - e. After two weeks of counting the videos' views, the videos were made publicly available and advertised using the BRC's social media outlets.

Goal 4: Identified substance use intervention funding opportunities

1. Identified grants from local, state, and federal levels that provide funding to non-profit organizations that provide substance use treatment to sexual and gender minorities.

2. Identified three grant opportunities that the BRC can apply for as a non-profit organization that provides substance use treatment.
3. The background and significance section of this project will serve as a text for the process of writing the grant proposal if the BRC chooses to apply to any of the funding opportunities that were identified through this activity.

Methods

Goal 1: Expanded the Purple Pages of El Paso

For this project, we contacted therapists, counselors, psychologists, psychiatrists, and other relevant mental health professionals who provide evidence-based substance use treatments and who are LGBTQ+ friendly and competent. In addition to these characteristics, we looked for providers located in El Paso and Las Cruces. These providers were identified using different online search engines such as Google, provider's referral lists, Medicare/Medicaid providers lists, and healthcare marketplace lists, among others. Also, we used the Borderland Rainbow Center's social media outlets for crowdsourcing to reach out to community members for their suggestions on providers in the Paso del Norte region who are LGBTQ+ friendly and competent.

The contact information, credentials, training, and services of the providers who were contacted were stored in a Google Sheets document for better organization and access to such information. Each mental health provider was contacted on a one-on-one basis to invite them to be included in the PPOEP. The preferred method for communicating with the newly found providers was in-person. Face-to-face interactions allow for the opportunity to assess aspects of importance for the PPOEP project, such as staff friendliness, welcoming and safe physical space in the provider's office, and building accessibility, among others. Although in-person communication was preferred, most contacts had to be made through email or by phone call based on the provider's needs and availability. Once all identified providers were contacted, those who agreed and gave consent to be listed in the PPOEP (and have their practice's information on the website) were included on the page. Moreover, to improve the accessibility to these new providers on the PPOEP website, a new tab entitled "Substance Use" was created

under the existing tab for mental health providers. This corresponds to the expanding component of the project.

Script for the email message to contact new providers:

Providers were contacted using a script like the following:

“Hello,

My name is Diana Barraza. I volunteer for the Borderland Rainbow Center (BRC), which is a non-profit LGBTQ+ community center. I am writing to you for two reasons. First, I am updating and expanding the Purple Pages of El Paso (PPoEP). The PPoEP is a provider directory in which general health, mental health, and social services providers who are LGBTQ+ friendly are listed. Your practice was recommended by members of the community, and we would like to list you in the directory. If you would like to be included, please let me know so I can go ahead and add your practice. The only information that I need from you is the following:

Agency

Address

Phone number

Primary Service(s)

Specialty

Languages in which your services are provided

Years in practice

Any LGBTQ+ community training taken (if any)

Second, I would like to share the links to a series of informational videos on how to create and provide a safe and welcoming environment for LGBTQ+ patients. Each

video contains pertinent information on how to provide a safe space, correct and sensitive terminology in the contexts of the LGBTQ+ community and addiction, as well as risk factors and health disparities that disproportionately affect this population. I encourage you to watch these videos as they might offer a different perspective to your practice!

Video 1: Safe and welcoming environment (7:17)

<https://www.youtube.com/watch?v=cVW7VMf6FWE>

Video 2: Correct Terminology (7:41)

<https://www.youtube.com/watch?v=ZIVRRCEFyjk>

Video 3: Health Disparities (6:38)

<https://www.youtube.com/watch?v=xCSKT-CUmRY>

If you have any questions about any of the items above, please do not hesitate to contact me via email or by phone (915.504.5286). Thank you in advance for your time and consideration.”

Goal 2: Updated the Purple Pages of El Paso

We contacted the providers who were listed the mental health tab of the PPOEP website to ensure that their information was up to date and still relevant, as well as to include any new pertinent information such as new training or certificates that concern the target population, change of address or contact, change of healthcare provider in the practice of interest, among others. These providers were contacted via phone call, or in some cases, via email, depending on the provider’s preference or availability. Their information was stored in the BRC’s drive cloud under a spreadsheet document to ensure that only allowed staff members who have access to the document can open it. The process of updating the PPOEP website started once all providers

were contacted to have their information confirmed and updated, and the information for newly identified providers was collected. A BRC's advocate provided the access to their Wix account, and the section for mental health providers was updated and expanded based on the new information obtained from the two activities listed under goals 1 and 2 (Abrahami et al., 2006).

Goal 3: Improved delivery of mental health/substance use treatment services through informational videos

We created a series of informational, evidence-based videos targeted to substance use treatment providers who provide services to LGBTQ+ individuals. A short literature review was conducted to supplement the information available in the background and significance section of this document. The information found through the conducted literature review was then divided into relevant sections for better delivery of the information. To ensure visibility and representation of the LGBTQ+ population, three members of the community were featured, one in each video, to deliver the information.

A total of three scripts were created for the videos that were shared with mental health/substance use treatment providers. The first script served as an introduction to the series and as a guide for providers on how to create a safe and welcoming environment for LGBTQ+ folks in their practice. In the second script, the importance of using correct language and terminology was discussed. This script contained definitions of commonly used terms that pertain to the LGBTQ+ community. Also, in this script, examples of outdated terms along with the preferred alternative were included in the contexts of sexual and gender minorities and addiction. Lastly, the third script contained information on health disparities and risk factors for addiction that affect sexual and gender minorities disproportionately to better understand

substance use problems in this community, and which treatment approaches have been more effective when treating LGBTQ+ patients. The three scripts created for this activity can be found in Appendix A. In addition, the content and materials presented in the three scripts, marked with timestamps on the topics discussed, are aligned with the accreditation standards for provision of care that are highlighted by The Joint Commission (The Joint Commission, 2011). This accreditation standard was created by The Joint Commission to provide an insight into the specific concerns facing the LGBTQ+ community in the healthcare sector (The Joint Commission, 2011). The Joint Commission's LGBT Field Guide was published in 2011 and it contains recommendations for best practice for sexual and gender minority patients, employees, and their families, with a new and revised version that will be effective January 1, 2023 (The Joint Commission, 2011). A complete checklist with the five domains and their recommendations can be found online in the Joint Commission website (The Joint Commission, 2011). The accreditation standard topics from the Joint Commission that were addressed in the informational videos can be found in Appendix A.

The videos were recorded using a recording studio that is available on the UTEP campus. All three of the video participants signed two release letters: (1) one for UTEP and (2) one for the BRC. The videos were recorded using a green screen to facilitate the use of visual aids on-screen and to reduce editing time. Once recorded, we edited the videos using the iMovie software and background music was added using the GarageBand software (Apple Inc., 1999, 2004). Lastly, all three videos were shared with an advocate from the BRC using Google Drive. The center uploaded the videos on their YouTube account and shared them on their other social media outlets to make the videos publicly available. The link for the YouTube videos was

included in the email used to establish contact with the newly included providers to invite them to watch the series of videos.

Goal 4: Identified substance use intervention funding opportunities

Lastly, we identified different funding opportunities for evidence-based and trauma-informed treatment for queer individuals who struggle with substance use. We searched and identified grants from local, state, and federal levels that award funding to non-profit organizations that provide substance use treatment services to sexual and gender minority populations. The grant opportunities were searched using keywords such as “evidence-based substance use treatments,” “LGBTQ community services,” “adapted substance use treatments,” and “501(c)(3) non-profit funding,” among others.

We selected the best three grant opportunities to which the BRC is eligible and can apply. To facilitate the application process for the center, the background and significance section of this project will serve as a text for the process of writing the grant proposal. A table with all pertinent information for each grant was created to facilitate identification and access for the Borderland Rainbow Center.

IRB APPROVAL

This proposal [1910841-1] was submitted for IRB review using the title “Substance Use Treatment and Providers for Sexual and Gender Minority Populations in a Texas-Mexico Border City” on August 31, 2022. It was determined to be “Not Research” by the IRB committee on September 7, 2022. An amendment to the project proposal had to be submitted on September 24, 2022, due to a change in Goal 3 of this project’s methods section. After determination from the

IRB committee, the amended project proposal [1910841-2] but the status did not change after review on September 27, 2022.

Results

Goal 1: Expanded the Purple Pages of El Paso

A total of 38 mental health specialists were identified through different search engines such as Google, Medicare/Medicaid referral and marketplace lists, providers' referrals lists, as well as taking in community recommendations given through the BRC's social media sites. In order to shorten the initial count of providers for contact, those mental health specialists who provide evidence-based substance use treatment approaches, those recommended by community members, and those who self-described as LGBTQ-friendly were included in the final list. Originally, providers who wished to be included in the Purple Pages of El Paso were required to complete an entry questionnaire with which the level of cultural competency to serve queer patients or clients could be assessed. However, the partner organization that manages the PPOEP opted to waive the entry requirement for any provider who wished to be included in the directory. Among the reasons for this was the low response rate from providers which in consequence had a direct impact on the number of resources available listed in the PPOEP. Another factor that directly influenced the decision to waive the survey requirement is that the PPOEP is the only resource of its kind in the Paso del Norte region, and there is an immediate need for the improvement of access to care for LGBTQ+ individuals who are reluctant to seek services due to fear of rejection and discrimination. Thus, by removing the survey requirement, more providers could be added to the online directory.

The process of identifying LGBTQ-competent providers began during the 2022 Summer semester and ended during the mid-2022 Fall semester. A total of 18 providers who meet the previously mentioned requirements were identified for contact. All of the providers were contacted via email and phone call, and a total of 12 responded. From those who responded, 10

providers agreed to be included in the PPOEP and provided us with the contact and service information necessary to be included. We expect to receive more responses from the providers who were contacted by email in the following months. The Borderland Rainbow Center will continue to have access to the email address that was used for contact after the completion of the project to monitor future follow-up responses from providers who were contacted but did not respond within the time of completion of this project. Table 1 contains a summary of the providers included in the new contact list who were contacted, as well as the count for those who answered and provided permission to be included in the PPOEP website, those who did not answer the contact attempts, and those who refused to be included in the directory.

Goal 2: Updated the Purple Pages of El Paso

Another activity of this project was to update the list of providers who are currently listed in the PPOEP. This included contacting all 25 mental health providers by phone and/or by email. At the beginning of the call, we would state that we are calling from the BRC and that the reason for the call was to confirm that the information that appears in the PPOEP was accurate, relevant, and up to date. The process of contacting currently listed providers was longer due to having to make several contact attempts for some of the providers. Another barrier that was encountered while attempting to contact them was that the contact information listed on the PPOEP was outdated and no new or updated contact information about the provider could be found online. Given that we had no way to contact these providers, we had to refrain to list them in the updated version of the PPOEP. Nonetheless, their information remains in the original PDF version of the directory for future contact attempts.

On the PPoEP website, a new section entitled “Substance Use Providers” was included under the “Mental Health” tab. In the original list of providers listed under the “Mental Health” tab, there were a total of 25 providers of which 21 were included in the final version. We could not contact or confirm the information of four providers who were originally listed in the directory. In this case, if we could not locate their new or updated contact information, or if we could not communicate with them, we decided to not include them in the final list. The count of the providers in the original list who were contacted and whose information got updated in the PPoEP, those whose information could not be updated due to lack of current or correct contact information and could not establish contact, and those who refused to confirm their information through the phone or email is located in Table 1. At the time of completion of this project, a total of 31 providers were listed in the updated version counting the 10 new providers who were recently added in Goal 1. Due to the nature of the PPoEP, further actions will be required in the future such as the periodical update of providers' information. Moreover, the BRC may still receive follow-ups in the future from providers who were contacted but from whom we could not confirm their information. Therefore, the BRC will continue to have access to the email that was used for the contact of providers.

Table 1. Count of providers in updated list and new contact list

Providers	Total Contacted	Accepted/Updated	No Answer/ Unsure	Refused
Updated List	25	21	3	1
New Contact List	18	10	6	2

Goal 3: Improved delivery of mental health/substance use treatment services through informational videos

Three short evidence-based, informational videos were created for this project. The first video, titled “Safe and Welcoming Environments,” served as an introduction to the series and a guide that provided advice and ideas on how to create and provide a safe and welcoming environment for LGBTQ+ patients and clients (Barraza, 2022a). This video included examples of a safe space including rainbow flags, gender-neutral bathrooms, LGBTQ+-specific informational brochures, data collection on patients’ gender identity, sexual orientation, preferred pronouns and names, and an overall more sensitive intake process. The second video, “Correct Terminology,” covered information on correct language and terminology in the contexts of sexual and gender minorities and addiction (Barraza, 2022b). A short but comprehensive list of terminology with their respective definitions was presented in the video. Then, examples of terms to avoid and what terms to use instead were described in both contexts. Lastly, the third and final video, “Health Disparities,” covered information on health disparities and risk factors that disproportionately affect substance use outcomes of sexual and gender minority populations and which substance use treatment approaches have been more effective when treating LGBTQ+ patients (Barraza, 2022c).

The videos were published in the BRC’s YouTube channel account with a privacy feature to ensure that only those with the web link could access and watch these videos. These videos were published on October 31st, 2022. New and previously listed providers in the mental health section were individually provided with the YouTube link via email on November 1st, 2022. Since we were interested in counting the number of views each video had to have an estimate of how many providers accessed and watched the videos, the privacy feature was kept for a total of

14 days. After this period expired, the videos were made publicly available by changing the security settings. Before the videos became publicly available, the “Safe and Welcoming Environments” video had 12 views, the “Correct terminology” video had eight views, and the “Health Disparities” video had eight views (Barraza, 2022a, 2022b, 2022c).

Video 1: Safe and welcoming environment (7:17)

<https://www.youtube.com/watch?v=cVW7VMf6FWE>

Video 2: Correct Terminology (7:41)

<https://www.youtube.com/watch?v=ZIVRRCEFyjk>

Video 3: Health Disparities (6:38)

<https://www.youtube.com/watch?v=xCSKT-CUmRY>

Goal 4: Identified substance use intervention funding opportunities

For this project, three relevant funding opportunities were identified for the BRC in the area of substance use treatment and social service interventions. The grant opportunities that were identified had substance use prevention and treatment interventions as eligibility requirements. Various other funding opportunities in the context of substance use were found, however, reasons to not include them in the list were: the deadline to apply was too soon to consider the grant as the deadline was November 1, 2022, the funder agency had restrictions on budget use, the grant type did not apply to the center, and/or grant was not intended for non-profit organizations. The three grant opportunities are described in Table 2.

Table 2. Funding Opportunities for the BRC

	Hanley Family Foundation (HFF) Grant	Dermody Properties (DP) Foundation Grant	Demonstrating the Power of Evidence-Based Programs to “Move the Needle” on Major U.S. Social Problems
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Who is the Funder	Hanley Family Foundation (HHF)	Dermody Properties (DP) Foundation	Laura and John Arnold Foundation (LJAF)- Arnold Ventures (AV)
Dollar Amount	Up to \$500,000	Up to \$3,000	Up to \$2 million for nonprofit organizations (20% cost rate)
Population the Grant Serves	Economically disadvantaged people, homeless people, and people with substance use problems.	Special emphasis on children, the elderly, the disabled, substance abuse, and the homeless.	Organizations that deliver evidence-based interventions addressing major social issues.
Eligibility Criteria	Grants are made only to 501(c)(3) non-profit charities with a focus on chemical dependency.	Applicants must provide IRS Verification of 501(c)(3) status.	Applicants may include nonprofit organizations, state, or local government agencies, federal agencies, or a combination thereof.
Grant Type	Intervention	Intervention	Research, RTC
Deadline to Apply	LOI Date: 01/31/23 Deadline Date: 03/31/23	Applications are mailed out in June and all requests for funding must be submitted in writing by August 1 of each year.	Ongoing
Contact	Michael Hanley info@hanleyfamilyfoundation.org	Taylor Ruepp truepp@demordy.com	Bridget Williamson BWilliamson@arnoldfoundation.org
Website	Hanley Family Foundation (HFF) Grant ¹	Dermody Properties (DP) Foundation Grant ²	Demonstrating the Power of Evidence-Based Programs to “Move the Needle” on Major U.S. Social Problems ³

¹<https://www.grantsoffice.com/GrantDetails.aspx?gid=29898#:~:text=At%20present%2C%20HFF%20is%20making,forms%20of%20substance%20use%20disorder.>

²<https://dermody.com/history-values/giving-back/dermody-properties-foundation/dermody-properties-foundation-application/>

³<https://www.arnoldventures.org/work/evidence-based-policy>

Discussion

Goal 1: Expanded the Purple Pages of El Paso

The outcomes of this activity have provided insight into the current state of the Paso del Norte region in terms of access to and quality of healthcare and substance use treatment services for the LGBTQ+ population in the area. It was the experience of this project that healthcare and mental health providers in the area of Las Cruces were more open to getting listed in the Purple Pages. Mental health providers from Las Cruces and surrounding areas in the state of New Mexico did not express or show any concern about having their practice in this LGBTQ-friendly directory and were even more likely to recommend colleagues to invite them to be included. The experience from the providers in El Paso was somewhat different. To facilitate and narrow the contacting process, we selected providers who were (1) recommended by members of the community and/or (2) self-identified as LGBTQ-friendly. For this reason, we did not face negative experiences when contacting providers. However, providers in El Paso expressed more hesitancy about being listed in the PPOEP, compared to providers located in the state of New Mexico. The providers who were already familiar with the PPOEP website were more likely to agree to be listed without hesitancy. However, among those providers who were not familiar with the PPOEP website, some were indecisive to provide consent to get listed and expressed they had questions about the PPOEP website, they need time to think about it, or preferred to contact us in the future with their answer.

Strengths

Since we decided to contact providers who were recommended by members of the community and providers who self-identified as LGBTQ-friendly, we had a positive response when contacting most providers. Also, most of these providers were already familiar with the

PPoEP website. When we contacted them to invite them to be listed, they demonstrated interest in being included and some showed interest in receiving LGBTQ sensitivity training.

Limitations

Although overall we received a positive response from mental health providers, some providers were hesitant to accept to get listed in the directory. As mentioned above, we experienced less hesitancy from providers who have their practice in New Mexico than from providers who practice in Texas. In previous years, legislation has been proposed in Texas by government officials that threaten and target the LGBTQ+ community, with some getting passed. For example, in November 2021 Texas was one of the 10 states that enacted anti-transgender sports ban legislations, and as of November 2022, the state's Anti-LGBTQ curriculum laws remain active and unchallenged (Human Rights Campaign, 2022b). Similarly, earlier this year, in March 2022, Texas governor Greg Abbott made negative remarks regarding the transgender community and youth. He labeled gender-affirming care for transgender kids as "child abuse" and threatened parents who seek gender-affirming care for their transgender children to get prosecuted and have Child Protective Services involved.

Goal 2: Updated the Purple Pages of El Paso

This activity was complemented during the 2022 summer semester in which we contacted the rest of the providers listed in the sections of general health and social services. The process of contacting all providers listed took approximately six weeks. This activity was long overdue as we had to update about 80% of the providers' information. Unfortunately, prior to us taking on this project, the Borderland Rainbow Center did not count with enough staff and resources to keep up with the updating of the provider information in the PPoEP. We reached out to all 25

mental health providers listed in the directory, but only 21 of these were included in the final version of the website. There were a few reasons why these four providers were not included in the final version, such as failed contact attempts with their practice due to having outdated contact information, and the impression of staff not being friendly toward the LGBTQ community, among others. It is important to mention that even though a practice/provider is already listed in the directory, unfriendly interactions with staff are essential to acknowledge in consideration of the person seeking treatment in this practice as they will interact with staff just as much as they will interact with the provider.

Strengths

A project such as the PPOEP requires periodical follow-ups and updates of the providers and their services that are listed in the directory. As we mentioned above, the BRC did not count on the staff, time, and resources to take on this responsibility, thus they rely on volunteer/intern time to have this need met. This can be considered a strength for this project. We were able to successfully achieve the completion of both Goals 1 and 2, resulting in the improvement of access to mental health and substance use treatment services for members of the LGBTQ+ community, their families, and allies. In consequence, this project can also serve as a tool to reduce health disparities that affect sexual and gender minority populations disproportionately and improve mental health outcomes in this community.

Limitations

The current political climate in the state of Texas served as a major limitation when taking over this project. Similar to what we mentioned as a limitation in the previous Goal, newly proposed legislations and threats that directly target sexual and gender minorities were a limitation when contacting providers. It was the case that some providers refused to respond or

provide information over the phone. In cases like these, we opted to visit the provider's clinic/office to confirm the information on a face-to-face basis. However, this type of outreach was not possible for some providers as their practice is out of town. Hesitancy from providers to confirm their information might have been a response to the fear of legal action taken against them by government officials, and/or fear of losing patients that do not agree with sexual and gender diversity. This does not necessarily mean that the provider is not LGBTQ-friendly and competent, but they may hesitate to provide information over the phone without confirmation of who is on the other side of the line.

Goal 3: Improved delivery of mental health/substance use treatment services through informational videos

The quality of the final product of this activity was possible thanks to the resources available at the recording studio in UTEP for students, staff, and faculty. In our videos, the folks who appeared on camera had the chance to deliver the information for each video in a way that they felt more comfortable with. Also, a staff member available at UTEP helped us with every step of the recording process, facilitating the creation of the videos. From the physical and social environment to the data collection process, these videos provide the viewer with definitions and examples to explain the importance of allowing the patient to feel safe. For many people, seeking help for substance use problems can be a very vulnerable experience and the perception of discrimination and rejection can have long-lasting damaging consequences such as distrust of the healthcare system, avoidance to seek treatment, exposure to further risk factors, and the widening of the gap in health disparities among vulnerable populations. Also, we have the presence of intersectionality and stigmatization that patients must face. Substance use problems often receive

negative connotations in the perception of society which results in stigma. A person with one or multiple minority statuses is subject to incremental or exponential levels of stigmatization. This is the result of the intersectionality of the person's identities (e.g., sexual orientation, gender identity, race, religion, social economical background, etc.). The process of creating a safe and welcoming environment, although uncomfortable at first, is manageable for health care and mental health providers. Active support is evidenced via visual illustrations such as Rainbow flags and brochures with LGBTQ-specific resources/information, as well as with interpersonal interactions. In person-to-person interactions, support can be shown by using correct language and terminology, asking for the patient's preferred pronouns, and continuing education by attending regular sensitivity training, among others. Incorporating these actions into one's practice might be uncomfortable for a person who is not well accustomed to LGBTQ+ sensitive practices. Nonetheless, the implementation of affirming and welcoming practices can be lifesaving for the individual seeking treatment. As for future directions for these activities, the BRC might decide to use the videos or their content during training opportunities. The videos contain important information on LGBTQ+ health that is subject to change or require an update, thus the videos may need to undergo modifications. If that is the case, the video scripts can be updated when they are ready to create new videos. I suggest that new video content continue to be aligned with the guidelines provided by The Joint Commission's accreditation standards of provision of care for the LGBTQ+ community and that these standards be included in the script as a guide on the basic tenets and recommendations for best practices in the healthcare sector.

Strengths

This series of informative videos can help shape a new road toward more culturally competent healthcare access for the LGBTQ+ population in El Paso and Las Cruces. There is an

extensive need for culturally competent substance use treatment and recovery practices in the city. Agencies and clinics that provide these services in the area often lack sensitive practices when treating queer patients, as per community members' feedback. Therefore, informational materials such as these videos are of great importance.

We were able to create quality videos thanks to the available support and resources from both UTEP and the BRC. The scripts were revised by advocates from the BRC to ensure that the content is sensitive, correct, and relevant. Furthermore, all three people who participated in the videos are members of the LGBTQ+ community and could also provide their feedback regarding the scripts. Also, staff at UTEP's recording studio provided invaluable help and support while recording each video as well as with the editing process. The result of this activity was to have three short, evidence-based informational videos with valuable content on safe spaces, appropriate terminology, and risk factors for substance use in the LGBTQ+ community.

Limitations

As for the limitations of this goal, the main barrier to producing better-quality materials was a lack of financial support. If we could have had access to funding for this project, better software would have been used for video and sound editing. Another limitation was the lack of time to complete the activity. Due to internal and external reasons, the originally listed activity under this goal had to be changed to the creation of the videos. The original activity consisted of providing LGBTQ+ sensitivity training to mental health/substance use treatment providers in the area. However, as a result of financial and resource limitations, this activity was changed to the creation of informational videos with the guidance of the BRC. Thereupon, once the new activity was fully developed, another issue with time emerged; to reserve the recording studio on short

notice and coordinate scheduling between all parties involved. The videos had to be recorded in two different sessions due to scheduling problems among video participants.

Goal 4: Identified substance use intervention funding opportunities

The process of finding funding opportunities the BRC could apply for was challenging due to limited knowledge and familiarity and experience with grant agencies and the grant application process. The goal was to identify grant opportunities for substance use treatments, applicable for non-profit organizations, directed to vulnerable populations such as the LGBTQ+ community, and that did not have a close-to-expire deadline. All of these filters limited the number of grants available. A total of four funding opportunities through private agencies were identified. Almost all four grants had the characteristics described above, except for one. One of the grants identified had a deadline of 11/01/22 making it non-relevant to the project due to the approximation of the date. Only one grant had a deadline for January 2023, while the other two grants had open/ongoing submission dates. Thus, the remaining three grants were eligible to be included in this project. The BRC qualifies to be a recipient of each grant, and the population of interest matched the population that the BRC serves.

Strengths

Most grant opportunities that were available through online search engines funded 501(c)(3) non-profit agencies directly, which is the status of the BRC. In addition to the four grants described in the previous section, other funding opportunities were identified through federal agencies such as SAMHSA and the NIH. However, the grants available at the moment through these agencies were limited to research-specific projects and pilot studies which may include the development of interventions, but not necessarily their implementation. We were

interested in finding funding opportunities for intervention programs. A strength of this activity was the ongoing support and guidance from the BRC.

Limitations

One limitation that emerged in the development of this activity was the lack of understanding of the different categories for non-profit organizations, different categories for types of grant/funding opportunities, and eligibility criteria (e.g., assessing whether the BRC is eligible for the grant). Another limitation of this activity was the various filters that had to be applied to fit the needs of the project and the needs of the BRC. These filters included but were not limited to, the population of interest, agency type, geographical area, grant type, and purpose for the grant, among others. We were interested in identifying funding opportunities for non-profit organizations for the implementation of evidence-based substance use treatment services that could be applied to different vulnerable populations. These filters limited the results. Furthermore, deadline applications were also limiting factors in the selection of grants. We envisioned selecting grants with reasonable deadlines to ensure that the BRC had enough time for the application process.

MPH Competencies

B. Public Health and Health Care Systems

6. Discuss how structural bias, social inequities, and racism undermine health and create challenges to achieving health equity at organizational, community, and societal levels

Rationale: For this project, a literature review on research around substance abuse and barriers to services among SGMs as well as general barriers to health care was conducted. It is intended to address this inequity by updating and adapting the PPOEP.

C. Planning and Management to Promote Health

7. Assess population needs, assets, and capacities that affect communities' health

Rationale: This project summarizes the unique needs and vulnerabilities of SGM populations, mostly in the context of LGBTQ+ individuals living in the Paso del Norte region by conducting a literature review on what are the characteristics and needs of the different subgroups in the LGBTQ+ population as well as what are the current barriers to care among SGMs. This project was informed by providers who serve LGBTQ+ individuals seeking substance use treatment, who also feel that providers locally do not know how to serve the community.

8. Apply awareness of cultural values and practices to the design or implementation of public health policies or programs

Rationale: In the background section, the importance of adapting substance use treatment and recovery approaches to specific populations such as SGM and Latinx populations was summarized, and the gaps in the literature are pointed out. In the activities for this project, providers were contacted and received a brief description of the

importance of delivering culturally adapted treatments that are tailored to specific populations through a series of videos.

9. Design a population-based policy, program, project, or intervention

Rationale: The design of this project has a population-based interest by summarizing the needs of LGBTQ+ individuals who seek substance use treatment, updating the PPOEP to increase the number of entries for substance use treatment providers, as well as increasing the number of substance use treatment providers in the area who are LGBTQ+ culturally competent. Grant opportunities were identified for the BRC to expand their substance use/mental health treatment services.

E. Leadership

16. Apply principles of leadership, governance, and management, which include creating a vision, empowering others, fostering collaboration, and guiding decision making

Rationale: A leadership stand was crucial for this project to achieve the goals and activities. Providers were contacted and guided through the process of being included in the PPOEP and received guidance on how to provide a safe space to SGM patients in their practice. There was a close collaboration with the BRC, and for the project to be successful, close communication with substance use treatment providers that expressed commitment in the area was needed when contacting them to update/expand the PPOEP and share the series of videos with them.

F. Communication

20. Describe the importance of cultural competence in communicating public health content

Rationale: This item was addressed in the background and significance section under Substance Abuse Treatments. Also, this competency was addressed by getting in contact

with substance use treatment providers and communicating the importance of culturally adapting substance use treatment and encouraging them to watch the series of videos created under Goal 3 on how to provide a safe and welcoming environment in their practice and adapt the SUT options available.

HISPANIC AND BORDER HEALTH CONCENTRATION COMPETENCIES

1. State the principles of prevention and control of disease and discuss how these can be modified to accommodate cultural values and practices in Hispanic and border communities.

Rationale: This competency was addressed in the background and significance section in which the principles of prevention and treatment of disease (e.g., substance use problems) were described. As for disease prevention in the Paso del Norte region, the PPOEP serves this purpose. We addressed this by updating and expanding the web-based directory in an attempt to improve access to treatment services. In addition, in the background and significance, the importance of culturally adapting substance use treatments and care for the Latinx LGBTQ+ population is described. Similarly, the series of videos created for this project may serve as guidelines on how to modify treatment practices to accommodate and better serve LGBTQ+ communities in the border region.

2. Develop prevention strategies for the different stages of the major communicable and non-communicable diseases in Hispanic and US/Mexico border communities.

Rationale: This competency was addressed by updating and expanding the PPOEP, which is a resource to reduce barriers to prevention, treatment, and recovery for substance use among the target population. Similarly, we addressed this item by providing educational materials and further patient advocacy training to medical and

mental health providers to promote cultural competency in substance use treatment and care for LGBTQ+ patients.

4. Distinguish health differences from health disparities on the U.S.-Mexico border and using the Toolkit for Community Action (National Partnership for Action to End Health Disparities) develop action plans for community prevention and intervention.

Rationale: This was described in the background and significance section in which health disparities among the LGBTQ+ population are described by comparing substance use rates among SGM populations in the border region with populations in other areas in the United States and Mexico. The PPOEP is an attempt to reduce health disparities in the Paso del Norte Region by improving access to care for LGBTQ+ individuals and improving patient-provider interactions through the series of videos created in Goal 3.

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Appendix

Safe and Welcoming Environments: Script

Time Stamp	Audio	Joint Commission Topics
[0:00]	Hello and Welcome to this series of videos. I'm Nayla Bejarano, my pronouns are She/Her. In the next three short videos we will be discussing different important topics on how to provide a safe and welcoming environment for LGBTQ+ folks who attend or want to attend your practice to receive any kind of treatment.	
[0:25]	Educating ourselves on the impact of representation and perception of support, the importance of the words we choose to use, and the unique situations that affect the LGBTQ+ community disproportionately, are crucial to create a safe space. Folks who identify as queer often face social stigma, discrimination, rejection, and other challenges that their cisgender and heterosexual peers do not face. As a result of these and other stressors that we will discuss in the following videos, LGBTQ+ individuals are at increased risk for various general health and mental health struggles, including substance use problems. In addition to having to navigate their environment with uncertainty and fear of discrimination, LGBTQ+ people have expressed that the presence of these and other societal, environmental, and cultural stressors are perceived as barriers to access healthcare services.	<ul style="list-style-type: none"> • Educate staff on LGBT employee concerns. • Collect feedback from LGBT patients and families and the surrounding LGBT community.
[1:16]	Today, we will guide you on how to build a positive, welcoming, and empowering environment for everyone, including LGBTQ folks. While these changes can seem to have little to no impact for some, the impact of these can be lifesaving. This is why safer spaces, especially in the healthcare system, are crucial. In the mental health field, this has an even greater impact, allowing LGBTQ folks to feel safe to be themselves in a space where they will not be judged or discriminated against, or in other words feel supported, contributes to better mental health outcomes. These perceptions are vital to	<ul style="list-style-type: none"> • Create a welcoming environment that is inclusive of LGBT patients.

	<p>promoting positive mental health and well-being, which are also vital when treating substance use problems and disorders. By promoting and providing a safe and welcoming space in your practice, you are taking an invaluable stand in supporting the dignity and respect of every patient that seeks mental health or substance use services.</p>	
[2:10]	<p>LGBTQ populations face stark challenges in achieving and maintaining health, receiving equal rights and equal opportunities, as well as facing social and systemic effects of oppression and discrimination. These are referred to as barriers to care. Research has suggested that queer individuals often experience hesitation to seeking medical attention due to fear of discrimination, insensitivity, incompetency, and lack of appropriate treatment options. By offering a safe and welcoming environment in addition to adapted treatment approaches, you can help reduce these barriers to care and in consequence, reduce health disparities among this population.</p>	
[2:48]	<p>For many LGBTQ+ people, many spaces can feel unsafe due to previous negative experiences. Specially in the healthcare area. The physical and visual environment to which the patient is going to be exposed must be inviting and be representative of active support and allyship. Some of the things you can include in your practice are:</p> <ul style="list-style-type: none"> • Symbols of support such as a Rainbow Flag, Safe Space stickers, resource cards and brochures of LGBTQ+ organizations and resources, queer magazines, pictures, or images of gender diverse couples, among others. • Offer gender neutral restrooms. • Participate in LGBTQ visibility campaigns <p>Having visual representation of your support and allyship can go a long way for patients who seek treatment services. It is important to understand that seeking mental health services may be a difficult and even vulnerable experience for many people, and for queer patients, it also means fearing to be double or even triple stigmatized, due to the intersectionality of other factors such as</p>	<ul style="list-style-type: none"> • Create a welcoming environment that is inclusive of LGBT patients. • Avoid assumptions about sexual orientation and gender identity.

	race, religion, social economical background, among others.	
[3:58]	<p>It is important to remember that a safe and welcoming space also encompasses the interpersonal interactions that will occur from the moment the patient enters the clinic or treatment center to the moment they leave. Cultural competence is key in this process. You can:</p> <ul style="list-style-type: none"> • Keep yourself updated in correct language and terminology, such as pronouns, gender neutral language, sensitive substance uses terms, etc. As well as being informed on outdated terms! • Stay up today on political issues and legislations that directly or indirectly affect queer folks on every level. • Be educated. Learn more about the community and participate in yearly trainings on topics that concern this population. Learn which treatment approaches have better outcomes when treating queer individuals with substance use problems. • Validate experiences and identities. And also as important, make sure to avoid assumptions, stereotypes, and generalizations. • Identify local resources that are LGBTQ affirming and other practitioners who are also LGBTQ-competent (this will be helpful when in need of a referral). • Make sure that your staff is also up to date, educated in these topics, and have received sensitivity training. Your staff engages with your patients just as much as you do, and their support or lack of thereof will have a big impact on your patient’s perception of safety. 	<ul style="list-style-type: none"> • Facilitate disclosure of sexual orientation and gender identity but be aware that disclosure or “coming out” is an individual process. • Provide information and guidance for the specific health concerns facing lesbian and bisexual women, gay and bisexual men, and transgender people. • Incorporate LGBT patient care information in new or existing employee staff training. • Ensure that communications and community outreach activities reflect a commitment to the LGBT community.
[5:40]	<p>Another important aspect to consider in your practice is incorporating data collection on gender identity, sexual orientation, and patient’s preferred pronouns. One of the main reasons why there is such a huge gap in the understanding of queer experiences in the healthcare system is lack of proper representation in data collection and analysis. There are various resources available that you can implement in your practice to ensure that queer patients are represented.</p>	<ul style="list-style-type: none"> • Identify opportunities to collect LGBT–relevant data and information during the health care encounter.

[6:08]	There have been impactful attempts at improving the delivery of services across the healthcare system. One of these is the Q Card Project. This project is rooted in the belief that all queer and trans individuals deserve quality, sensitive healthcare that can meet their needs, recognizes their agency, and empowers them to advocate for themselves and actively participate in their health. You can use resources like this one to update the forms and questionnaires that are used as part of the intake process.	<ul style="list-style-type: none"> • Use available population-level data to help determine the needs of the surrounding community.
[6:40]	Another great resource available to improve access to services for queer folks is the Purple Pages of El Paso. The PPOEP is a LGBTQ-friendly provider directory list that connects queer individuals and their families in the El Paso Del Norte region with high quality, culturally sensitive health care and social services. This is a great tool to refer to when seeking referral services for one of your queer patients.	<ul style="list-style-type: none"> • Establish partnerships with community health centers and other health care facilities in your community.
[7:08]	Today we learned about the things that you can do in your practice to make us feel safer. I hope you can do this and incorporate them into your practice. Thank you!	

Correct Terminology: Script

Time Stamp	Audio	Joint Commission Topics
[0:00]	Welcome to part two of this series of informational videos on how to provide a safe and welcoming environment to queer patients seeking substance use treatment and care. My name is Adren Warling, and my pronouns are He/Him. The main focus of this episode is to describe the importance and impact of choosing the correct terminology and language in your practice. By this point, we have briefly discussed different ways to show support and acceptance to queer patients and take the lead in providing a safe space for those who come to your practice.	
[0:40]	In order to provide a welcoming environment, we also need to be conscious about the language and words we use or allow others to use. For this reason, we will take some time to review some of	<ul style="list-style-type: none"> • Be aware of misconceptions, bias, stereotypes, and

	<p>the most common queer terms along with their definitions:</p> <ul style="list-style-type: none"> • LGBTQ: lesbian, gay, bisexual, transgender, queer/questioning. In addition, you may also see this acronym with an I that refers to intersex, A that refers to asexual, or a + sign that refers to all other identities in the spectrum. • Sexual orientation: an enduring emotional, romantic, or sexual attraction to other people. This can be different from the person’s gender identity and expression. • Gender: a set of social, psychological, and emotional traits that classify an individual as feminine, masculine, androgynous, or other. • Gender identity: the role that the person claims for themselves. May or may not align to their biological sex. • Gender expression: how a person behaves, dresses, and present themselves. • Transgender: an umbrella term describing people whose gender identity does not match the sex they were assigned at birth. • Cisgender: a person whose gender identity matches their sex assigned at birth. • Queer: a unique identity, and also an umbrella term for the LGBTQ community. 	<p>other communication barriers.</p>
[2:23]	<p>Just as important to keep up to date on what terminology to use and how to incorporate these terms into our day-to-day language, it is also important to be aware of which terms are outdated or are considered offensive to the queer community. Some examples of terms to avoid and what to use instead are the following:</p> <ul style="list-style-type: none"> • Avoid “sexual preference” or “gay lifestyle.” Instead use sexual orientation or just orientation. • Avoid “admitted homosexual.” Instead use openly gay/lesbian/bisexual or simple out. • Avoid “gay agenda.” Instead use accurate description of the issues such as hate crime laws. • Avoid “a transgender,” “tranny.” Instead use transgender, transgender person. • Avoid “sex change/pre-op/post-op.” Instead use transition 	<ul style="list-style-type: none"> • Seek information and stay up to date on LGBT health topics. Be prepared with appropriate information and referrals.
[3:25]	<p>Part of being culturally sensitive is to not make assumptions about the person’s identity, orientation, cultural background, behaviors or lifestyle, preferred pronouns, and partners. It is</p>	<ul style="list-style-type: none"> • Refrain from making assumptions

	<p>often easy to make the mistake of applying heteronormative expectations on people who do not fall under this umbrella. Examples of this is to make assumptions on their partner's gender identity, that they are in a monogamous relationship, that they engage in risky behaviors or dangerous lifestyle, among others. A couple of ways to prevent this from happening is to ask open-ended questions during the session, and update patient intake forms to one that includes patient's preferred name and pronouns, sexual orientation, gender identity, and a space for the patient to write any other identifying information that they perceive as pertinent to their treatment process.</p>	<p>about a person's sexual orientation or gender identity based on appearance.</p> <ul style="list-style-type: none"> • Be aware of misconceptions, bias, stereotypes, and other communication barriers. • Recognize that self-identification and behaviors do not always align. • Train staff to collect sexual orientation and gender identity data.
<p>[4:18]</p>	<p>At first, it can be difficult to start the conversation on how to ask a person for their preferred pronouns, name, and identities. In order to feel comfortable in engaging in this important conversation with your patients, you need to practice! We mentioned earlier that data collection during the intake process is important. You can guide yourself using the information that your patient shared in their paperwork, as a start. Remember, what is on paper can easily change! Be open with your patients and regularly ask them if there is anything new or a change. Also, make sure that the staff at your practice engage in using the preferred language and terms expressed by the patient. And remember, language evolves and changes rapidly, so stay informed!</p>	<ul style="list-style-type: none"> • Listen to and reflect patients' choice of language when they describe their own sexual orientation and how they refer to their relationship or partner. • Update training and educational material on a regular basis.
<p>[5:05]</p>	<p>Similar to queer terminology, when talking about addiction, there are terms that are correct to use and terms that are outdated and we should avoid. We will offer some tips to keep in mind while using person-first language, as</p>	

	<p>well as what terms to avoid in your practice to help reduce stigma and negative bias when discussing substance use problems with your patient. Remember the concept of intersectionality and how a person can be subject to double or triple stigmatization due to their orientation, race, and other social factors. In our society, the topic of addiction is often discussed through a negative scope and moral blaming the person struggling with addiction. Seeking treatment for substance use problems can be a very vulnerable and difficult experience for the person, and if stressors are added to their experience, such as feeling rejection from their provider based on their identity and/or race, it can severely impact the outcome of their recovery and treatment process.</p>	
[6:04]	<p>Feeling stigmatized can reduce the willingness of individuals to seek or continue treatment. Stigmatizing language can negatively influence your perceptions as a health care provider. For this reason, we will discuss what terms to use and which to avoid when talking about addiction.</p> <ul style="list-style-type: none"> • Avoid addict. Instead use person with substance use problem • Avoid user. Instead use person with substance/opioid/alcohol use disorder (SUD, OUD, AUD). • Avoid Junkie. Instead use person in active use; use the person’s name. • Avoid former addict. Instead use person in recovery or long term-recovery. • Avoid abuse. Instead use use (for illicit drugs) and misuse (for prescription medications). • Avoid clean. Instead use abstinent from drugs. 	<ul style="list-style-type: none"> • Ask LGBT patients and families about staff responsiveness to their needs during care planning and treatment and include whether and how these needs were accommodated.
[7:02]	<p>The reason why we should avoid these terms when using person-first language is because the change to the preferred terms shows that the person “has” a problem rather than assuming that the person “is” the problem and that they are at fault of the situation they are in. These terms also elicit negative associations and individual blame, perpetuating cycles of discrimination and stigma among people who use drugs.</p>	
[7:25]	<p>Thank you for listening to this talk today. We hope that you are able to use proper terminology for the LGBTQ community and people who use drugs in order to make your practice for everybody who is coming. Thank you!</p>	

Health Disparities: Script

Time Stamp	Audio	Joint Commission Topics
[0:00]	<p>Welcome to the third and last video of this series. My name is Tevin Henry, and my pronouns are He/Him. In this video we are going to talk about health disparities among the LGBTQ community, risk factors for substance use problems, common dual diagnoses, treatment options with higher levels of efficacy, and important information to know about substance use rates across the U.S.</p>	
[0:26]	<p>Let's begin with a definition. According to the National Institutes of Health (NIH), health disparities are the differences that exist among specific population groups in the attainment of full health potential. These health differences are preventable, and stem from systemic inequities that are often experienced by socially disadvantaged populations. Research suggests that queer individuals face health disparities that are linked to societal stigma, discrimination, and denial of their civil and human rights. The discrimination and stigma that the queer population has had to endure has been associated with high rates of mental health issues (such as anxiety, depression, and social phobia), substance use problems, and suicide. Experiences of violence and victimization are frequent occurrences in this group and have long-lasting effects on the individual and community levels. Moreover, despite the fact that the queer community has had to endure discrimination and rejection practices from society for many decades, it wasn't until 2016 that the NIH formally designated the LGBTQ community as health disparity population. The structural, cultural, and systemic challenges in our society have created barriers for minority populations to access health care services. These barriers to care, in result, lead to negative health outcomes and to an increase in health disparities among those affected. The omission of sensitivity principles in the health care system is one of the main factors as to why minority</p>	<ul style="list-style-type: none"> • Use available population-level data to help determine the needs of the surrounding community.

	populations do not seek medical services, and when they do, perceptions of rejection and unsafe spaces, lead them to refrain from services, resulting in worse health outcomes.	
[2:08]	Research is consistent in showing that little to no social and community support, isolation, adverse childhood experiences, history of violence, and experiencing a constant state of rejection and discrimination are the leading risk factors that contribute to mental health issues and disorders such as anxiety, depression, and substance use. Although there are higher rates of substance use problems among minority groups, especially among queer individuals, this health outcome must not be seen as a behavioral problem associated to the individual. Rather, substance use, in this context, must be seen as a self-medication mechanism that the person employs to cope with layers of stigmatization. In other words, addiction must be understood as a symptom of trauma.	
[2:53]	<p>When it comes to substance use treatments, there is no one-size-fits-all. In fact, there is a variety of different treatment options that are used in different modalities. The modality of use is decided based on the specific needs of the individual seeking help. Moreover, treatment approaches must fit to the patient, and not the other way around. Treatment options, show higher levels of efficacy when they adapted to the minority group based on their own social context and risk factors to addiction. According to the published literature, the treatment approaches that were shown to have higher levels of efficacy when treating substance use problems and other mental health issues among the LGBTQ population are cognitive-behavioral therapy (CBT), eye movement desensitization and reprocessing therapy (EMDR), motivational interviewing (MI), harm reduction approaches, and trauma informed treatment. Let's go over a couple of these to understand why they have better treatment outcomes when used on queer patients.</p> <ul style="list-style-type: none"> • EMDR is a psychotherapy treatment that facilitates the accessing and processing of traumatic memories and other adverse life experience to bring these to an adaptive resolution. EMDR has yielded positive treatment outcomes for treating PTSD, depressive and 	<ul style="list-style-type: none"> • Use aggregated patient-level sexual orientation and gender identity data to develop or modify services, programs, or initiatives to meet patient population needs.

	<p>anxiety symptoms, positive behavioral changes, and decrease in addiction severity.</p> <ul style="list-style-type: none"> • Trauma-informed care is an approach that recognized the presence of trauma symptoms and the role that trauma plays in an individual’s life. Trauma-informed care considers the extensive nature of trauma during the recovery process, and it promotes environments of healing. This approach has high levels on efficacy when used with LGBTQ patients and should be implemented in combination with other treatment practices. Trauma, a risk factor for addiction, affects each individual differently. Remember when we mentioned that it is important to understand the individual’s needs to provide adequate care? Well, trauma-informed care brings that framework to the therapy session. And in the context of LGBTQ patients, the acknowledgment of symptoms and consequences of trauma allows for a trusting and safe environment in which the patient will have better opportunities to thrive in their treatment and recovery process. 	
[5:02]	<p>Traditionally, the health of queer individuals has been focused primarily on risk, that is, higher levels of engagement in risk-taking behaviors perpetuating a continuum of discrimination, victimization, and harassment towards this population as a result of homophobia and transphobia. When it comes to LGBTQ health, these issues serve as barriers to care, that then lead to negative health outcomes and an increase in health disparities among this population. I want to bring back the concept of addiction being a symptom of trauma.</p> <p>Queer folks are at greater risk of living in unhealthy and mentally draining environments due to lack of support and cultural stigma. What happens when other factors come into play? Factors such as race, language, culture, religion, age, disability, physical and mental health. Addiction is a mental health problem that is highly stigmatized by society. What happens when all of these factors intersect? And more importantly, what can we do to reduce the stigma? You can help provide a safe space for your queer patients who are struggling with mental health issues as a result of trauma. By adapting the delivery of your services and employing the tools and resources that were</p>	<ul style="list-style-type: none"> • Create a welcoming environment that is inclusive of LGBTQ patients • Demonstrate ongoing leadership commitment to inclusivity for LGBTQ patients and families. • Identify an individual directly accountable to leadership for overseeing organizational efforts to provide more culturally competent

	discussed in the previous videos, you can offer a life-changing opportunity to members of the community. Providing a safe space, where a queer person can feel welcomed, understood, accepted, and supported can make a difference in their treatment and recovery process. A difference that can save their lives. Thank you!	and patient-centered care to LGBT patients and families.
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Vita

Diana Barraza was born in El Paso, Texas and grew up in Ciudad Juarez, Mexico. She graduated from the Colegio de Bachilleres, Plantel 5 in Ciudad Juarez, Mexico in 2014. She attended The University of Texas at El Paso (UTEP) as an undergraduate where she graduated with the highest honors and earned a Bachelor of Arts in Psychology with a minor in Communication Studies in May 2020. Upon graduation, she continued her education and received her Master of Public Health Sciences (MPH) with a concentration in Hispanic and Border Health from UTEP in December 2022. For her Master of Public Health thesis, Diana worked with her faculty mentor Dr. Oralia Loza from the Department of Public Health Sciences. She was also part of the Students for Public Health organization at UTEP.

During her last year in the MPH Program, Diana completed her practicum at the Borderland Rainbow Center and started working at the Center Against Sexual and Family Violence (CASFV) as an outreach facilitator. In the December 2022 commencement ceremony, she graduated with the honor of serving as the Graduate Student Marshal of Students for the College of Health Sciences. Post-graduation, Diana continued working at CASFV in the same position. After entering the workforce for a few years, she intends to pursue a second Master's degree in Health Psychology. If you need to contact Diana, you may email her at dianabarrazacorr@gmail.com.