Report to the Toronto Central LHIN

Submitted by Breakaway Addiction Services

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Contents

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The agencies and individuals with whom we met, and the party promoters and licensed venues who gave us access to their events.

And, most of all, all those who participated by filling out the survey and/or attending the focus groups.

Executive Summary

The project was funded by the Toronto Central LHIN, and was conducted between December 22nd 2014 and March 31st 2015. The six (6) project staff represented the population i.e. LGBTTQQ2SIA transitional age youth in recovery from substance use (apart from the consultant, who is a family member).

The literature review, which utilized 103 references, primarily from sources in Canada, the U.S. and Australia, documents the prevalence of substance use in the population.

A survey was conducted with 28 agencies in Toronto who serve either youth, the LGBTTQ2SIA population and/or those abusing substances. 60 agencies were originally contacted, but time constraints meant that less than 50% were actually interviewed. Project staff met with staff from each of the agencies individually to gather the information. In addition, information was collected from several other individuals and groups serving the population, and the project benefitted greatly from the guidance and input of the Project Steering Committee, which met on three (3) occasions.

Project staff then developed a survey to be administered to the target population; the survey was publicized in social media, and was also administered in person. Various key locations were selected for this. The survey was administered between February 4th and March 13th, and 640 valid responses were collected. Honoraria were provided to the participants who responded in person, and the on-line participants were entered into a random draw for ten prizes.

During the third week of March, five (5) focus groups were conducted across Toronto with a total of 41 participants. The purpose of the focus groups was to elicit information regarding program design, content and philosophy. All participants received an honorarium and a meal.

All of the above information was collated, and utilized by the project staff in the design of the proposed program, which will provide non-judgmental, empowering, safe, community building and anti-oppressive substance use services to the target population. It will provide a combination of individual support and group modules, focusing on a variety of different topics. All staff will be members of the target population.

Methodologies and Limitations

The methodologies specific to each phase of the project, as well as their associated limitations, are summarized in detail below.

Despite the project team's best efforts, the limited time available in which to complete an undertaking of such breadth and depth was a major constraint. This was reflected primarily in the inability to conduct community-specific outreach to engage sub-populations of LGBTTQQ2SIA communities that experience multiple, intersecting points of marginalization, including people of colour, indigenous people, people with disabilities, and transgender women and/or trans-feminine people.

The project does, however, highlight the efficacy and integrity of community-based, peer-led initiatives. The queer and trans-identified project staff received a tremendous amount of support from the communities of which they are a part. The understanding and experiences they brought aided their approach and analysis immeasurably. Further, the support they received from their communities as a result of this enabled them to complete a project whose successful culmination would have been otherwise impossible.

Project Staff

The Pieces to Pathways project team is comprised of six (6) staff members. Following is a brief description detailing each person's social location. The varying positions of subjectivity among the team impacts both the limitations and scope of the project.

Yasmeen Finjan – Student Placement

Yasmeen is a mixed race Iraqi/Acadian queer genderqueer trans student currently completing their undergrad in Child and Youth Care at Humber College. Yasmeen identifies as an alcoholic in recovery who is currently accessing a 12-step based recovery.

Yasmeen's extended family also has widespread addiction and mental health issues. Diagnosed with Post Traumatic Stress Disorder in 2015, Yasmeen is currently attempting to access programming specifically for youth experiencing substance use issues and other mental health issues and is residing in transitional recovery housing.

Bridget Liang - Statistician

Bridget Liang is a mixed race Chinese/White, queer, transfeminine, neurodiverse, disabled, fat fangirl doing an MA in Critical Disability Studies at York University.

Bridget was raised primarily by their Chinese, immigrant mother and her parents with their White father only present in the background. They survived "corrective" surgery as an infant, racism and sexism directed towards their family, and abuse from their mother. Their father was an alcoholic. Due to their family background, Bridget avoided substance use and when they did try substances, they didn't react well or became ill. They were fortunate enough to have had a high school teacher who recognized the signs of abuse and assisted them getting into therapy where they were fortunate enough to find queer therapists.

Claire McConnell – Project Manager

Claire McConnell is a white female living in Toronto. She is the parent of a transitional age trans male youth in recovery. She grew up in England but moved to Toronto in the early 1980's. Her extended family has experience with both addiction and mental illness, and she experienced a major depression six (6) years ago. She is also a professional who has worked in mental health and addictions for many years: as a front-line staff, in senior management, at the Ministry of Health and Long-Term Care and at the Central East Local Health Integration Network. For the last 5 years she has run her own consulting business, specializing in healthcare system planning. She is passionately committed to increasing and improving services for LGBTTQQ2SIA youth and has found the experience of working on this project incredibly fulfilling, with many new learnings.

Tim McConnell – Project Coordinator

Tim is a white trans-masculine queer person from Toronto, Ontario. They identify as an addict, and are currently practising abstinence-based recovery. Tim navigates the on-going impacts of multiple mental health issues and trauma experiences, and has begun to utilize zine writing to explore the intersections of trans identity, trauma and intimacy.

Pina Newman – Outreach Worker

Pina is a white nursing student living in Toronto, Ontario. She identifies as a transgender woman with queer sexuality. She has hopes of one day becoming a doctor while continuing to be an active member of her communities.

Pina was born in Maryland but grew up in Winnipeg, Manitoba. Her immediate family still lives there. Pina's family has been directly affected by alcoholism and mental health conditions. Pina also identifies as an alcoholic and drug addict in recovery. She practices abstinence but believes in harm reduction as well.

Pieces to Pathways has been an incredible opportunity for Pina to feel more involved in multiple communities. She feels very grateful to have been involved and hopes to continue working on similar projects in the future.

Geoff Wilson – Project Coordinator

Geoff Wilson is a mixed race gender queer activist, grassroots community organizer and writer. They identify as a sober addict in recovery.

Geoff is a graduate of the Social Service Worker program at George Brown College. Recently, they completed their undergraduate degree at the University of Toronto, majoring in Equity and Sexual Diversity Studies. They wish to politicize their experiences with substance use and sobriety while unravelling the limited representation of the addicted body.

Service Provider Interviews

Methodology

The project began by conducting interviews with health and social service providers offering support and resources to:

a) Youth (within the 16-29 age range)
b) People that use alcohol and/or other drugs
c) LGBTTQQ2SIA-identified people, or
d) Any combination thereof

Service providers were contacted via e-mail, through which they were informed of the intentions and scope of the project and encouraged to provide dates/times at which they were available to meet. The eventual meetings comprised a one-hour interview during which project staff tried to ascertain the accessibility of the services provided by each agency, as well as their perceptions of the service needs within the target population[1].

60 agencies were contacted, and meetings were ultimately held with 28[2]. In selecting organizations with which to establish contact, the goal was to generate a cross-section of agencies with varying target populations and service orientations. Based on provider eligibility criteria, the organizations with whom meetings were held had the following areas of focus:

- Twelve (12) agencies worked specifically with youth
- Seven (7) agencies worked specifically with substance users
- Three (3) agencies worked specifically with LGBTTQQ2SIA-identified youth
- Two (2) agencies worked specifically with LGBTTQQ2SIA-identified people of any age

[1] See *Appendix 3* for a full list of interview questions and responses
[2] See *Appendix 2* for a full list of agencies surveyed

- Two (2) agencies worked specifically with LGBTTQQ2SIA-identified substance users
- Two (2) agencies worked specifically with youth substance users

Notably, although any number of these organizations may encounter LGBTTQQ2SIA-indentified youth that use substances, none offered services designed specifically for this population.

Limitations

Primarily, the limitations associated with this phase of the project are related to the absence of agencies with which meetings could not be scheduled. The limited time period (approximately one month) available in which to conduct these interviews resulted in the following omissions:

- With the exception of the Centre for Addiction and Mental Health, no meetings were held with any hospitals and/or primary health care providers
- No meetings were held with organizations providing support services specifically to families, newcomers, people with disabilities, Indigenous people and people that are currently incarcerated or have been recently released from custody
- The majority of interviews were conducted with organizations providing services in central Toronto. The unique needs of service users in Etobicoke (where no interviews were conducted), Scarborough (where three [3] interviews were conducted) and North York (where three [3] interviews were conducted) are therefore under-represented in this review.

Survey Design

Methodology

In administering an alcohol and other drug use survey to LGBTTQQ2SIA-identified youth (ages 16-29), the project staff hoped to derive the following information:

- Self-perception of alcohol and other drug use
- Previous experiences of service access
- Barriers to service access
- Service Preferences
- Demographics

The primary concern in designing the survey was generating an accessible document that balanced the project's research interests with the needs of participants. That is, the goals were not to overwhelm respondents with either survey length – constructing it to result in a completion time of 7-15 minutes - or question content. Regarding the latter point, attempts were made to ensure that the enquiries were as noninvasive as possible, thereby minimizing the potential of triggering

participants. To this end, an initial screening page was created, in which it was explicitly stated that participants were entitled to skip any question with which they were uncomfortable, and were not obligated to complete the survey once they had commenced.

Additionally, the aforementioned page contained three (3) screening questions to determine participant eligibility. Potential respondents were required to offer affirmative responses to these enquiries to be eligible to participate in the project[3].

Although the need for quantitative statistics undoubtedly influenced the design of the survey, space for respondents to elaborate on quantitative responses at their discretion was incorporated. When soliciting demographic information, the respondents were allowed to select as many identity markers as they wished. Further, for almost all questions, the oft-used catch-all "Other" to was deliberately altered to "Anything we missed", in order to avoid both creating exhaustive categories and "othering"[4] the identities and experiences of participants.

Finally, although the majority of the survey was designed by project staff, a valid measurement scale to quantify substance use prevalence was also needed. After much discussion, agreement was reached as to the use of the grid component of the Adolescent Alcohol and Drug Use Scale (AADIS), an adaptation of Mayer and Filstead's Adolescent Alcohol Involvement Scale. Because the AADIS assesses both alcohol and other drug use frequency in a single chart, it is a relatively brief screening instrument that minimizes the differential social stigmatization attributed to these substances. Further, the AADIS is publicly available, able to be self-administered, and brief. It is therefore optimally situated for use in this study. Despite the utility of the frequency chart, however, a number of alterations were made that should not have affected the validity of the measurements:

- Acknowledging the flexibility of substance users' relationships to alcohol and other drug use, the phrase "Tried but quit" to was changed to "Tried but stopped"
- Working with one of the project partners, TRIP (the Toronto Ravers Information Project), the substances included and terminology utilized were updated, with the addition of distinct categories for ketamine, MDMA, methamphetamine, prescription opiates and phenethylamines and the elimination of tobacco

Unfortunately, the grid component of the AADIS – the only section project staff opted to utilize – is not incorporated into the same scoring system as the rest of the assessment, which quantifies substance use severity through an analysis of the consequences of use. The inclusion of these additional questions would have nearly

[3] See *Appendix 6* for the Screener Page and Survey
[4] Popularized by Edward Said, the process of 'othering' involves "emphasizing the perceived weaknesses of marginalized groups as a way of stressing the alleged strength of those in positions of power" (Jones, et al., 1999)

doubled the length of the survey. Instead, staff devised their own multiple choice question quantifying participants' self-perceptions of their alcohol and other drug use.

Limitations

As a group of young queer and trans community researchers, project staff strove to prioritize the diverse, vulnerable, and silenced voices that are often erased within their communities. Ultimately, their efforts to prioritize the communities' varied means of expressing their identities and experiences resulted in several flaws in the survey design.

Despite attempts to utilize inclusive language and offer myriad experiential and identification options, it is recognized that the utilization of categories, in and of themselves, impedes individual autonomy and self-determination. No series of classifications, therefore, can ever hope to be exhaustive. As a result, there were undoubtedly those who did not feel themselves to be appropriately represented in the survey. Although it would have been preferable to allow each participant to describe themselves in their own terms, quantifiable data was required, and therefore categories through which respondents were obligated to define their identities and experiences were necessary. Specifically, it is regrettable that a "Questioning" option for gender identity was not provided; however, one was provided for sexual orientation. As well, limited categories of racial and ethnic identities were offered, particularly for black and indigenous respondents, and there was not a mixed race option. The latter oversight was especially problematic, as FluidSurveys – through which the online version of the survey was hosted – would not allow the outputting of unique combinations of identity categories. Instead, the program documents only the number of responses for each option within a particular question. This prohibited the documentation of the diverse ways in which racial and ethnic identities intersect, effectively erasing mixed race respondents. Similarly, because the majority of participants endorsed multiple gender identity and sexual orientation options, it was not possible to document the ways in which these identity categories intersect to create distinct experiences of gender and/or sexuality.

Further, in the attempt to maximize respondents' sense of comfort and safety, it explicitly stated that it was permissible for them to skip any question for any reason. Although this was integral to the ethical quality of the survey, it resulted in low response rates for the majority of enquiries. Despite having 640 total participants, many questions were answered by, at most, 350 unique respondents. As well, because participants were not required to specify whether or not particular sections applied to them, it is not known whether certain questions received less responses because of their limited applicability. This resulted in a loss of clarity, particularly when questions pertained to previous experiences of service access.

Finally, because of the breadth of information that was sought – encompassing substance use prevalence, previous experiences of service access, and service

preferences – some respondents felt the survey was designed more for those that had previously or would like to access support services for alcohol and/or other drug use. Therefore, the multiple areas of interest resulted in a document that marginalized the experiences of some respondents. Although several people tested the survey and provided feedback before it was released on and offline, all those who acted as 'testers' had previously accessed support services for alcohol and/or other drug use.

Online and Offline Promotion/Administration

Methodology

In order to maximize the accessibility of the survey – and thereby to increase the response rate –a number of platforms and outreach strategies were used to engage participants. The survey was available online from February 4 to March 9, and could be accessed through a link provided on the website and promotional material[5]. Online outreach was conducted through various social media platforms. Project staff posted the promotional flyer and provided a link to the project's website on their own Facebook pages, as well in several LGBTTQQ2SIA-specific groups and event pages. Those that saw the post were encouraged to like and/or share the post, thereby increasing its visibility. Tumblr and Instagram were also used, similarly with similar encouragement to users to reblog, like, and/or share the post. The project received tremendous support online, indicating the efficacy of utilizing community members as project leaders. It is clear that the promotional support – in the form of liking, sharing, re-posting and re-blogging – was integral to the breadth of responses we received. Ultimately, project staff collected 440 valid surveys through their online administration.

Respondents were first met with a Screener Page that detailed project staffs' positionalities as researchers, their intentions in conducting the survey, information on anonymity and confidentiality, informed consent, and a commitment to their safety and comfort as participants. That is, they were informed that they could skip any question for any reason, were not obligated to complete the survey once they had commenced, and, further, that this would not compromise their access to the incentives provided. They were then asked the following questions to determine eligibility:

1. Do you identify as LGBTTQQ2SIA?* (*A is for Asexual, not Ally)
2. Do you live or access services in Toronto?
3. Are you 16-29 years old?

Respondents were required to answer "Yes" to all three questions in order to be able to participate. If they so chose, online respondents were eligible to submit their e-mail to be entered into a draw to win one of ten $30 e-gift cards to a retailer of their choice. After pressing the "Submit" button on the survey, they were redirected to a

[5] See *Appendix 4* for the promotional flyer

separate page on which they could enter their e-mail for consideration. Because the information in the two surveys was not linked, there was no means of connecting a particular e-mail to a specific set of responses. A random number generator was later used to select ten winners.

Staff began administering the hard copy (offline) version of the survey – a document identical to that provided online – on February 4, and concluded on March 13. The hard copy of the survey was administered in a variety of different environments, including service provision contexts, party/bar/club spaces, and community events[6]. By necessity, the methodology varied slightly, depending on the context. When administering the survey in service provision environments – generally in drop-in or group contexts – a brief announcement would be made regarding the project, encouraging patrons to speak to staff should they wish to participate or have any questions. Conversely, because bar/club/party environments habitually did not have a central mechanism through which all those present in the space could be informed of the project's intentions, staff instead spoke to potential participants individually. They would introduce themselves and the project, offer a flyer, and identify a location within the venue at which attendees could engage with them if they so chose. When making announcements and speaking to individual patrons, project staff always explicitly situated themselves as young queer and trans people with histories of alcohol and/or other drug use.

When administering the hard copy survey, staff explained the intention of the project, summarized the content of the questions, delineated the procedures regarding anonymity and confidentiality, and encouraged potential participants to answer only those questions with which they were comfortable. They were further assured that not completing the survey would not compromise their access to the incentives advertised – in this case, a $5 Tim Horton's gift card and two (2) TTC tokens – and that staff was available to debrief with them should they decide they wanted support. As well, because no identifying information was taken, explicit verbal consent was obtained from each participant before administering the survey in lieu of soliciting signatures.

At the conclusion of the hard copy administration, a team of volunteers – all of whom signed confidentiality agreements – helped the core Pieces to Pathways team in inputting the offline responses into the online database. 207 hard copy responses were received, resulting in a total of 647 surveys available for analysis.

Limitations

The two means by which respondents were able to engage with the survey – online and offline – have unique methodological limitations.

Firstly, because staff wanted to safeguard the anonymity of participants, they did not track the IP addresses utilized by respondents. Although this was the appropriate

[6] See *Appendix 5* for a list of survey locations

ethical decision, it is possible that individuals may have participated multiple times, thereby skewing the data that was obtained. There were no means of identifying duplicate responses. As well, it was initially hoped that the locations from which each response was obtained could be coded, in hopes of identifying disparities based on the context in which the survey was conducted. It was not possible to do this, however, and staff is limited to analyzing the data-set in its entirety.

Additionally, due to the time period within which the survey was conducted – early February to March – it was not possible to conduct traditional street outreach. Instead, staff attempted to administer the survey in a variety of non-service contexts, attending a number of parties and community events. Within these environments, however, circumstances necessitated that they leave relatively early (before midnight), after which the level of intoxication present prohibited potential participants from offering informed consent. This ultimately limited the number of people available to survey, and effectively excluded those who did not arrive before midnight, and who, it is suspected, may have had a greater tendency towards problematic substance use. As well, although staff tried to attend a variety of parties and/or community events, they were unable to receive permission to conduct surveys in bathhouses or after hours clubs – both notorious for the presence of alcohol and other drugs – and did not attend any parties that prioritized the experiences of people of colour, young cisgender gay men, or the BDSM/kink community. Further, because they received a higher response rate in service provision environments, the sample likely minimized the presence of those for whom service contexts are unsafe and/or inaccessible.

As well, staff struggled with the ethical dilemma of administering an LGBTTQQ2SIA-specific survey in non-LGBTTQQ2SIA-specific and/or positive environments, for fear of forcing participants to out themselves in spaces in which it may not be safe for them to do so. Therefore, off-line respondents were surveyed in exclusively LGBTTQQ2SIA-specific service environments, limiting the generalizability of the findings. Similarly, they were unable to survey any shelter residents.

Primarily, therefore, the sample is limited to those for whom party environments and/or service provision contexts are already accessible.

Focus Groups

Methodology

To further develop recommendations regarding the ideal form and content of an LGBTTQQ2SIA-specific substance use support program, five (5) two-hour focus groups were facilitated in various areas of the city. Sessions were conducted in the following locations:

- Central Toronto, hosted by Sherbourne Health Centre (10 participants)
- Central-West Toronto, hosted by LOFT Community Services (15 participants)

- Midtown, hosted by Delisle Youth Services (9 participants)
- North York, hosted by Griffin Centre (5 participants)
- Scarborough, hosted by Youthlink (1 participant)

Participants were recruited through engagement with both the online and offline versions of the survey, as well as postings in a number of LGBTTQQ2SIA-specific groups on social media sites. Further, an LGBTTQQ2SIA-identified member of the deaf community was contracted to make a promotional ASL video, which was then disseminated online.

Because staff specifically recruited those who had previously accessed or would consider accessing formal support related to alcohol and other drug use, this sample is broadly representative of the range of service needs of LGBTTQQ2SIA youth.

All groups were held in physically accessible locations with access to gender neutral washrooms. ASL interpretation was booked and advertised as available for the Downtown West group. However, as no participants, when asked via e-mail about any accessibility needs and dietary preferences they would like to share, specifically requested ASL, the booking was cancelled. When recruited to participate, potential attendees were informed that they would receive a $20 cash honorarium, two (2) TTC tokens, and a full meal to compensate them for their time.

A minimum of three (3) Pieces to Pathways team members were present at each group: one primary facilitator, one secondary facilitator/active listener, and one note-taker. Prior to commencing each group, participants were offered a brief overview of the project, the intentions for the group, and a detailed explanation of the consent and confidentiality forms provided. Further, specific group guidelines were provided, and each group began with a check-in asking participants to share their names, pronouns and access needs.

Limitations

Unfortunately, because of the limited time available in which to promote the focus groups, it was not possible to conduct community-specific outreach. Participants were recruited through their participation in the online and offline versions of the survey, and are therefore subject to the same demographic limitations delineated above[7].

As well, despite specifically stating the intention of the group as the development of an LGBTTQQ2SIA-specific alcohol and other drug use support program, no screening questions were asked to determine participant eligibility. Prior to their arrival, although it was known that all participants were LGBTTQQ2SIA-identified youth, their level of alcohol and/or other drug use involvement was not known. Although it later emerged that participants generally identified as addicts, alcoholics,

[7] See the section on the Focus Groups later in this report for a more detailed discussion of the focus group demographics

and/or with problematic substance use, screening prior to participation would likely have enabled staff to ensure a variety of experiences prior to facilitating each session.

Finally, although the original intention was to utilize the survey results to inform the focus group questions, statistical analysis was not completed prior to the first focus group session. Therefore, the questions were developed based on the literature review, as well as personal experiences of substance use and service access.

Literature Review

The following is a synopsis of the key findings of the literature review. For the sake of brevity, references are not included in this summary. The full literature review and associated references can be found in *Appendix 1*.

This literature review summarizes findings regarding alcohol and substance use among LGBTTQQ2SIA transitional age youth, and shows that the population has rates of substance use substantially higher than those of the general population, experiences distinct psycho-social challenges, expresses consequent treatment concerns, and displays a greater frequency of unmet treatment needs. Information has been divided into the following sections: prevalence rates, causal explanations, barriers to service access, experiences in treatment, and recommendations. Sections have been further subdivided according to sub-populations: cisgender males and females endorsing minority sexual orientations, attraction, and/or relationships, and gender minority populations. There is also a sub-section for indigenous gender and sexual minority communities.

As much as possible, each authors' language choices have been mirrored in the reporting the findings of their research. Although not ideal, as certain terms may appear somewhat inappropriate and archaic, it is believed that this ensures the greatest transparency in our report, and also ensures that the summaries are reflective of the original research findings.

Population-Based Studies

Although “few epidemiological surveys have assessed participant sexual orientation”, one such survey offered a preliminary indication of elevated rates of substance use in sexual minority populations. Men with male partners of endorsed a lifetime prevalence of illicit substance use of 72.8%, compared to 54.6% for men with no previous year history of same-sex sexual behaviour. For women, 77.9% of those reporting a history of female partners endorsed lifetime use of illicit substances compared to 42.3% for women indicating only male partners.

One meta-analysis and methodological review examining sexual orientation and adolescent substance use across eighteen studies published over an eight (8) year period quantified the odds of substance use for LGB youth as being, on average, 190% higher than for heterosexual youth. These results indicated elevated risks for specific sub-populations of LGB youth, including bisexual youth and females. Youth endorsing a sexual minority orientation, romantic attraction, or relationship were two (2) to five (5) times more likely to report the use of substances. As well, one national survey reported that non-heterosexuals had higher rates of risky drinking than heterosexuals; were more likely than heterosexuals to have ever used illicit drugs and were more likely to have used illicit drugs in the previous 12 months.

Comparing the results of heterosexual respondents from the aforementioned survey with a cross-sectional survey conducted at a youth LGBT festival in the same country it was found that while approximately 25% of 18-29 year-olds in the national survey cohort reported drug use in the previous 12 months, 50% of the respondents in the LGBT festival survey reported drug use in the previous 6 months. Among the general youth population, 77% of 12–15 year olds reported abstaining, as compared to 30% of the gender and sexual minority participants. Hazardous drinking was also more frequently reported by LGBT youth when compared to the national sample, with particularly acute disparities documented during adolescence, and the same trend was apparent in the use of illicit substances.

The elevated rates of substance use among gender and sexual minority youth can be contrasted with those reported by a general youth population. One report shows that only 20.3% of the general youth population ages 15 – 24 endorsed past year use of cannabis, with insufficient data available to report on other illicit substances, as their use was so infrequently endorsed. Further, " fewer than one in five teens in school have ever tried any drugs other than alcohol and cannabis", while an approximately equivalent proportion use these substances regularly, and even fewer have used "street drugs" such as heroin, cocaine, or methamphetamine.

Sub-Populations

Sexual Minority Men

Young men endorsing same or both-sex sexual orientations, attraction and/or relationships have rates of substance use higher than their heterosexual counterparts. Sexual minority men ages 18-25 participating in one survey were found to have the highest rates of club drug usage and dependence of all respondents. Similarly, 69% of sexual minority male youth participants in another study reported having used an illicit drug. 90% of the sample reported a lifetime use of alcohol, 23% reported use of cocaine, and 20% reported use of crystal methamphetamine.

Some research has shown that increased alcohol and other drug (AOD) use may be associated with participation in the "gay scene" of licensed venues. Several authors have linked "higher levels of participation in the scene" with "recent and regular" AOD use in sexual minority men, particularly the use of 'club drugs'.

Research exploring different dimensions of sexual identity indicates that youth who espouse a sexual minority identity have higher rates of substance use than those exclusively endorsing same-sex romantic attractions and/or relationships. Male sexual minority youth endorsing relationships with both sexes, as well those who explicitly identify as bisexual, appear to have rates of AOD use higher than non-sexual minority youth, and equal to or higher than gay-identified male youth.

Sexual Minority Women

Sexual orientation disparities in relation to substance use are believed to be larger in females than in males. Data from one study showed that "when gender modified the relationship between sexual orientation and drug use, the elevated risk experienced by sexual minorities relative to heterosexuals was larger among females than males." Another study found that "females who identified as lesbian or bisexual, who reported at least some same gender attraction, or who reported sexual activity with partners of both genders had significantly higher odds of all forms of substance use" and, further, that bisexual females had the highest past-year prevalence of drug use amongst all groups for all drug categories except heroin".

Sexual minority women who frequent sexual minority-specific night club venues similarly experience increased odds of AOD use. A survey of 254 sexual minority women ages 18-25 found that 76% of respondents reported alcohol use that could be classified as hazardous, while 28% reported using club drugs in the preceding 6 months. Among those who had used club drugs during this time period, 26% of females had scores indicative of "current dependence on at least one of these drugs".

A survey of sexual minority young women ages 18-25 found that of the 49% of respondents that reported using illicit drugs in the previous six months, bisexual women were more likely than other participants to report using drugs, as well as being younger upon initial use. The same study found that a higher proportion of lesbian and bisexual women had hazardous scores when compared to gay and bisexual men. As well, bisexual women were found to be at elevated risk for the use of cocaine, methamphetamine and heroin when compared to other groups, and "sexual minority women presenting for publicly funded treatment, overall, have more severe drug use patterns" when compared to their non-sexual minority peers.

Gender Minority Populations

Most studies documenting substance use prevalence rates in sexual minority communities explicitly exclude gender minority participants. While some researchers have surveyed AOD use in gender minority communities, there is much less information available regarding these rates than those in sexual minority populations. Despite this, ample evidence indicates that AOD use in gender minority populations is more pronounced than in cisgender populations, including rates recorded in sexual minority communities. As well, because behavioural patterns (related to substance use) exhibited by youth may well predict adult behaviour, results documented in adult studies can reasonably be applied to youth populations.

Results of the comparison of three studies with another survey measuring the rate of AOD use in the general population showed that 0.9% of the general population reported the use of crack-cocaine, as opposed to between 7% and 21% of male to

female (MTF) participants, and that 6.7% of the general population could be classified as 'heavy drinkers' compared to 24% - 37% of MTF respondents

Additionally, one survey found that among MTF respondents, 66% reported lifetime use of cocaine, 57% reported lifetime use of speed, 48% reported lifetime use of crack, 24% reported lifetime use of heroin, and 34% reported a history of injection drug use; among female to male (FTM) participants, 52% reported lifetime use of cocaine, 50% reported lifetime use of speed, and 18% reported a history of injection drug use.

In the only survey not to have dichotomized gender minority respondents according to MTF or FTM identity, a national study of LGBT youth ages 13-24 found that a greater percentage of gender diverse respondents reported the use of stimulants, prescription medications and opiates, and were twice as likely to be poly-drug users when compared to cisgender respondents.

Finally, while little information exists regarding substance use in racialized gender minority communities, it is likely that AOD use is higher than the rates mentioned above. One survey found that “transgender racial minorities, particularly MTF transgender persons, fared worse than Whites in almost every category surveyed, including substance use”.

Indigenous Populations

While relatively little information is available regarding AOD use in Indigenous gender and sexual minority communities, preliminary evidence indicates prevalence rates may be substantially higher within these populations. One study found that), 23% of the indigenous population indicated that they required services specific to their AOD use. As well, among a sample of 71 gender and sexual minority American Indian men, two-spirit respondents reported the highest levels of HIV risk behaviours, including substance use, when compared to heterosexual participants. Interestingly, the few studies documenting gender and sexual minority identities and behaviours in Indigenous communities indicate that “American Indian youth have a higher prevalence of self-reported gay, lesbian, bisexual, and "unsure" sexual identities than non-American Indian youth”.

Causal Explanations

Three primary theories have emerged in an attempt to explain elevated rates of AOD use in gender and sexual minority communities:

1. The extent to which LGBTTQQ2SIA social life is centred around attendance at licensed venues may increase participants' risk of alcohol and drug use
2. Gender and sexual minority individuals face stressors to which the general population is not subject 'minority stress theory' – and are therefore vulnerable to elevated rates of psychological distress

3. Internalized heterosexism may result in guilt, shame, self-loathing, and consequent substance use

Reliance on Licensed Venues

In part, the prevalence of substance use in gender and sexual minority communities is attributed to the extent to which their social lives may be organized around bar spaces, seen as places where they can safely socialize and develop community cohesion and connectedness. Increased attendance at sexual and gender minority specific licensed venues is believed to augment the risk of AOD use.

Minority Stress

Minority stress encompasses three fundamental varieties of experience:

1. Objective events and conditions, such as discrimination and violence
2. Vigilance resulting from expectations of further mistreatment
3. Internalizing of negative attitudes to which gender and sexual minorities are exposed

Minority stresses are seen as existing along a continuum from objective events (including harassment, violence and discrimination) to subjective experiences (including vigilance and internalization). According to this model, “stress can be considered the mediator in the relationship between social status and addictive behaviours among people who belong to stigmatized minority groups.”

Ample evidence indicates that sexual and gender minority youth are disproportionately subject to instances of violence and discrimination when compared with their non-gender and sexual minority. 94% of participants in a needs assessment surveying gender and sexual minority youth age 15 – 26 reported hearing homophobic comments, while 87% reported hearing transphobic comments. Further, 46.9% of respondents indicated daily exposure to homophobia, and 31.7% reported daily exposure to transphobia. In one study of LGBT adolescent gender non-conformity, “both adolescent and young adult levels of gender nonconformity and LGBT school victimization were positively correlated”, and further, victimization experiences were associated with higher rates of depression in young adulthood.

School-based studies of gender minority adolescents have been relatively scarce. A meta-analysis of 39 studies identified only 12 studies that included transgender participants, of which only four (4) assessed their experiences independently of sexual minority youth. In research that has addressed only gender-minority experiences, rates of victimization are universally higher than those reported by cisgender heterosexual and sexual minority youth, indicating that gender-minority youth are at increased risk of peer-based victimization, and are therefore more susceptible to adverse psycho-social consequences.

Exposure to harassment, violence and discrimination has been amply documented in gender minority adult populations, and these statistics can likely be extended to gender-minority youth. Most recently, results from a transgender health study indicated high rates of exposure to violence, with 38% of participants reporting that they had been physically assaulted since age 13. 31% of respondents indicated that their families were not supportive of their transgender identity, and 37% disclosed negative high school experiences, including hostility from peers, teachers, and school administrators. The study further emphasized that "being younger at age of first transgender awareness was significantly associated with discrimination".

Birth assigned males and racialized gender minorities have increased exposure to maltreatment. Data from a study analyzing the substance use treatment experiences of gender minority adults found that "African-American transgender/transsexual participants reported the highest level of transphobic events in the past year", while a transgender discrimination survey demonstrated that " transgender racial minorities, particularly MTF transgender persons, fared worse than Whites in almost every category surveyed". In another study, 92% of racial minority respondents reported experiencing transphobia, while 90% indicated that they had been subjected to racism or ethnicity-based discrimination. Subsequent analyses indicated that "increases in experience of one type of discrimination had strongest effects on HIV risk when coupled with high levels of the other."

Mediating Variables

Many authors have endorsed Meyer's minority stress model, identifying exposure to violence, harassment and discrimination as enhancing risks of depression, anxiety, suicidality, self-harm behaviours and substance use. One study found that sexual minority youth were nearly twice as likely to report suicidal ideation and more than three times as likely to report suicide attempts as their heterosexual peers, and concluded that " elevated levels of sexual minority-specific victimization are partly responsible for the higher prevalence of depressive symptoms and suicidality in sexual minority youth [SMY]". Another study found that "SMY who experience higher levels of victimization are 2.6 times more likely to report depression and 5.6 times more likely to attempt suicide than SMY who experience lower levels of victimization". The same relationship appears to be present in gender minority experiences of victimization.

Studies quantifying psycho-social distress in gender minority communities show that these youth are at greater risk of adverse health outcomes when compared to both cisgender sexual minority and cisgender heterosexual youth. One study found that experiences of interpersonal violence, particularly during childhood and adolescence, "correlated with high rates of depression and suicidal ideation among MTF transgender persons"; an analysis of independent predictors of attempted suicide among 515 transgender respondents found both gender minority discrimination and victimization to be "independently associated with attempted suicide."

Finally, several authors report findings offering preliminary indications that substance use in gender and sexual minority communities may be attributable to experiences of violence and discrimination.

Internalized Heterosexism

"The most prevalent explanation of the link between substance abuse and LGBT status is internalized homophobia [heterosexism]", or, alternatively, internalized cissexism. LGBTTQQ2SIA individuals internalizing these ideas are apt to experience shame, guilt and consequent psychological distress. Increased levels of internalized heterosexism and cissexism are hypothesized to "correlate positively with substance abuse" in gender and sexual minority individuals. None of the studies reviewed in this area explored the experiences of gender minority individuals.

Indigenous Gender and Sexual Minorities

Among Indigenous participants in one study, 73% had experienced violence attributable to their gender minority status, 90 % had experienced transphobia, and 76% had contemplated suicide. Further, a study of the victimization experiences of two-spirit men found reported lifetime prevalence of both physical and sexual assault to be substantially higher than those indicated by non-indigenous sexual minority respondents. Because of increased exposure to both physical and cultural violence, Indigenous gender and sexual minority youth likely experience heightened risk for AOD use.

Barriers to Service Access

Proportion Accessing Services

One study estimated the percentage of clients in "mainstream" treatment programs to be approximately 1%. Another study of LGBT clients receiving publicly funded treatment found that only 2.46%, or 269 of the 24,792 people in the entire study sample, were identified as LGBT. Considering the elevated rates of substance use in sexual and gender-minority communities, these statistics indicate service underutilization. Additionally, a survey of sexual minority youth ages 18 – 25 found that only 6% of the 572 respondents had sought treatment, despite exhibiting a 70% frequency of scores indicative of hazardous alcohol use. Comparatively, 22% of a national population sample with alcohol use disorder reported accessing treatment.

Barriers Endorsed

In an analysis on sexuality, gender identity, social bias and mental health, it was found that gender and sexual minority respondents were more likely to indicate a need for mental health care services, and more frequently endorsed not having accessed services when compared to non-gender and sexual minority participants. Gender minority respondents were the most under-served sub-population.

Experiences of discrimination, in addition to being a life stressor that likely precipitates significant psycho-social distress, also increases the likelihood that individuals will avoid seeking needed mental health care services.

Gender minority youth may report additional barriers, as well as increased exposure to discrimination in service provision contexts. Results from one survey identified health care as the most common context in which they reported discrimination; as well, 28% reported postponing medical care when they were sick or injured due to discrimination. A similar percentage reported experiencing harassment in medical settings, while 19% indicated that they were refused care due to their gender minority status. The survey also found that the likelihood of experiencing discrimination increased when providers were aware of the respondent's gender minority identity.

Finally, a survey of transgender patient perceptions of stigma in health care contexts identified previous negative experiences with healthcare, fear of treatment and stigma concerns to be the most frequently endorsed barriers related to seeking mental health services. Respondents' descriptions of maltreatment "coalesced around six themes: gender insensitivity, displays of discomfort, denied services, substandard care, verbal abuse, and forced care" and "71% of the sample reported at least one instance of mistreatment in health care contexts".

The use of gender as an administrative category to structure service access may create additional vulnerability for those whose identities do not correspond to these assumptions. This is particularly relevant to substance use treatment, in which programs are frequently segregated according to sex. Gender minority individuals trying to access these services may find institutions whose admission policies and program streams do not accommodate their uniqueness. Although the influence of these organizational classifications has not yet been studied, it is unlikely that individuals will access services that do not appear to acknowledge their identities, and that they may assume that these environments will be unsafe.

Indigenous Gender and Sexual Minority Populations

Indigenous gender and sexual minority populations probably face additional barriers to health care access. Beyond the barriers explicitly related to gender and/or sexual minority status, Indigenous communities may be distrustful of governmental organizations/services, and experience the marginalization of Indigenist health practices in modern medical contexts. One survey found that among Indigenous trans respondents, 61% reported at least one unmet health care need within the previous year, with a substantial proportion of participants indicating that they required, but were unable to obtain addiction services during the same period.

Experiences in Service Provision Contexts

Significant concern has been expressed regarding the substance use treatment experiences of gender and sexual minority clients; they have consistently been found to have poor treatment outcomes, including lower levels of abstinence (when required) and program completion, when compared to heterosexual and cisgender populations.

In a survey of treatment providers' attitudes toward LGBT individuals among a sample of 46 substance abuse treatment counselors, "15.2% believed that substance abuse treatment was more effective for heterosexuals, 26.1% found it difficult to relate to the specific problems that LGBT individuals present in treatment, and 17.4% believed all clients should see the nuclear family as the ideal social unit". The literature also reveals that treatment counselors in 'mainstream' programs will not have received sufficient training in gender and sexual minority-specific care, and will therefore not provide adequate support to gender and sexual minority clients. These issues must be addressed in treatment environments if interventions are to be successful.

A survey of the gender and sexual minority awareness of substance use treatment providers found a dearth of expertise. 56% of respondents reported little to no familiarity with gender and sexual minority-specific familial issues, 47% lacked knowledge of internalized homophobia, and 38% were unfamiliar with the 'coming out process'. This is particularly troubling, as several authors have suggested correlations between counsellor knowledge base and client satisfaction.

One can infer that in the presence of hetero- and cissexist social norms, and lacking culturally relevant support, gender and sexual minority clients will not feel sufficiently comfortable to address the issues that precipitated their substance use. Experiences of gender and sexual minority specific maltreatment are very traumatic and lead to the implementation of specific coping mechanisms, including substance abuse. It is imperative that these experiences and their ramifications be addressed in the therapeutic context. However, when such traumas occur in the clinical environment, resolving them becomes impossible.

Additionally, several authors have noted the tendency of substance use treatment providers to individualize the issues with which clients present in treatment, particularly in facilities adhering to the disease model of addiction, in which substance use disorders are viewed as "primary" (i.e. they are not caused by anything else). This perspective may not acknowledge the genesis of victimization experiences embedded in larger social contexts. Therefore, treatment programs often address individual deficiencies without regard for the larger social context. Despite the "growing recognition that substance user and misuser treatment models based on the experiences of white, heterosexual men have limited applicability to many types of clients", many treatment facilities lack training in cultural competence and fail to address the distinct intersections of marginalized identities. This may be

especially dangerous for gender and sexual minority populations, whose experiences of substance use are often correlated with socially sanctioned exposure to harassment, violence and discrimination.

Several studies have evaluated the differential substance use treatment experiences of gender and sexual minority populations. Utilizing a convenience sample of 120 gay, lesbian and bisexual former clients of traditional substance abuse programs (including outpatient, residential, inpatient and methadone maintenance programs), a comparison was made of the perceptions, reported abstinence and completion rates of lesbian, gay, bisexual, and heterosexual clients in substance abuse treatment, and it was found that:

- Gay and bisexual respondents of both genders had lower mean scores for all four perception variables (feelings of connection, therapeutic support, ability to be open/honest, treatment satisfaction) than heterosexual respondents
- Gay/bisexual respondents were significantly less likely to have completed treatment and more likely to have left treatment due to their needs not being met or their being discharged
- Being gay/bisexual was a significant negative predictor of both “abstinence at end of treatment” and “current abstinence”
- Gay and bisexual men reported the lowest abstinence rates at the end of treatment and at the current time of any cohort, including lesbian and bisexual women
- In open-ended responses, 57% of participants reported that their sexual minority identity negatively impacted their treatment experiences. Four central themes emerged: experiencing homophobia from heterosexual clients, difficulty being honest and open about gay/bisexual issues, feeling vulnerable and unsafe, and feeling alienated and not understood”

Similarly, a comparison treatment experiences of gay and bisexual men in traditional treatment programs, gay and bisexual men in culturally specific treatment, and heterosexual men in traditional treatment found that:

- Heterosexual men and gay/bisexual men in LGBT specialized treatment had more favorable results than did gay/bisexual men in traditional programs
- No significant differences in abstinence rates existed between heterosexual men and gay/bisexual men in LGBT specialized treatment
- Heterosexual men were significantly more likely to report that they had completed treatment than were gay/bisexual men in traditional treatment, but there were no significant differences in completion rates between heterosexual men and gay/bisexual men in LGBT specialized treatment

Further, in a qualitative study of three (3) lesbian women and ten (10) gay men who attended substance abuse treatment programs, respondents endorsed six themes in relation to their treatment experiences: “feelings of isolation, feelings of not being understood by staff and clients, fear of being open about their sexual orientation,

having their sexual issues ignored, hearing hurtful comments by both staff and clients regarding their sexual orientation, and being the recipient of hurtful actions (including physical abuse)." Respondents also endorsed the development of LGBT-specific programming for substance use.

Comparatively little research has explored the specific treatment needs of sexual minority women or gender minority populations in treatment environments. Interestingly, research indicates that sexual minority women are more likely than heterosexual women to seek treatment for alcohol and drug related issues. As well, relatively few studies have examined the substance use treatment experiences of gender minority populations. Existing research, however, indicates that low completion and abstinence rates, as well as negative treatment experiences, prevail among gender minority clients. Extracting data from a larger study examining the substance use treatment experiences of sexual minority clients, one study found that the 11 transgender participants reported significantly lower levels of feelings of therapeutic support, connectedness and satisfaction with treatment when compared to both cisgender and sexual minority respondents. Similarly, transgender participants reported less than half the rates of current abstinence and treatment completion than cisgender and sexual minority respondents. In open-ended questions, several gender minority respondents stated that their treatment experiences "made me (feel) isolated and afraid" and were "not helpful because I was not able to be totally honest about my personal problems".

One national study surveying the residential treatment experiences of 90 transgender participants found that:

- 20% reported being verbally abused by treatment staff
- 11.8% had been physically assaulted by fellow clients
- 33% reported being prevented from discussing trans issues
- 60% reported being required to use inappropriate sleeping and shower areas

Respondents indicated that they were more frequently victimized/harassed by treatment staff than fellow clients or participants in self-help programs. A subsequent statistical analysis revealed that a greater number of transphobic encounters with treatment staff was associated with drug use within the past 30 days.

While no studies have explicitly evaluated the relationship between internalized cissexism and substance use in gender minority communities, research has suggested correlations between peer and familial rejection and psychological distress. In one study, those who "experienced parental rejection reported suicidal ideation and attempts three times higher than those who felt accepted by their parents" . As well, "family rejection correlated with a higher rate of AOD use (32%), whereas family acceptance correlated with a lower AOD rate (19%)". These implications may be especially relevant to gender minority youth, who are disproportionately exposed to peer and familial rejection and/or violence. One study found that up to 73% of transgender youth experienced verbal abuse by their

parents for their nonconforming gender expression, some of which occurred in front of others; and up to 36% of transgender youth experienced physical abuse by their parents.

Recommendations

As shown by the articles reviewed above, gender and sexual minority youth seeking support services related to AOD use are likely to present with treatment concerns distinct to those evinced by heterosexual and cisgender populations. Because, according to one study, “substance use may be related to LGBT-specific stresses”, specific services must be provided to this population.

Sexual Minority Clients

Following Meyer's Minority Stress Model, it is vital that substance use interventions developed for sexual minority populations address the impact of sexual minority-specific victimization and its correlates, as well as the potential presence of internalized heterosexism. Due to the elevated rates of exposure to violence, harassment and discrimination, culturally appropriate programming should incorporate a trauma-informed framework that actively integrates the management of various psycho-social stresses into treatment planning. Clinicians should expect program participants to present with internalizing and externalizing behaviours consistent with exposure to sexual minority specific victimization, including depression, anxiety, self-harm and suicidality. This may be especially true of racialized sexual minority youth, who may use substances to cope with exposure to racism as well as heterosexism.

Further, as clients will likely continue to be at risk for ongoing experiences of victimization, “researchers have stressed the importance of substance abuse treatment for this population incorporating relapse prevention strategies that can counter these factors during and after treatment”; successful interventions must facilitate the development of alternative coping mechanisms.

Additional attention must be given to alleviating internalized heterosexism, but providers must exercise caution in assuming the absence of sexual identity disclosure to be indicative of this phenomena. Several recent studies have, in fact, indicated that opting not to disclose one's sexual identity may be advantageous when disclosure reactions are likely to be negative, and the focus be on self-acceptance, “rather than self-disclosure and membership identity”.

Clients will likely have varying needs regarding relationships with families. Because “connectedness with family has repeatedly been found to be highly protective against drug use” it is anticipated that many sexual minority individuals experiencing substance dependence are more likely to be alienated from their families of origin. While substance use treatment often emphasizes the importance of reconciling with one's family of origin, this may be not be feasible – or safe – for sexual minority clients. Much has been written regarding the development of a “chosen family”

among marginalized communities, meaning that treatment providers need to validate non-traditional definitions of family, and incorporate these arrangements into the treatment planning process as much as possible.

Further, while research suggests that community connectedness may minimize risk of AOD use, increased involvement in sexual minority-specific licensed venues is also believed to augment risk for substance use. It is therefore suggested that clinicians provide alternative means for service users to engage with their chosen communities, and develop relapse prevention strategies "targeting the relationship between the use of substances and social aspects of being gay, lesbian, or bisexual".

Studies examining the mental health symptomatology of sexual minority clients accessing substance use treatment found them to be more likely to have used/need treatment of mental health concerns when compared to heterosexual clients. Consequently, it was suggested that " integrated mental health treatment could greatly augment the services being provided to LGB[T] clients in substance use treatment". This does not imply that sexual minority identity is predictive of pathology; rather, it indicates that disproportionate exposure to psycho-social trauma may manifest in symptoms consistent with mental illness, and that the resolution of these concerns is integral to successful substance abuse treatment.

Gender Minority Clients

While gender minority individuals navigate similar experiences of victimization, these communities are subject to increased social marginalization, and therefore experience more adverse health outcomes. Consequently, these populations are more likely to exhibit mental health symptoms, the presence of which "does not necessarily indicate chronic mental health issues." Rather, these tendencies are likely the cumulative result of myriad psycho-social stresses, and, "in the overwhelming majority of cases, mental health symptoms have psychosocial causes". On this basis, successful interventions with gender minority individuals "require[s] an understanding of the multifactoral issues that commonly drive transgender individuals' addiction", including "attempted suppression of transgender feelings, management of historical violence/trauma, self-medication for physical or mental illness".

Successful counselling of gender minority substance abusers necessarily involves viewing gender difference as "an integral part of the client's identity, not as pathology". Therefore, effective therapeutic support must acknowledge the client's inalienable right to self-determination. Practically, this involves the validation of any form of gender variance expressed by the client as manifest in a demeanour that is "respectful, sensitive, accepting, affirming, empathic, compassionate, and supportive".

Those developing interventions for these populations should also be aware that those actively espousing a gender minority identity are likely at increased risk of victimization. This constitutes a central difficulty in navigating gender minority experiences: while identity affirmation and connectedness to a gender minority community are cited as “critical factors in mental health functioning”, the social expression of that identity elevates one's risk of victimization. Therefore, while actively affirmation their clients' gender identities, clinicians must also incorporate the development of specific coping strategies to be employed in response to experiences of victimization. Programs should additionally emphasize the cultivation of protective and resilience factors, including: pride in one's gender identities; the “ability to identify, acknowledge, and assertively navigate through instances of discrimination” and access to community organizations and support groups

Similarly, a recent qualitative study of transgender resilience identified seven central themes endorsed by participants, recommending that they be utilized to develop interventions for gender minority populations: “(a) evolving a self-generated definition of self, (b) embracing self-worth, (c) awareness of oppression, (d) community support, (e) cultivating hope, (f) social activism, and (g) being a positive role model.

Although some youth may be clear about the level of medical intervention they require others may be actively navigating alternative approaches while attempting to address their AOD use. It has been therefore suggested that the “administration of hormones...be incorporated into long-term treatment planning.” It is recommended that a psychiatrist “be part of a multidisciplinary treatment team”, ensuring that program participants retain access to necessary medical care without impeding their ability to engage with those providing support related to AOD use.

Providers should be aware of the psycho-social issues with which gender minority individuals must contend, and integrate their resolution into long term treatment planning, including:

- Gender dysphoria and body image issues
- Marginalization in a variety of social spheres, including employment, housing, education and interpersonal relationships
- Disclosure of transgender status to relationship partners
- Cumulative grief and loss of familial relationships, friendships, and separation from ethnocultural/religious communities
- Low self-esteem and social isolation resultant of suppression of transgender feelings

Additionally, because gender minority individuals have documented rates of HIV infection substantially higher than those reported in the general population, it is quite possible that gender minority clients may present with specific health care needs, which need to be addressed.

Insidious Trauma and Microaggressions

While most of the research discussed above has emphasized psychological distress as a correlate of exposure to violence and discrimination, this framework may be insufficient when describing the marginalization of gender minority populations. Critical trauma theorists are re-conceptualizing oppression as traumatic. An alternative framework emerging from the field of ethnic minority psychology, Insidious Trauma posits that the insults of daily life, taken cumulatively in the lives of members of marginalized groups, constitute a traumatic stressor for those populations. Insidious Trauma suggests that repeated exposure to micro-aggressions may cause the insidiously traumatized person to develop symptoms of post-traumatic stress when the apparent psychosocial stressor appears relatively small and non-threatening.

In addition, the identities of gender minority individuals are implicitly invalidated by social systems that deny the legitimacy these, including sex-segregated treatment programs and the use of binary gender options as administrative classifications. Policies and procedures genuinely conducive to an inclusive therapeutic environment must be in place.

Indigenous Populations

While the above recommendations are largely relevant to indigenous gender and sexual minority individuals, these populations have other cultural needs that must be addressed. Providers working with Indigenous gender and sexual minority youth should be aware that they will have unique experiences of historical trauma, as well as cultural specific approaches to healing. While it would be inappropriate for us, as non-Indigenous individuals, to suggest specific interventions, a number of Indigenous organizations are actively developing health programs reflective of their diverse communities, and should be consulted regarding any further proposals in this area.

Service Provider Surveys

28 agencies/programs in Toronto, providing services to youth, substance users, LGBTTQQ2SIA-identified people, or any combination thereof, were surveyed. 32 other similar agencies were invited to participate, but it was not possible in the time available to meet with them. The list of agencies with whom it was not possible to meet included both general hospitals and primary care providers, so their perspectives are unfortunately missing. Also, most of the agencies were situated within the City of Toronto, so the perspectives of those providing services outside this area were not well represented. In addition, agencies specifically serving families, newcomers, people with disabilities, Indigenous people and those currently incarcerated or recently released were not able to be included.

The list of agencies surveyed can be found in *Appendix 2*. The full survey responses can be found in *Appendix 3*. Here follows a summary of the key responses.

Question 1: What types of services do you provide?
All the responses to this question can be found in *Appendix 3.*

Question 2: Do LGBTTQQ2SIA, youth from 16-29 years old or people that use substances access your services? If so, how many of these people do you see on a monthly basis?

This question had a response rate of 100% *(n=28).*

- 92% *(n=26)* of service providers said that LGBTTQQ2SIA clients access their services
- 92% *(n=26)* said that youth aged 16-29 access their services
- 68% *(n=19* said that substance users access their services
- 64% *(n=18)* said that all 3 access their services
- Of the agencies who said LGBTTQQ2SIA clients access their services, 33% gave more specific information
- From this group, the percentage of clients that they see from this population on a monthly basis ranges from 10% - 60%
- The average number of LGBTTQQ2SIA clients was 30%
- No details were provided regarding the percentage of clients who are from the other two groups (youth aged 16-29 and substance users)

Question 3: Do any of your staff have lived experience as a LGBTTTQQ2SIA person, a person that uses substances or a person in recovery from addiction?

This question had a response rate of 71% *(n=20)*. Of those that responded:

- 70% *(n=14)* of service providers had staff with lived experience, either as a LGBTTQQ2SIA person or with substance use
- 45% *(n=9)* had staff with lived experience as LGBTTQQ2SIA
- 50% *(n=10)* had staff with lived experience with substance use
- 40% *(n=8)* mentioned the benefits of having staff or volunteers with lived experience

"It is important that service providers have lived experience or cultural experiences"

"The benefit of staff with lived experience is commonality and helps build trust and helps to build connections"

Question 4: Do you believe your services are accessible to LGBTTQQ2SIA people? People that use substances? Youth? If so, why or why not?

This question had a response rate of 100%.

- 54% *(n=15)* of service providers said their services were accessible to LGBTTQQ2SIA clients
- 72% *(n=21)* said their services were accessible to youth aged 16-29
- 54% *(n=15)* said their services were accessible to substance users
- 29% *(n=8)* said their services were accessible to all three groups

"There has been an immense shift for 5 years to being LGBT positive. Substance users feel comfortable coming into space, requires representative staff with necessary experiences and deep understanding of substances"

"We think it is, but clients may have a different opinion"

Question 5: Are there sub demographics among LGBTTQQ2SIA youth that use substances that may face additional barriers? If yes, what demographics and what types of barriers?

The following sub-demographics and barriers were identified:

- People who have survived trauma, such as violence or sexual abuse, with trust and feelings of safety seen as barriers *(n=5)*
- Homeless LGBTTQQ2SIA youth who use substances, with the transient nature of their living situation and priorities (basic needs) seen as barriers *(n=5)*

- Those suffering from mental health issues, with the concurrent mental health issue seen as a barrier *(n=5)*
- New immigrants, people from other cultures, or people of a visible minority; one explanation offered for this was that they are coming from cultures with higher levels of homophobia and transphobia and this creates an additional barrier for this group *(n=4)*
- Students. For this group, experiencing homophobia and transphobia at the hands of other students and even teachers acts as a barrier for them going to school. This in itself may not create barriers for accessing services but it definitely makes them more vulnerable to joining the other sub demographics of trauma survivors, homeless youth, or someone with a concurrent mental health issue *(n=3)*
- Those living in more isolated areas, with the lack of services in close proximity and the travel involved to access these services seen as barriers *(n=2)*
- Sex workers *(n=1)*

Question 6: How has your agency taken steps to ensure that your services are accessible? For example, do you have LGBT policies and procedures, do you have anti-oppressive training for staff or do you have staff with lived experience?

Agencies identified the following steps:

- Staff training *(n=8)*
- Staff with lived experience *(n=7)*
- Anti-discrimination policies *(n=5)*
- Focus on harm reduction *(n=4)*
- Anti-oppression training *(n=3)*
- Modification of forms in order to be more inclusive *(n=2)*
- Client training *(n=2)*
- Provision of trans awareness training in other agencies *(n=2)*
- Use of inclusive and self-identification language *(n=2)*
- Specific queer programming *(n=2)*
- Client-centered approach *(n=2)*
- Racial, gender and sexual diversity well accepted and valued *(n=1)*
- Respectful staff who treat all clients with dignity *(n=1)*
- Drug use not stigmatized *(n=1)*
- Participation in Pride community events *(n=1)*
- Peer training *(n=1)*
- Volunteer training *(n=1)*
- Development of LGBT toolkit *(n=1)*
- Research with clients and staff *(n=1)*
- Statement of inclusivity *(n=1)*
- Visible pride flag *(n=1)*

- Focus on keeping space safe for youth *(n=1)*
- Queer and trans people on the Board *(n=1)*
- Volunteer presenters in schools who become a point of reference with LGBT visibility to other queer and trans folks *(n=1)*
- Workshops at high schools and agencies to talk about drugs and real harms *(n=1)*
- Trans access working group *(n=1)*
- Continuous surveys and feedback *(n=1)*
- Peer outreach *(n=1)*
- Examination of policies and procedures by 519 *(n=1)*
- Positive space signage *(n=1)*
- Creation of sense of safety and sense of community *(n=1)*
- Respect agreement developed in collaboration with youth *(n=1)*
- Weekly youth group called YAAHA (Young Advocating Anti-Homophobia) *(n=1)*
- Trans youth able to live into the women only residence *(n=1)*

Four (4) agencies specifically identified the need for more training.

Question 7: What types of circumstances are barriers for LGBTTQQ2SIA people, youth and people that use substances to accessing services? At your organization? In general (personal, organizational and systemic)?

The following systemic barriers were identified :

- Lack of specific services for LGBTTQQ2SIA youth who use substances *(n=17)* Without specific services this group is much less likely to access traditional services for fear of homophobia, judgment, and even violence
- Fear of violence *(n=5)*
- Lack of training for staff *(n=4)*
- Lack of lived experience among staff *(n=4)*
- Difficulty of navigating the system and gaining access to appropriate services *(n=4)*
- Stigma, fear and shame that is sometimes experienced by LGBTTQQ2SIA clients when attempting to access traditional services *(n=3).* [This was identified as both a personal and a systemic barrier]
- Service location *(n=2)* e.g. all services are located downtown and are less accessible to people in Scarborough
- Cost of services *(n=1)*
- Waiting lists for shelters/beds *(n=1)*
- Being a Christian organization – this may mean that clients don't know what to expect from them *(n=1)*

"The normative experience within the community regarding substance use influences their participation in treatment"

Question 8: What recommendations do you have for engaging LGBTTQQ2SIA youth that use substances?

The following recommendations were made:

- Be non-judgmental, engage, listen and understand the clients. The relationship with clients is most important, having mutual respect and treating them with dignity *(n=6)*
- Take clients where they are at *(n=5)*
- Help with meeting basic needs, including food and TTC tokens *(n=5)*
- Do outreach: in communities with different cultures, to street-involved youth and in the party scene *(n=4)*
- Have an inclusive space *(n=3)*

"In terms of the utility of creating culturally specific spaces, this opens up the possibility for them to receive services, because they see themselves culturally represented within the service organization. There is then more opportunity for engagement right through to treatments"

Question 9: What types of services do you think would be beneficial to LGBTTQQ2SIA youth that use substances?

The following types of services were identified:

- Offer specific programming to this defined population *(n=15)*
- Involve the youth in helping determine what services are offered *(n=7)* [it is important that there is an element of self-determination]
- Offer harm reduction services *(n=6)*
- Ensure that staff is properly trained to help the population/have lived experience *(n=3)*
- Offer multiple services and programs be offered under one roof – "one stop shopping *(n=3)*
- Provide trauma counselling *(n=2)*
- Provide one to one counselling *(n=2)*
- Provide a mix of designated spaces and open spaces, as well as a mix of specific programming and closed programming with open, general programming *(n=2)*
- Engage in a great deal of networking with other service providers in order to better understand what others are doing well; this will lead to more referrals

and clients having an easier time finding and accessing appropriate services *(n=2)*

- Include life skills training and education, so clients develop tools and skills that they can use in different contexts *(n=2)*
- Offer programming both during the day and in the evening *(n=1)*
- Offer after-care or follow-up services with clients once they are out of the program *(n=1)*
- Have a drop-in component *(n=1)*
- Have family support services in place *(n=1)*

"There is a great utility to shared experience. Their experiences in other programs didn't allow them to share their LGBTQ experiences"

Other Consultations with Service Providers

Project Planning Committee

The Project Planning Committee was established at the start of the project, and its membership comprised the project staff, three representatives from Breakaway Addiction Services, two representatives from TRIP, two representatives from Toronto East General Hospital Withdrawal Management Centre, and one representative from each of Sherbourne Health Centre, LOFT and Youthline. The role of this committee was to provide advice to the staff in the design and implementation of the project. The committee met three times, in January, February and March, and each meeting was two hours in length.

Other Meetings

Meetings were held with the following groups/individuals:

- Mental Health and Youth Addictions Network
- Toronto Research Group on Drug Use
- Dr. Joyce Bernstein, Epidemiologist, Toronto Public Health
- Dr. E.B. Brownlie, Project Scientist, Child, Family and Youth Program, CAMH
- Susan Davis, Executive Director, Gerstein Centre
- Dr. Chris McIntosh, Head of Adult Gender Identity Clinic, CAMH

All endorsed the need for more services for this population.

"This is a sorely needed service….substance abuse issues are quite frequent with the people we see, and it's not easy for them to go to regular adult services" - Dr. Chris McIntosh

In addition, project staff will be presenting at the Toronto Drug Strategy Implementation Panel on May 28th, 2015.

Population Survey

There were two ways in which the survey was completed: online and in person. The survey was available online from February 4th – March 9th and was extensively promoted through social media. If they chose, respondents were eligible to submit their e-mail address to be entered into a draw to win one of ten $30 e-gift cards to a retailer of their choice. *Appendix 4* contains the flyer used to promote the survey online and *Appendix 5* contains the list of locations in which the survey was promoted/administered. The hard copy version of the survey was administered from February 4th – March 11th in a variety of different environments. Those who completed the hard copy survey were offered the following incentives: a $5 Tim Hortons card and two (2) TTC tokens. Unfortunately, because of the winter weather, it was not possible to conduct traditional street outreach.

The survey can be found in *Appendix 6.* Please note that the attached survey in the appendix is the hard copy survey. There are slight formatting differences between the online and offline survey but the content remains the same.

The report on the survey is written to follow the order of questions.

In total, there were 640 valid entries. In order for an entry to be valid, the person had to respond with a "yes" to the following questions:

- Do you identify as LGBTTQQ2SIA? ("A" is for asexual, not ally)
- Do you live or access services in Toronto?
- Are you 16-29 years old?

All entries that did not responded with "yes" to these questions were disqualified.

Self-Perceptions of Alcohol and Other Drug Use

After passing the qualifying questions, participants were asked how they perceived their drug and alcohol use. The statistics for these two categories are as follows.

Drug Use *(n=560)*
Participants were able to select one response to this question
49.6% *(n=278)* are fine with their drug use
16.1% *(n=90)* have stopped using all drugs
11.8% *(n=66)* have stopped using some drugs but not others
7.9% *(n=44)* would like to cut down some drugs, but haven't yet
5.4% *(n=30)* are trying to cut down using some drugs
3.9% *(n=22)* are trying to stop using drugs completely
2.1% *(n=12)* are trying to stop using some drugs
2% *(n=11)* are trying to cut down using all drugs

1.3% (n=7) would like to stop using some drugs, but haven't yet

> 44.3% of respondents wish/are trying to either reduce or eliminate their drug use

Alcohol Use (*n=590*)
Participants were able to select one response to this question
59.3% *(n=350)* are fine with their alcohol use
11.9% *(n=70)* would like to cut down but haven't yet
9.7% *(n=57)* are trying to cut down their drinking
3.9 *(n=23)* are trying to stop drinking
3.9% *(n=23)* have stopped drinking
2.9% *(n=17)* would like to stop drinking but haven't yet

> 36.8% of respondents wish/are trying to either reduce or eliminate their alcohol use

Previous Experiences of Service Access

Types of services accessed *(n=281)*
Participants were able to select multiple responses to this question
65.5% *(n=184)* have used individual counselling
37.4% *(n=105)* have used harm reduction
21.4% *(n=60)* have used group counselling
20.6% *(n=58)* have used 12 step programs
15.7% *(n=44)* have used other
13.2% *(n=37)* have used outpatient day programs
8.2% *(n=23)* have used residential programs
1.7% *(n=30)* have used withdrawal management

Anything we missed included:
CAMH (*n=2)*
Inpatient program
Community support, impromptu social spaces created to discuss use

Online services
Methadone maintenance program
Programs like SOY and EGALE
Rainbow Services Harm Reduction at CAMH
Other sobriety programs like SOS SMART Recovery
Peer support

Respondents who indicated that they had previously accessed formal support related to alcohol and other drug use – 43.9% of the total sample[8] – were then asked to evaluate those experiences with reference to three identity categories: LGBTTQQ2SIA status, race and disability.

On the basis of my queer/trans identity… *(n=183)*
Participants were able to select multiple responses to this question.
58.5*% (n=107)* did not feel safe disclosing their identity
38.8% *(n=71)* felt the services did not meet their needs
29% *(n=53)* felt staff did not accept them
24.6% *(n=45)* felt the clients did not accept them
14.2% *(n=26)* were mistreated by clients
12.6% *(n=23)* were mistreated by staff

> Notably, 65.1% of those that accessed formal support indicated that provider and/or client orientation towards their LGBTTQQ2SIA identity negatively impacted their service use experiences.

On the basis of my race…*(n=50)*
Participants were able to select multiple responses to this question.
64% *(n=32)* felt the services did not meet their needs
42% *(n=21)* felt the staff did not accept them
38% *(n=19)* felt the clients did not accept them
32% *(n=16)* were mistreated by staff

[8] Although this question explicitly asked respondents about their experiences accessing formal support related to alcohol and/or other drug use, some participants expressed confusion regarding the nature of the enquiry. On multiple occasions, project staff administering the hard copy survey were asked if those who had accessed individual counselling unrelated to AOD use should answer this question. Project staff would then specify that they were prioritizing the experiences of those accessing support for AOD use. This indicates that the response rate may not be an accurate reflection of service access related to AOD use

24% *(n=12)* were mistreated by clients

> 17.8% of those that accessed formal support indicated that provider and/or client orientation towards their race negatively impacted their service use experiences. This is particularly troubling, as nearly half of the total sample endorsed an exclusively white identity, yet nearly one fifth of those accessing services indicated negative experiences on basis of race.

On the basis of my disability…*(n=66)*
Participants were able to select multiple responses to this question.
71.2% *(n=47)* felt the services did not meet their needs
45.5% *(n=30)* felt the staff did not accept them
37.9% *(n=25)* were mistreated by staff
31.8% *(n=21)* felt the clients did not accept them
27.3% *(n=18)* were mistreated by clients

> 23.5% of those that accessed formal support indicated that provider and/or client orientation towards their disability negatively impacted their service use experiences. This, again, is troubling, as 43.6% of total sample endorsed a formally or self-diagnosed disability, mental health or medical condition, yet nearly one quarter of those accessing services indicated negative experiences on basis of disability.

We then asked participants to share any aspects of their service use experiences that had not yet been covered. We received a range of responses, which included:

I have had positive experiences *(n=10)*
I wasn't listened to/understood/recognized/supported *(n=8)*

"I have faced stigma/judgement/mistreatment from service providers in regards to my involvement with sex work, or I haven't felt comfortable to disclose that information due fear of judgement....it was especially difficult in the past when I was a very frequent drug user and drinker to discuss my involvement with sex work with counsellors/service providers because of the assumptions made about connections between sex work and substance use (i.e. doing sex work was a problem and as long as I was doing it I wouldn't be able to properly address my substance use issues.)...assumptions which didn't match up with my actual experience"

Barriers to Support

Participants that had not yet accessed formal support regarding their alcohol and other drug use were then asked to specify what had impeded their ability to engage with service providers.

Please check the statement if it applies to you *(n=343)*
Participants were able to select multiple responses to this question.
56.3% *(n=193)* don't know if they need support
50.1% *(n=172)* don't know what's available
30% *(n=103)* don't know what would work with them
29.7% *(n=102)* don't know if the staff will understand them
26.5% *(n=91)* have other obligations that keep them from accessing services
25.7% *(n=88)* don't know if staff will accept them as a queer/trans person
22.7% *(n=78)* have been discriminated against before and don't want to be in that position again
18.7% *(n=64)* don't think services available will meet their needs as a queer/trans person
18.1% *(n=64)* don't know if clients will accept them as a queer/trans person
10.8% *(n=37)* don't think if staff will understand them as a racialized/non-white/mixed person
10.8% *(n=37)* don't have any services in their area

9.9% *(n=34)* don't know if staff will accept them as a racialized person
8.2% *(n=28)* don't think the services available will meet their needs as a disabled person
7.6% *(n=26)* don't know if clients will understand them as a racialized person
7.6% *(n=26)* don't think the services available will meet their needs as a racialized person
7.3% *(n=25)* Anything we missed?
6.7% *(n=21)* don't know if clients will accept them as a disabled person
6.1% *(n=21)* don't know if staff will accept them as a disabled person
2.3% *(n=8)* cannot physically access the space due to their disability

"As a biracial Indigenous queer transgender person living with disabilities I have experienced a lot of lack of access to services that are open to all of the intersections of my identity(s)"

"I have accessed services before but there have been times when I have not due to not feeling safe disclosing one or multiple parts of my identity or feeling that if I were to disclose this the services would no longer be able to help me as I need them to"

Service Preferences

Attempting to discern the service preferences of participants, we asked three questions regarding:

a) Service Framework
b) Program Orientation/Content
c) Additional Resources

Which publicly available services would be helpful to you? *(n=317)*
Participants were able to select multiple responses to this question.
83.3% *(n=264)* Individual counselling
47.9% *(n=152)* Group counselling
34.4% *(n=109)* 21-28 day residential treatment program
17.4% *(n=55)* 12 step support group

14.5% *(n=46)* Withdrawal management
12.9% (*n=41)* 21 day outpatient treatment program
10.4% (*n=33)* Long-term (6 months+) residential treatment program
10.4% *(n=33)* Safer injection sites
10.1*% (n=32)* 28 day outpatient treatment program
9.5% *(n=30)* Medium-term (3-6 months) residential treatment program
8.8% *(n=28)* Anything we missed?
5.7% *(n=18)* Methadone or suboxone

Anything we missed included:
Harm reduction booklets, equipment *(n=3)*
Peer based groups but not 12 step programs *(n=3)*

It is interesting to note that 54.3% of respondents expressed interest in residential services (both short-, medium- and longer-term).

"There needs to be more stabilization programs; programs that give people the resources to not feel ashamed about their alcohol or other drug dependence and a framework that addressed the everyday concerns that the people in our communities have. Instead of pathologizing the way our addiction works -- there should be a dialogue about how societal expectations and norms placed upon us as a community create a culture that leaves us susceptible to drinking and using drugs. Even just programs that implement healthier coping strategies for young queer people is helpful and tools to use in order to avoid or cut down using. Today in the health care field practitioners and service providers are so quick to judge and diagnose. There should be some level of acceptance from both parties, when one is looking to get help and making this help

accessible to all no matter what identity one may fall under"

Preferred Services *(n=374)*
Participants were able to select multiple responses to this question.
65.8% *(n=246)* LGBT+ specific services
64.4% *(n=241)* Services delivered by LGBT+ people
52.9% *(n=198)* Programs that explore gender and sexuality
52.1% *(n=195)* Harm reduction focus
46.8% *(n=175)* Peer led services
40.4% *(n=151)* Services delivered by trans* people
33.2% *(n=124)* Gender specific services
32.1% *(n=120)* Trans* specific services
29.7% *(n=111)* Services delivered by LGB people
20.9% *(n=78)* Both harm reduction and abstinence focus
10.4% *(n=39)* Abstinence focus
7.2% *(n=27)* Anything we missed

Notably, the overwhelming majority of participants indicated a preference for queer and trans specific services.

As well, although only 44% of respondents espoused some form of transgender identity (that is, they did not endorse any cisgender identities, and, if they endorsed a male or female identity, also endorsed at least one additional non-cisgender identity), but 40.4% of all respondents preferred services delivered by trans people, and 32.1% wanted trans-specific services.

What kinds of additional services would support your drug and alcohol goals?*(n=341)*
Participants were able to select multiple responses to this question.
73.6% (*n=251*) Mental health support
46.9% *(n=160)* Trauma support
41.9% *(n=143)* Sexual health services
35.8% *(n=122)* Crisis counselling
28.2% *(n=96)* Housing support

27% *(n=92)* Stop smoking support
25.2% *(n=86)* Anger management
24.3% *(n=83)* Family counselling
22.3% *(n=76)* Medical transition support
20.8% *(n=71)* Sex work advocacy and support
20.2% *(n=69)* Legal services
19.6% *(n=67)* Support for leaving abusive situations
16.1% *(n=55)* HIV/AIDS services
11.7% *(n=40)* Shelter services
4.7% *(n=16)* Anything we missed?

It is extremely significant that nearly 75% of respondents identified mental health support and more than 45% identified trauma support as services that they need in order to support their drug and alcohol goals.

Additionally, although 44% of the total sample endorsed transgender identities, 22.3% of respondents identified medical transition support as integral to the furtherance of their alcohol and other drug use goals, indicating the necessity of providing these resources to transgender service users.

"I think some of the issues I've had with substances has been as a coping mechanism for trauma and to cope with a lack of proper mental health support and transition related healthcare"

"My issues with mental health and trauma are directly related to my substance abuse. Receiving help with these issues will help me find other outlets than using"

Alcohol and Other Drug Use Prevalence

The following sub-section is a record of how frequently respondents endorsed the usage of specific substances.

Utilizing the 2012 Canadian Alcohol and Drug Use Monitoring Survey (CADUMS) conducted by Health Canada, we were able to identify the extent to which our prevalence rates differed from those documented in the general population. The results of this comparison are summarized below.

	CADUMS 2012		Pieces to Pathways	
	Lifetime	Past Year	Lifetime	Past Year
Alcohol	91.4%	78.4%	98.9%	93.4%
Amphetamines	Unavailable	0.5% (2011)	41.7%	19.2%
Crack/Cocaine*	7.3%	1.1%	29.5%	16.5%
Hallucinogens	12.5%	1.1%	56.2%	29.7%
Heroin	0.5%	Unavailable	13%	3.9%
Marijuana	41.5%	10.2%	90.3%	71.4%
MDMA	4.4%	0.6%	57.6%	34.3%
Methamphetamine	0.7%	Unavailable	18.5%	8.8%
Prescription Opiates**	Unavailable	0.9%	42.8%	21.1%

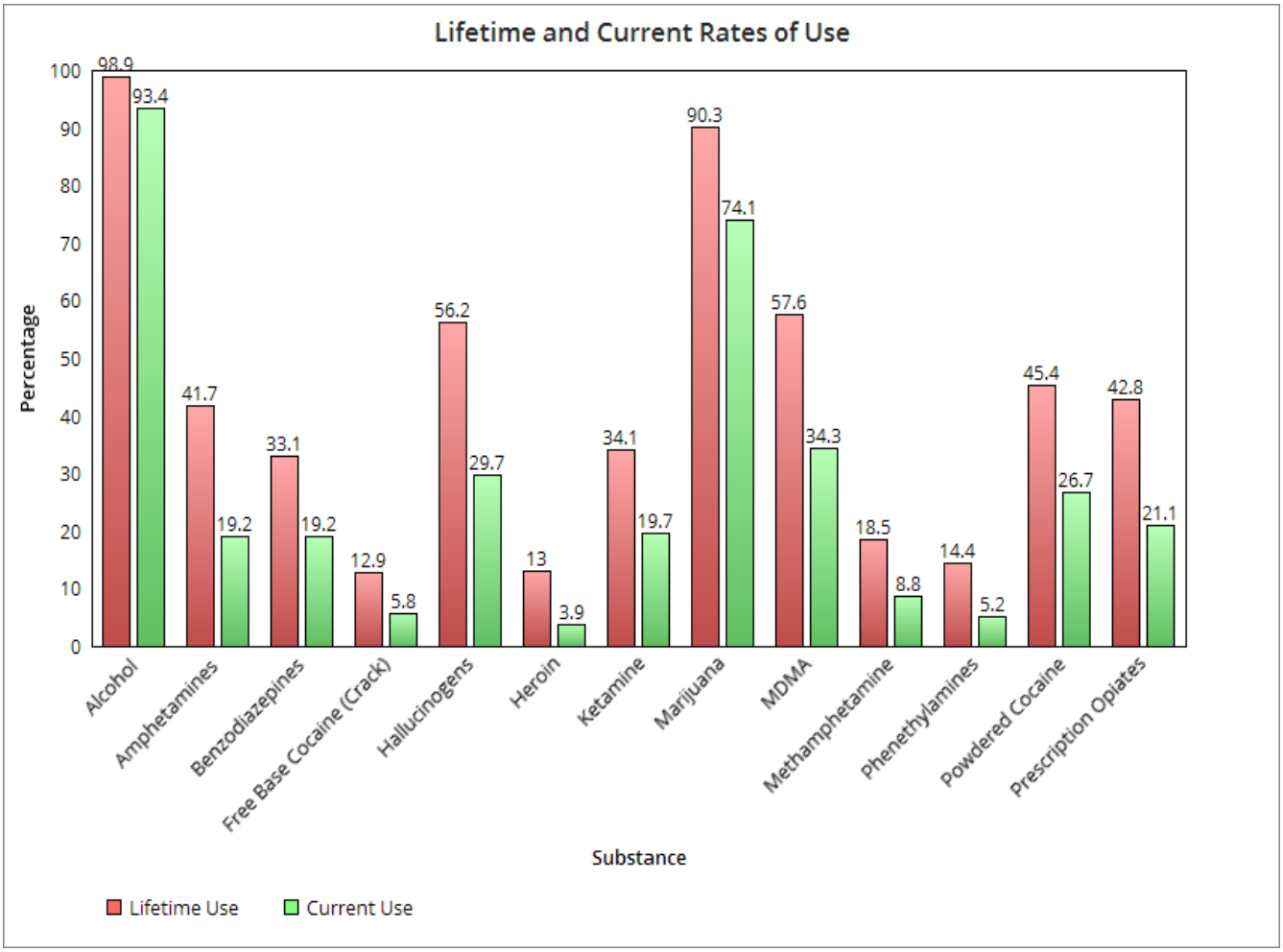
* Free base and powder cocaine were combined in the CADUMS report

** Because we excluded those using medication as prescribed, we utilized the rate categorized CADUMS as "Abused, including to get high".

Notably, the lifetime prevalence rates in LGBTTQQ2SIA youth communities range from 1.08 – 26.4 times those documented in the general Canadian population, an elevation of 8% - 2452.9%.

Similarly, the past year prevalence rates in LGBTTQQ2SIA youth communities range from 1.19 – 57.2 times those documented in the general Canadian population, an elevation of 19.1% - 5616.6%.

The full lifetime and current rates of use of our sample are documented below.



Alcohol *(n=366)*
Participants were able to select one response to this question.
27.9% *(n=102)* several times a week
22.7% *(n=83)* several times a month
18.9% *(n=69)* weekends only
16.1% *(n=59)* several times a year
6.3% *(n=23)* daily
5.5% *(n=20)* tried but stopped
1.6% *(n=6)* multiple times a day
1.1% *(n=4)* never

98.9% of respondents either have used or are still using alcohol, and the current rate of use is 93.4%.

Amphetamines (*n=333)*
Participants were able to select one response to this question.
58.3% *(n=194)* never
22.5% *(n=75*) tried but stopped
11.1% *(n=37)* several times a year
3% *(n=10)* several times a month
1.9% *(n=6)* several times a week
1.5% *(n=5)* weekends only
1.5% *(n=5)* daily
0.3% *(n=1)* multiple times a day

41.7% of respondents either have used or are still using amphetamines, and the current rate of use is 19.2%. While the 2012 CADMUS survey was unable to obtain reliable data regarding the use of amphetamines, the 2011 report found that 0.5% of Canadians had used amphetamines within the past year. Therefore, past year amphetamine use within our sample was 38.4 times higher.

Benzodiazepines (*n=332)*
Participants were able to select one response to this question.
66.9% *(n=222)* never
13.9% *(n=46)* tried but stopped
8.4% (n=*28)* several times a year
4.2% *(n=14)* several times a month
3.3% *(n=11)* several times a week
1.8% *(n=6)* daily
1.2% *(n=4)* weekends only

0.3% *(n=1)* multiple times a day

33.1% of respondents either have used or are still using benzodiazepines, and the current rate of use is 19.2%.

Free base cocaine *(n=325)*
Participants were able to select one response to this question.
87.1% *(n=283)* never
7.1% *(n=23*) tried but stopped
3.1% *(n=10)* several times a year
1.2% *(n=4)* several times a month
0.6% *(n=2)* weekends only
0.3% *(n=1)* several times a week
0.3% *(n=1)* daily
0.3% *(n=1)* multiple times a day

12.9% of respondents either have used or are still using free base cocaine, and the current rate of use is 5.8%. Comparatively, only 0.9% of NSDUH – an American population-based survey - respondents reported the use of free base cocaine in 2002. Lifetime use is therefore 14.3 times higher in our sample.

Hallucinogens *(n=336)*
Participants were able to select one response to this question.
43.8% *(n=147)* never
26.5% *(n=89)* tried but stopped
24.4% *(n=82)* several times a year
3% *(n=10)* several times a month
1.5% *(n=5)* weekends
0.3% *(n=1)* several times a week
0.3% *(n=1)* daily

0.3% *(n=1)* multiple times a day

56.2% of respondents either have used or are still using hallucinogens, and the current rate of use is 29.7%. Comparatively, the 2012 CADUMS report found a past year prevalence rate of 1.1%. Past year use within our sample is therefore 27 times higher.

Heroin *(n=330)*
Participants were able to select one response to this question.
87% *(n=287)* never
9.1% *(n=30)* tried but stopped
1.5% *(n=5)* several times a year
0.6% *(n=2)* daily
0.6% *(n=2)* several times a day
0.6% *(n=2)* weekends
0.3% *(n=1)* several times a month
0.3% *(n=1)* several times a week

13% of respondents either have used or are still using heroin, and the current rate of use is 3.9%. Comparatively, the 2012 CADUMS report found a lifetime prevalence rate of 0.5%. Lifetime use within our sample is therefore 26 times higher.

Ketamine *(n=331)*
Participants were able to select one response to this question.
65.9% *(n=218)* never
22.4% *(n=74)* tried but stopped
6.9% *(n=23)* several times a year
2.7% *(n=9)* several times a month
0.6% *(n=2)* weekends

1.2% *(n=4)* several times a week
0.3% *(n=1)* several times a day
0% *(n=0)* daily

> 34.1% of respondents either have used or are still using ketamine, and the current rate of use is 19.7%.

Marijuana *(n=359)*
Participants were able to select one response to this question.
22.6% *(n=81)* several times a year
16.2% *(n=58)* tried but stopped
12.8% (46 responses) several times a day
12.3% *(n=44)* daily
11.7% *(n=42)* several times a month
10.6% (n=38) several times a week
9.7% *(n=35)* never
4.2% *(n=15)* weekends

> 90.3% of respondents either have used or are still using marijuana, and the current rate of use is 74.1%. The 2012 CADUMS report on use of marijuana in the general population aged 15-24 puts use at 20.3%, whereas the rate of use of youth aged 16-24 in this survey is 89.8%

MDMA *(n=342)*
Participants were able to select one response to this question.
42.4% *(n=145)* never
24.3% *(n=83)* several times a year
22.2% *(n=76)* tried but stopped
5.3% *(n=18)* several times a month
4.1% *(n=14)* weekends
1.5% *(n=5)* several times a week

0.3% *(n=1)* several times a day
0% *(n=0)* daily

57.6% of respondents either have used or are still using MDMA, and the current rate of use is 34.3%. Comparatively, the 2012 CADUMS report found a past year prevalence rate of 0.6%. Past year use within our sample is therefore 57 times higher.

Methamphetamine *(n=330)*
Participants were able to select one response to this question.
81.5% *(n=269)* never
9.7% *(n=32)* tried but stopped
6.1% *(n=20)* several times a year
1.2% *(n=4)* several times a month
0.9% *(n=3)* several times a day
0.3% *(n=1)* several times a week
0.3% *(n=1)* daily
0% weekends

18.5% of respondents either have used or are still using methamphetamine, and the current rate of use is 8.8%. Comparatively, the 2012 CADUMS report found a lifetime prevalence rate of 0.7% in the general population. Lifetime use within our sample is therefore 26.4 times higher.

Phenethylamines (2CI, 2CB, 2CT-7) *n=326*
Participants were able to select one response to this question.
85.6% *(n=279)* never
9.2% *(n=30)* tried but stopped
3.7% *(n=12)* several times a year

0.6% *(n=2)* weekends
0.3% *(n=1)* several times a month
0.3% *(n=1)* several times a day
0.3% *(n=1)* several times a week
0% *(n=0)* daily

14.4% of respondents either have used or are still using phenethylamines, and the current rate of total use is 5.2%.

Powdered Cocaine *(n=336)*
Participants were able to select one response to this question.
54.5% *(n=183)* never
18.8% *(n=63)* tried but stopped
18.5% *(n=62)* several times a year
4.8% *(n=16)* several times a month
2.1% *(n=7)* weekends
1.2% *(n=4)* several times a week
0.3% *(n=1)* several times a day
0% *(n=0)* daily

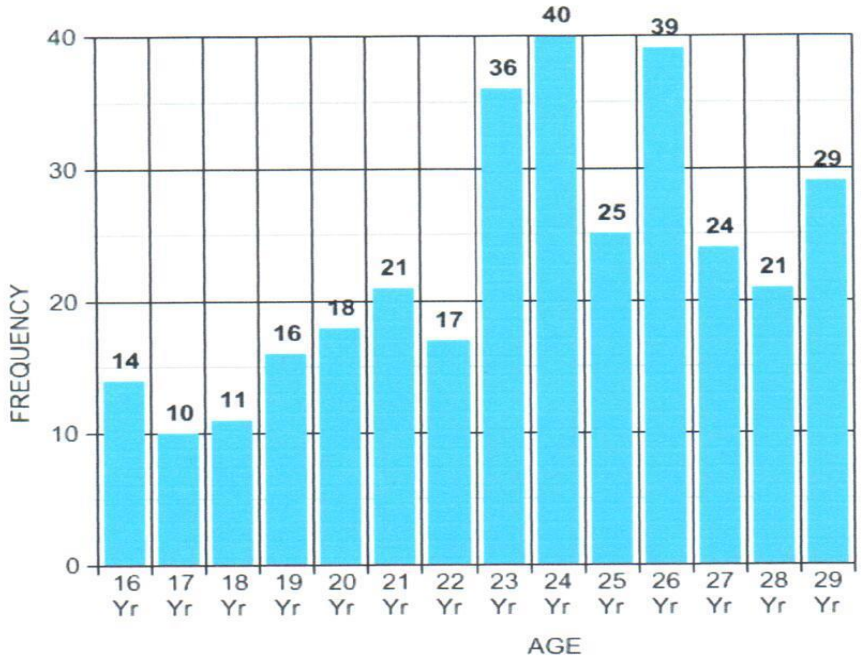
45.4% of respondents either have used or are still using powdered cocaine, and the current rate of use is 26.7%.

Prescription Opiates *(n=341)*
Participants were able to select one response to this question.
57.2% *(n=195)* never
21.7% *(n=73)* tried but stopped
12% *(n=42)* many times a year
4.1% *(n-14)* many times a month
2.6% *(n=9)* many times a week
1.5% *(n=5)* daily
0.3% *(n=1)* several times a day

42.8% of respondents either have used or are still using prescription opiates, and the current rate of use is 21.1%.Comparatively, the 2012 CADUMS report found a past year prevalence rate of 0.9%. Lifetime use within our sample is therefore 23.4 times higher.

Demographics

The mean age of participants is 23.7, while the median age is 24.



Gender *(n=411)*
Participants were able to select multiple responses to this question.
29.2% *(n=120)* Woman
26.8% *(n=110)* Man
19.2% *(n=79)* Cis Woman
19% *(n=78)* Genderqueer
17.3% *(n=71)* Non-Binary

13.1% *(n=54)* Genderfluid
11.7% *(n=48)* Transgender
11.2% *(n=46)* Cisgender
9.5% *(n=39)* Cis Man
9% *(n=37)* Trans Man
6.3% *(n=26)* Transmasculine
6.3% *(n=26)* Anything we missed?
5.1% *(n=21)* Agender
4.6% *(n=19)* Two Spirit
3.4% *(n=14)* Trans Woman
2.7% *(n=11)* Transfeminine
2.4% *(n=10)* Transsexual
0.5% (2 responses) Intersex

Anything we missed included:

Questioning *(n=7)*
Neutrois/Gender Neutral *(n=3)*
Genderfluid/2 spirit *(n=2)*
Genderflux *(n=2)*

44% (n=180) of respondents espoused some form of trans identity.

Sexual Preference *(n=398)*

Participants were able to select multiple responses to this question.

49.5% *(n=197)* Queer
27.1% *(n=108)* Bisexual
26.1% *(n=104)* Pansexual
25.6% *(n=102)* Gay
14.8% *(n=59)* Lesbian
8.5% *(n=34)* Anything we missed?
8.3% *(n=33)* Man who has sex with men
6.8% *(n=27)* Demisexual
6.8% *(n=27)* Questioning
4.5% *(n=18)* Straight
3.3% *(n=13)* Asexual
2.8% *(n=11)* Heterosexual
1.7% *(n=7)* Woman who has sex with women

Anything we missed included:
Heteroflexible *(n=3)*
Straight trans female *(n=2)*
Polysexual *(n=2)*
Prefer the term fluid *(n=2)*

Race and Ethnicity *(n=471)*
Participants were able to select multiple responses to this question.
71.2% *(n=272)* White
15.4% (n=59) Black
9.4% *(n=36)* Latin@
8.9% *(n=34)* Indigenous
6% *(n=23)* East Asian
6% *(n=23)* Middle Eastern
3.1% *(n=12)* South Asian
3.1% *(n=12)* South East Asian

48% (n=226) of respondents identified as exclusively white.

Living Situation *(n=399)*
Participants were able to select multiple responses to this question.
56.6% *(n=226)* Apartment
28.6% *(n=114)* House
11.5% *(n=46)* Relative's Place
9% *(n=36)* Anything we missed
4% *(n=16)* Friend's Place
2.8% *(n=11)* Shelter
1.8% *(n=8)* No Fixed Address
0.8% *(n=3)* Street

Disabilities *(n=306)*
In this qualitative question, participants were asked if they had a self- or formally diagnosed disability, mental health or medical condition. Of the 306 responses, 297 responded affirmatively.
Responses included:
43.4% *(n=133)* Depression/Mood Disorder

40.8% *(n=125)* Anxiety
14% *(n=43)* PTSD/C-PTSD
13.7% *(n=42)* ADD/ADHD
11.8% *(n=36)* Bipolar Disorder
9.2% *(n=28)* Borderline Personality Disorder
8.2% *(n=25)* Obsessive Compulsive Disorder
3.9% *(n=12)* Learning Disability
3.4% *(n=11)* Eating Disorder
2.9% *(n=9)* Panic Disorder
2.6% *(n=8)* Autism Spectrum/Asperger's
2.2% *(n=7)* Fibromyalgia/Chronic Fatigue
1.6% *(n=5)* Chronic Pain
1.6% *(n=5)* Dissociative Identity Disorder/Multiple Personality Disorder
1.3% *(n=4)* Insomnia/Sleep Disorder
1.3% *(n=4)* Irritable Bowel Syndrome/Gastrointestinal Disorder
1% *(n=3)* Deaf/Hard of Hearing
1% *(n=3)* Paranoia
1% *(n=3)* Oppositional Defiance Disorder
1% *(n=3)* Asthma

91.2% (n=279) of respondents identified as having a formal/self-diagnosed disability, mental health and/or medical condition.

"We all had fucked up childhoods. It's not normal to hide who you are for literally your entire life, with loved ones persecuting what you are in front of your face, and to have to struggle with sexual identity for years when everyone around us is happily certain of who they do and do not like. That's gotta do something to your head. We should start working towards how to deal with that, and how to deal with how society looks at us, because we're not just queer and that's why we do drugs. It's definitely more complicated than that."

Focus Groups

To further develop recommendations regarding the ideal form and content of an LGBTTQQ2SIA-specific substance use support program, five (5) two-hour focus groups were facilitated in various areas of the city. Sessions were conducted in the following locations:

- Central Toronto, hosted by Sherbourne Health Centre (10 participants)
- Central-West Toronto, hosted by LOFT Community Services (15 participants)
- Midtown, hosted by Delisle Youth Services (9 participants)
- North York, hosted by Griffin Centre (5 participants)
- Scarborough, hosted by Youthlink (1 participant)

Project staff was struck, throughout each of these groups, by the openness and gratitude evinced by participants. Staffs' appreciation of participants' involvement was matched only by their willingness to share their experiences, and apparent surprise that someone was available to listen.

Demographics

Participants ranged in age from 18-29, with a mean age of 23.55 years, and espoused a variety of gender identities and sexual orientations.

Unfortunately, as explained in the Methodologies and Limitations section previously, the limited time in which to conduct outreach to potential participants resulted in the under-representation of specific sub-demographics of LGBTTQQ2SIA communities, particularly those habitually designated as "hard to reach". Since it was not possible to conduct community-specific outreach – instead, relying on larger organizations through which to disseminate the call for participants - those that responded to the invitation likely already access services at established agencies, and are therefore not representative of communities to which existing programs are not accessible.

Specifically, although 52.5% of participants identified explicitly with non-cisgender identities - to the extent that they selected neither "cis[gender] man", "cis[gender] woman", nor "cisgender" on the demographic forms provided, and did not endorse exclusively male or female identities without also selecting additional non-cisgender identities – only 5% of participants identified as transgender women. The range of gender identities endorsed by participants are as follows:

- Woman 37.5% *(n=15)*
- Man 25% *(n=10)*
- Genderqueer 22.5% *(n=9)*
- Cis woman 17.5% *(n =7)*
- Genderfluid 17.5% *(n=7)*

- Cis man 12.5% *(n=5)*
- Non-binary 10% *(n=4)*
- Transgender 10% *(n =4)*
- Transmasculine 10% *(n=4)*
- Transsexual 5% *(n=2)*
- Agender 5% *(n=2)*
- Transfeminine 5% *(n=2)*
- Trans woman: 5% *(n=2)*
- Trans man 5% *(n=2)*
- Two-spirit 2.5% *(n=1)*

In addition, the sample lacked a substantial number of youth of colour. 62.5% (n=25) of participants selected "White" as their only racial/ethnic identity. The range of racial/ethnic identities are as follows:

- White 77.5% *(n=31)* (includes the 62.5% of participants who selected "White" as their only racial/ethnic identity)
- Indigenous 17.5% *(n=7)*
- East Asian 7.5% *(n=3)*
- Hispanic/Latin@ 7.5% *(n=3)*
- Middle Eastern 7.5% *(n=3)*
- Caribbean 2.5% *(n=1)*
- South Asian 2.5% (n=1)
- South East Asian 2.5% (n=1)

A substantial portion of participants (82.5%) responded affirmatively to the inquiry: "Do you have a formally diagnosed or self-diagnosed disability, mental health or medical condition?" Of the aforementioned 82.5% (n=33), 88% (n=29) opted to specify their (self-)diagnosis. The results were as follows:

- Anxiety 40% *(n=16)*
- Post-Traumatic Stress Disorder or Complex Post-Traumatic Stress Disorder 27.5% *(n=11)*
- Depression 25% *(n=10)*
- Bipolar Disorder (Types I and II) 15% *(n=6)*
- Borderline Personality Disorder 12.5%[9] *(n=5)*
- Eating Disorder 5% *(n=2)*

Methodology

Attempting to maximize participant discussion while minimizing potentially biased facilitation, only three (3) questions were asked:

[9] The percentages offered are derived from the total sample ($n=40$)

1. Thinking about your past experiences accessing services and supports related to alcohol and other drug use in Toronto, can you please share what you appreciated about these services, or something you would change about these services?
2. What would your ideal alcohol and other drug use service look like?
3. What types of content would you like to see in an alcohol and other drug support program?

The first two (2) questions were answered in a group discussion, while participants responded to the third question by making notes on Post-Its, which were then displayed around the room and reflected on through a walking activity. When time permitted, participants were encouraged to share any suggestions that resonated with them. The varied format ensured that no particular means of engagement/expression was priorized.

The results of the responses are summarized below.

Question 1: Previous Experiences of Service Access

While the experiences and perspectives shared by participants were varied and uniquely personal, factors related to the perceived efficacy of a particular service coalesced around five (5) central themes:

1. Knowledge/Treatment of Sexual and Gender Identities
2. Flexibility/Range of Services
3. Accessibility
4. Safety/Comfort
5. Connection

Although each of these categories undoubtedly influence one another – knowledge and treatment of sexual and gender identities impacting accessibility, comfort informing connection – they are summarized separately here, for the sake of clarity.

Knowledge/Treatment of Sexual and Gender Identities

"A rainbow flag doesn't make a space safe - we need to do more. I feel that I'm always alone calling out behaviour in these spaces, because they are largely cis/het [cisgender, heterosexual] dominated. I haven't often felt supported in terms of my queerness."

Not surprisingly, the factor that featured most prominently in the focus group discussions was service providers' treatment and knowledge of sexual and gender identities. Mentioned 21 times – of which only five (5) references described positive experiences – provider orientation toward sexual and gender minority identities was

integral in determining whether participants experienced interactions with service providers as positive or negative. Positive experiences included those in which organizations appeared knowledgeable about experiences unique to LGBTTQQ2SIA communities, did not assume clients' sexual and/or gender identities, asked for pronouns, and employed staff members who were LGBTTQQ2SIA-identified.

Notably, although several of the agencies cited by participants stated at the commencement of their group sessions that they intended to maintain an LGBTTQQ2SIA-positive space, several focus group participants indicated that many organizations did not “live up” to these claims. Specifically, participants noted the use of oppressive, gendered and presumptive language, as well as the pathologization of queer and trans identities. Regarding the latter point, several group members recounted experiences in which the disclosure of a gender or sexual minority identity led to additional mental health diagnoses and the attribution of sexual promiscuity. One (1) participant additionally indicated that they opted not to disclose their sexual orientation because they “[didn't] want the doctor to think mental health stuff is related to queerness”, while another stated that their worker “wasn’t able to grasp complexities of queerness and gender identity”.

One (1) group member advocated exercising caution when conflating queer positive services with those accessible to transgender clients. Specifically, she shared that she has generally experienced environments advertised as positive spaces for sexual minority clients as being both unwelcoming to and unsafe for gender minority patrons. She further noted that being assigned a cisgender, heterosexual counsellor was unhelpful, and “created a lack of trust”.

Similarly, another participant expressed frustration with accessing services in which cisgender, heterosexual staff members have the power to make decisions regarding the health service needs of LGBTTQQ2SIA clients. In response to this comment, facilitators of the Sherbourne Health Centre group conducted an impromptu poll in which all *(n=10)* participants indicated a preference for LGBTTQQ2SIA-identified staff members. Nearly identical concerns were expressed during the Delisle Focus Group:

“I wouldn't feel comfortable going to a straight doctor [because] they don't understand about hormones, and might ask about my genitalia”

Flexibility/Range of Services

When reflecting on their previous experiences of service access, participants continually emphasized the importance of being provided a variety of program options from which they could freely choose. Indeed, this theme was mentioned18 times over the five groups (second only to providers' knowledge/treatment of gender and sexual minority identities). Of these references, seven (7) evoked positive

experiences - in which the range of services provided successfully met the client's needs - while eleven evoked negative experiences. Experiences perceived as positive were those in which organizations emphasized agency, autonomy, self-determination, and choice. Conversely, negative experiences were those in which agencies imposed a particular treatment orientation to which participants were expected to adhere.

Interestingly, although provider adherence to the allegedly divergent treatment philosophies of abstinence and harm reduction garnered 17 mentions, the perspectives expressed by participants were not nearly as contentious as we had initially anticipated. Much of the dissatisfaction *(n=5)* concerned the application of either harm reduction or abstinence-based modalities to those with different recovery goals. Specifically, three (3) participants characterized their service experiences as negative because they expressed an interest in abstinence based programming, only to have their aspirations dismissed by staff members as "unrealistic". Conversely, two (2) participants described being denied care by service providers who pathologized non-problematic substance use as being inherently self-destructive:

"The worker was very disrespectful and denied [me] services unless [I was] willing to go to abstinence treatment services"

Similarly indicating the need for a range of services conducive to a variety of substance use concerns, several participants expressed a reluctance to engage in formal service provision contexts because:

a) They recognized the need for support, but did not feel that their substance use was severe enough to justify formal engagement *(n=7)*
b) They did not see the particular type of substance use with which they struggled to fit into the service parameters of existing agencies *(n=2)*

This appears to be related to the cultural construction of addiction, a comparison and consequent minimization of one's own experience, and an inability to recognize oneself in a particular organization's service demographics. Regarding a), one participant stated that they "did not want to take up space from someone that needs it more", while another expressed:

"that [not feeling that their using was 'severe' enough] was a major reason why for a really long time I didn't seek help for my using - I would think, I know people who do it substantially more so I shouldn't take up space that someone else could be using. Later I realized, I really could have been using those resources and getting help a lot sooner"

Regarding point b), one participant shared that they had found it difficult to identify the service most appropriate to their needs, as they did not feel that their usage was "bad enough" to justify accessing inpatient treatment services, but found harm reduction services "too light" Similarly, another participant stated that because her substance use is restricted to medication prescribed by a doctor, she doesn't "want to take up space where people need support more than I do , because I have some type of support."

Accessibility

Although all of the considerations discussed in this section can be considered issues related to accessibility – definition – this discussion is limited to those related to

a) Participant ability to physically access a particular service environment, and
b) The communication of program content.

These do not comprise a comprehensive description of accessibility, but many of the factors that could have been included here were better suited to their own unique categories.

Characteristics related to this operationalization of accessibility therefore include wait lists *(n=3),* language *(n=1),* location *(n=1),* time of day *(n=1)* and basic needs *(n=1).* These features universally precluded participants from accessing services, as the physical location, time at which the service was offered, language utilized (i.e. spoken English only), waiting period, and lack of food provided functioned as prohibitive factors.

Comfort/Safety

"The whole institutional environment is disempowering"

Participants further indicated that their sense of comfort and/or safety significantly determined whether they found a service helpful. Comfort and safety are combined into a single category because the two factors are intimately related, particularly for those with histories of trauma. In such instances, feelings of discomfort may immediately trigger a lack of safety, while insecurity may initially be indicated by a sense of discomfort.

Comfort was related to participants' ability to feel welcome in a service environment, and freely disclose their experiences to peers and service providers without fear of judgement or reprisal. Regarding the former point, two (2) participants referenced being greeted by staff members and peers as being vital in allowing them to integrate into a service environment. Conversely, one participant expressed that the lack of engagement from other members in a peer support group led her to feel uncomfortable and unwanted.

Regarding the latter, several participants described negative reactions by service providers regarding non-traditional forms of employment – sex work and drug dealing – as causing them to disengage from a particular service. Conversely, two (2) participants attributed their positive service experiences to their workers' abilities to support and affirm their choices without judgement.

Discussions related to safety in service provision contexts centred primarily on the imposition of medical models of care and the experience of being 'psychiatrized'. Of the ten references to this topic, all were negative. Participants described medical environments (including hospitals, psychiatric units and doctors' offices) as "coercive", "disempowering" and "traumatic". Experiences recounted by participants included being given medication in lieu of other preferred therapies and being denied services because of a "diagnosis erroneously ascribed by a medical professional" and forced experiences of hospitalization. When a poll was conducted at the group at Sherbourne Health Centre, half of the participants stated that they were uncomfortable in medical settings, and over three quarters indicated that they would prefer community-based programs.

Connection

"I felt like there was a sense of community. I'm not sure if it's because we were all addicts, or all queer, or both, but it was a community"

Experiences associated with a sense of connectedness generally involved an recognition of relatedness based in shared experiences, aspirations, and/or identity markers. Although the majority of references related to integration into an LGBTTQQ2SIA community, participants also noted affiliation on the basis of shared experiences of substance use and sex work. Three participants reported that the feeling of connectedness positively influenced their service access experiences, while one stated that his inability to identify with others in his support group caused his attendance to decrease. Significantly, one participant noted that affiliation on the basis solely of addiction was insufficient, stating that although he appreciated the recovery goals shared by those attending 12-Step fellowships, he found that membership demographics consisted of predominantly "cis [cisgender] white men" and therefore didn't "end up connecting with folks".

Question 2: Ideal alcohol and other drug use services

When discussing the appearance of their ideal substance use support service, participants' responses coalesced around the following five themes:

1. Service Structure *(n=37)*
2. Service Framework/Orientation *(n=14)*
3. Community *(n=12)*
4. Accessibility *(n=9)*
5. Comfort and Safety *(n=7)*

Service Structure

"Services tend to be based on one school of thought as opposed to the other - why not focus on the person rather than pushing an ideology? I think it would be helpful to have treatment options for people with different needs- as it is, you have to pick harm reduction, abstinence, etc.- it's almost factional"

The majority of comments solicited detailed participants' ideal service structure *(n=37),* a construct encompassing the following considerations:

- Range of services *(n=8)*
- Drop-in model *(n=8)*
- Flexibility regarding the number of sessions available per week *(n=4)*
- The provision of harm reduction materials *(n=3)*
- The availability of a 24-hour space *(n=3)*
- Individual counselling *(n=3)*
- A direct phone service *(n=2)*
- 24-hour crisis support *(n=2)*
- Group counselling (n=2)
- A residential treatment environment *(n=2)*

Highlighting the necessity of service flexibility, participants emphasized the utility of providing a variety of programming from which service users can freely choose. One participant, for example, suggested "having different groups with different approaches with different frequency and provide different services."

Characteristic of this preference was the espousal of a drop-in model through which case management, individual counselling, and group therapy would be available. Several participants noted that such a structure would ensure maximum accessibility, enabling service users to select programming most relevant to their needs, while providing a safe environment in which to develop peer relationships

with other LGBTTQQ2SIA-identified youth with substance use concerns. Participants appeared to prefer a structure in which they would have access to a counsellor/case manager, peer support workers, group counselling, and a community of queer and trans youth who are similarly concerned with alcohol and/or other drug use. One participant, for example, articulated that their ideal service would comprise "an opportunity to forge an individual relationship with a worker or counsellor who can figure out how best to cater to your specific needs", while another advocated for the provision of "a one on one space but also a group space at the same time."

Participants expressed varying levels of interest and comfort in:

- Structured group programming
- A supervised drop-in through which they could socialize with other service users
- Individual counselling and case management

The majority of participants indicated a preference for a combination of the aforementioned components, generating an image of a service environment in which they could develop mutually supportive relationships with varying degrees of external structure, collectively develop skills and insights through the guidance of an experienced group facilitator, and receive individualized support/counselling through a primary counsellor/case manager.

Community

"For us, by us"

Participants further emphasized the potential of service spaces to function as sites of community building and peer engagement. This is a particularly salient point, as the majority of similarly-intentioned environments available to LGBTTQQ2SIA communities often centre/mandate/prioritize the consumption of alcohol and other drugs. Participants recognized, therefore, the efficacy of utilizing a potential program as an ideal point of contact through which to develop supportive relationships with LGBTTQQ2SIA peers.

Additionally, participants prioritized the employment of LGBTTQQ2SIA-identified staff members – particularly those with experiences of alcohol and other drug use – as integral to ensuring the safety and integrity of the service environment. Five (5) participants explicitly stated their preference for queer and trans identified staff members.

"Programs run by queer and trans people is my ideal. I just don't feel as comfortable around cis[gender], het[erosexual]

people. I would like a place to go where I can express myself as a queer person comfortably"

As well as extolling the efficacy of LGBTTQQ2SIA-identified staff members, participants further indicated a preference for staff members with lived experience of alcohol and other drug use *(n=7).* Specifically, one group member stated that " a peer with similar experiences would be the best", while another noted that "having people with lived experiences of delivering the services would be excellent".

Service Framework/Orientation

In the eleven (11) comments pertaining to program framework/orientation, participants stated that they wanted:

- A non-clinical and non-pathologizing approach *(n=3)*
- An integration of mental health and substance use concerns *(n=3)*
- A program appropriate to a range of alcohol and other drug use frequency/severity *(n=2)*
- Education and support resources for biological and chosen family members *(n=2)*
- A 12-Step positive program *(n=1)*
- An integration of systemic issues related to alcohol and other drug use *(n=1)*

Echoing concerns expressed when discussing previous experiences of service access, participants were adamant that their ideal service not operate from a medical model, noting the tendency of some such services reduce concerns regarding alcohol and other drug use to the espousal of LGBTTQQ2SIA identity. They insisted that their ideal program would be a space in which they could bring every aspect of their identities and experiences without fear of judgement, persecution, or pathologization.

Despite eschewing psychiatric models of care, however, participants did prioritize the integration of mental health and substance use concerns. Therefore, the ideal service model espoused by participants is one which mental health and substance use are treated concurrently in community-based environments.

Notably, any mention of an LGBTTQQ2SIA-specific service orientation was conspicuously absent from this discussion. It is assumed, however, that because these groups were based explicitly on the development of an LGBTTQQ2SIA-specific substance use support program, the notion of queer and trans exclusivity was the implicit foundation on which all of our exchanges were based.

Accessibility

"You shouldn't have to make a choice between getting help and surviving"

Focus group discussions related to accessibility were somewhat limited, as they rarely included the access needs of those with physical and developmental disabilities. Further, the framework invoked in this section does not include considerations related to cultural accessibility, a category into which all of the responses to the focus group questions could be incorporated. However, participants noted several components that would enable them to engage with support services, including:

- Evening programming *(n=3)*
- TTC tokens/transportation support *(n=3)*
- The provision of food *(n=1)*
- The availability of additional incentives *(n=1)*
- Physically accessible environments *(n=1)*

The majority of these considerations related to participants experiences of economic marginalization, as they cited tasks related to the fulfilment of their immediate and basic needs as impeding them from accessing services. The availability of evening programming – during which participants stated they were less likely to be working – as well as the provision of food, TTC tokens, and additional incentives would ensure the accessibility of support services to those of varying financial means.

Comfort/Safety

Participants emphasized the importance of creating a safe, welcoming environment for service users, relating these characteristics to:

- Non-judgemental and supportive staff members *(n=5)*
- Anti-oppression principles and practices *(n=2)*

Further, although those attending the focus groups prioritized support for all sexual and gender identities, several participants noted the importance of non-judgemental attitudes towards sex workers, stating that:

"because its criminalized, people feel like they can't talk about it, but then there's also a lot of addictions within those communities. People shouldn't have to lie about how they make their money"

Question 3: Preferred components of an alcohol and other drug support program

The responses to this question were not elicited through a discussion format, so the key themes are presented here solely in quantified form, as follows:

Overall philosophy & environment

- Queer positive and safe environment allowing for queer based community healing/community building *(n=19)*
- Harm reduction *(n=14)*
- Abstinence *(n=12)*
- Non-judgmental *(n=2)* and empowering *(n=1)*

Counselling/therapy

- Individual counselling *(n=7)*
- CBT *(n=7)*

Note: although group counselling was only specifically mentioned as a modality three times, several of the topics identified could well be managed in a group format, e.g. building and maintaining positive relationships, coping with anxiety, concurrent disorders.

Health and Wellness

- Art *(n=9)*
- Yoga, tai chi, chi gong *(n=7)*
- Holistic well-being, including spirituality (n=6)
- Writing *(n=5)*
- Meditation *(n=5)*
- Pet therapy *(n=4)*

"Not forcing talking to others as a method of healing"

Education and Life Skills

- Nutrition, food bank & pot luck meals (n=7)
- Legal information *(n=2)*
- Employment training/services *(n=1)*
- Housing help *(n=1)*

Proposed Program

The proposed program is based on the findings from all the work conducted, including the literature search, the agency surveys, the population surveys and the focus groups.

Framework and Model

The program will focus on all recovery goals, embracing harm reduction and abstinence equally. It will be based on the principles of respect, empathy and empowerment. It will provide a safe space for participants to create a positive community for themselves in which they can recover and thrive.

Its focus will be anti-oppressive, incorporating understanding of both individual and systemic factors that lead to substance use. It will be trans affirmative, sex worker positive, support participants' exploration of gender and sexuality and support those who wish to medically transition.

It will be staffed by peer workers, who are both members of the LGBTTQQ2SIA population and in recovery (however that is conceptualized by them). They will be trauma (including insidious and collective trauma) and mental health informed, and will not pathologize participants' issues and experiences.

"LGBTQ+ specific services are huge. I don't feel the need to access services now but as a younger teen, I would have been too nervous to access mainstream counselling. I would likely have had difficulty in recovery due to not being open about my sexuality and experiences"

Elements/Content

Services provided will be both individual and group-based. Hours of service will priorize afternoon and evenings.

Each participant will have a peer staff to work with them, who will provide both case management and counselling.

In terms of group work, this will be centered on a series of modules. The primary focus of these will be the topic, with all programming grounded in reducing and/or eliminating substance use. Modules will include:

- Wellness
- Mindfulness and CBT
- Gender and sexuality

- Information about substances and medications
- Building healthy relationships
- Systemic issues re queer and trans identities
- Physical health
- Mental health
- Education about issues such as legal rights
- Skills teaching e.g. cooking, accessing housing, job seeking and so on

"I would say get youth more informed about the usage of alcohol and drugs because, just like in many cases, it begins at an average young age. The LGBT community sometimes become dependent on these things to help better cope and if we all just found a way to better one's situation or help through it, it can be cut down or even eliminated"

Many modules will utilize a variety of creative methods, including writing, art and music.

All program participants will be able to attend these. There will also be two (2) groups offered each week, one for those practising harm reduction and one for those practicing abstinence. A weekly separate space will be offered to persons of colour and trans people. A drop-in group will be offered, which will include food.

A support and education group will be established for family members (representing participants' chosen family members, whoever these may be), with links to more intensive family counselling services for those who require this.

"Crisis and family counselling are really important cause they are the reason why people go towards alcohol & drugs in the first place"

As well as full-time staff, it is hoped to have a paid "pool" of people with various skills and experiences who can come in as needed to run specific groups.

Program staff will also focus on outreach to specific locations/communities.

"Outreach in clubs/bars would be good. Giving cards and information to people to spread knowledge of what services are available to them or anyone they know"

Program staffs' work will include education to other service providers, in terms of how to work effectively with the LGBTTQQ2SIA population and create safe spaces that are truly safe, and not safe in name only.

Partnerships

Gerstein Centre

- Crisis services
- Training: mental health, crisis, suicide prevention and management

LOFT

- Training
- Space for programming

Evaluation

The evaluation tools to be used to determine whether/how the program is helping the clients will be:

a. The Gains Short Screener
b. The Service User Survey
c. The Outcome Rating Scale
d. The General Self-Efficacy Scale
e. The Contemplation Ladder

Outcomes

Client Experience

- Improved access to culturally appropriate service for transitional age LGBTTQQ2SIA youth using substances
- Increased engagement of target population in community based addictions service
- Increased retention in service
- Increased number of population achieving positive recovery outcomes
- Positive experience of care

Quality

- Increased satisfaction with services
- Increased number of population receiving evidence based treatment
- Increased number of population receiving peer support

Cost

- Decreased use of ED services /referral from/shorter stay in ED

Staffing

4.0 peer case managers/facilitators

1.5 part-time/contract staffing

0.75 RN

0.5 Breakaway Youth Worker

1.0 Reception/intake/Administrative staff

Psychiatric consultation

Management and admin. support

Appendices

Appendix 1 – Literature Review

Introduction

The following review will summarize salient findings regarding alcohol and substance use among LGBTTQQ2SIA transitional age youth. Although not exhaustive – a characteristic prohibited by the breadth of the review, as well as the limited time in which it was compiled – it encapsulates pertinent information, from which research not included does not substantially deviate. Therefore, it can be considered an accurate representation of findings in this area. The cumulative picture provided indicates that LGBTTQQ2SIA youth have rates of substance use substantially higher than those evinced by the general population, and distinct psycho-social experiences and consequent treatment concerns, as well as displaying a greater frequency of unmet treatment needs.

Organization and Sources

Information has been divided into the following sections: prevalence rates, causal explanations, barriers to service access, experiences in treatment, and recommendations. Sections have been further subdivided according to sub-populations to facilitate an examination of the differential experiences of specific demographics. By its nature, this review is limited to the information provided by existing studies. Therefore, although not ideal, the aforementioned sub-populations are organized according to the identity categories differentiated by the reference material. Therefore, while not allowing for the recognition of sexual and/or gender fluidity, the presence of multiple orientations among gender and sexual minorities, and utilizing consistently gendered language, sub-sections are organized according to cisgender males and females endorsing minority sexual orientations, attraction, and/or relationships; and gender minority populations.

As well, we have opted to create a separate section for indigenous gender and sexual minority communities. This was not done to 'other' this population, but rather in recognition of the ongoing colonial violence with which these individuals have to contend. Further, because Euro-American terminology may not be applicable to these communities, classifying members according to the categories mentioned above would be tantamount to cultural erasure.

The majority of information presented in this review is derived from peer-reviewed articles published in academic journals. Documents published by Canadian government institutions and local needs assessments conducted in Ontario have also been included. While we attempted to include surveys administered between 2004 and 2014, in some instances this information was not available. In the absence of more recent data, supplementary information from earlier research has been included. As well, Canadian sources are under-represented in this review, reflective of the relative scarcity of domestic research material. The limited Canadian material

available, however, mirrors the more substantial findings of international publications, and the latter data is therefore likely applicable to local contexts.

Notes on Language

As much as possible, we have attempted to mirror each authors' language choices when reporting the findings of their research. Although not ideal, as certain terms may appear somewhat inappropriate and archaic, we believe that this ensures the greatest transparency in our report, and also ensures that our summaries are reflective of the original research findings. This, in some instances, has resulted in the use of certain terms we find to be inappropriate or archaic. Specifically, the equation of those explicitly identified as lesbian, gay or bisexual as representative of all those endorsing sexual minority identities is problematic, as it excludes those endorsing alternative orientations. The majority of research, however, reports findings only according to these identity categories, and we are hesitant in imposing these results on individuals whose identities are not explicitly included.

Similar issues persist in the delineation of transgender and gender non-conforming populations. While gender identity encapsulates myriad configurations and self-identities, the majority of research in this area refers exclusively to transgender or transsexual individuals endorsing MTF (male-to-female/feminine) or FTM (female-to-male/masculine) self-concepts. This is particularly problematic, as "health researchers increasingly recognize the need to understand, measure, and distinguish among the impacts of gender relations, gendered identity, and sex-linked biology in order to support the development of effective policy, programmatic, and clinical interventions" (Johnson, Greaves, & Repta, 2009; Krieger, 2003, cited in Kuper, Nussbaum, & Mustanski, 2012). As well, operationalizing gender transition according to directionality, although helpful in assessing the relative risks of those assigned male or female at birth, misrepresents the heterogeneity of this community. According to the Trans PULSE Project, only a "minority of trans Ontarians reported a linear transition from one sex to another" despite the popular assumption that this trajectory constitutes a community norm (Kuper et al., 2012). As well, although the term transgender was intended, at its inception, to be inclusive of all those whose gender identity or expression diverges from culturally defined categories of sex and gender, transgressing and transcending gender binary, not everyone who is externally identified as transgender will necessarily identify with this term. The language according to which members of gender-minority communities self-identify has changed substantially over the past several decades, and the variety of terms found in this review are likely reflective of what was considered most culturally appropriate at each juncture.

As well, we have found that many researchers appear to use the terms 'sex' and 'gender' interchangeably. While sex refers to the biological characteristics (internal and external genitalia, hormones and chromosomes) by which individuals are identified as male, female or intersex, gender denotes the social role associated with the sex assigned at birth. These two terms are frequently conflated, as the binary

sex/gender system through which our understandings of these concepts are structured assume gender to be static and dictated by sex. In the context of this review, therefore, the use of the term 'sex' is generally a reflection of the language used in the original studies.

Additional confusion often results from the variety of measures utilized to measure sexual and gender orientations and/or identities, including romantic attraction, relationship partners, and self-identification. Wherever possible, we use the term 'sexual minority' to denote those who experience same or multiple gender attractions, engage in same or multiple gender sexual behaviours, or endorse non-heterosexual orientations. Similarly, we use the term gender minority to denote those who do not identify as cisgender. Although not explicit, we assume that researchers surveying sexual minority populations have used cisgender comparison samples when referencing non-sexual minority cohorts. While we identify as cissexist the assumptions that individuals not explicitly endorsing a gender minority identity are implicitly cisgender, we are unable to impose this identity category when it is not otherwise stated, and apologize for perpetuating this cissexist social discourse.

Finally, among indigenous populations the term two-spirit is used to reference indigenous individuals with gender and/or sexual minority orientations. A “culturally distinct, contemporary term used by some American Indians to connote diverse sexual orientation, gender variant identities and/or alternate gender roles”, this term was developed as a cultural shorthand to denote the myriad orientations present in a variety of indigenous cultures. (Burks, Robbins & Durtschi, 2011) Some indigenous gender and sexual minority individuals may identify with the term two-spirit, others may use English terms with which Canadian readers are familiar, and some may use terms in their own languages for which there is no adequate English translation. Unfortunately, in mirroring the language used by researchers, we are limited to English terms in this review.

1. Prevalence

1a) Introduction to Methodologies and Limitations

Although extant research has provided a near-universal affirmation of elevated rates of alcohol and other drugs (AOD) use in LGBTTQQ2SIA communities, the precise rate at which gender and sexual minority populations use substances remains contested. Therefore, while the cumulative picture provided by the data presented herein is compelling, researchers have advocated approaching individual studies with caution.

Attempting to account for these divergences, multiple authors have demonstrated the presence of numerous methodological issues in studies investigating the incidence of AOD use in the aforementioned communities (Lea, Reynolds & De Wit, 2013a; Roberto, D'Alessio & Fiorenzo, 2010; Marshal, Friedman, Stall, King, Miles,

Gold & Morse, 2009; Talley, Sher & Littlefield, 2010). Specifically, the majority of relevant surveys have involved the use of non-representative, convenience samples of LGBTTQQ2SIA individuals. Although acknowledged to be an appropriate method of engaging "hard-to-reach" populations, this type of sampling incurs the risk of self-selection bias, and limits the generalizability of research findings (Brewster & Tilman, 2012). This approach appears to have been partially a function of necessity, as few epidemiological studies assess participant sexual orientation. This, to some extent, encapsulates the difficulties inherent in attempting quantitative research with marginalized populations: while convenience samples have limited generalizability, population-based studies rarely screen gender and sexual minorities identities as demographic variables, making the extraction of these subsets effectively impossible.

As well, studies differ in the means by which they operationalize sexual minority identity, alternatively structuring their measures according to self-identification, sexual and/or romantic attraction and sexual relationships (Russell, Driscoll, & Truong, 2002; Lea, et al., 2013a; Herrick, Matthews, & Garofalo, 2010; Marshal et al., 2009; Marshal, Friedman, Stall, King, Miles, Gold, & Morse, 2008). This problematizes the capacity of results to be compared across studies, as individuals endorsing sexual minority identities differ from those indicating same or both gender attractions and/or sexual partners in relative rates of substance use (Brewster & Tilman, 2012).

Additionally, studies predominantly limit sexual minority identity categories to lesbian, gay, and bisexual identifications, and establish relationship and attraction vectors according to same and other sex criteria. Therefore, individuals who do not identify with the above-mentioned orientations, as well as those who experience attraction to and/or engage in relationships with partners of multiple genders are summarily excluded from this research. Further, these analyses rarely examine queer as an identity category, and limited research has been conducted with questioning youth. As stated by Espelage, Aragon, Birkett & Koenig, (2008) "questioning youth might experience risk because of internal or external pressures to foreclose on their sexual identity development or from less sense of belonging among the heterosexual or LGB community" (cited in V. Paul, Brian, Aragon, & Espelage, 2009). Similarly, a 2009 survey of high school students across 18 schools in the American mid-west found that questioning youth generally reported the highest levels of substance use when compared to LGB and heterosexual cohorts, and, further, that experiences of victimization correlated more strongly with substance use among questioning males than their heterosexual peers (V. Paul et al., 2009).

Further, we could identify only four (Cochran, & Cauce, 2006; Cochran, Peavy & Santa, 2007; V. Paul et al., 2009) studies allowing for individuals questioning their sexual orientation, and only one of these studies provided separate results for questioning participants. Similarly, only one study allowed the endorsement of a queer identity, and did not provide separate results for queer respondents (Kipke,

Weiss, Ramirez, Dorey, Ritt-Olson, Iverson, & Ford, 2007). Further, we could identify no studies documenting substance use prevalence rates for asexual youth. While several studies mentioned low rates of alcohol and substance use for LGB-identified youth abstaining from sexual contact, this construct is distinct from an asexual orientation/identity, and should not be interpreted as representative of this population.

Among those studies evaluating substance use in gender minority communities, the majority operationalize gender vectors according to the sex assigned at birth, alternatively designating participants MTF or FTM (Corliss, Beizer, Forbes & Wilson, 2007; Herbst, Jacobs, Finlayson, McKleroy, Neumann & Crepaz, 2008; Bradford, Reisner, Honnold & Xavier, 2013; Ignatavicius, 2013; Wolf & Dew, 2012). This effectively excludes those who do not identify with binary gender options. Although some studies have allowed the endorsement of non-binary identities, a 2008 literature review could find no research addressing substance use "among gender variant persons who do not correspond to the MTF or FTM dichotomy" (Herbst et al., 2008). This is a particularly conspicuous omission, as, according to the results of a 2011 study exploring the diversity of gender orientations, 45.2% of respondents identified as neither male nor female, and returned genderqueer as the most frequently endorsed identity (Kuper et al., 2012). As well, the 2011 National Transgender Discrimination survey, which included 6,450 transgender and gender non-conforming participants from all 50 US states, the District of Columbia, Puerto Rico, Guam and the U.S. Virgin Islands, found that while 75% of the sample could be categorized as MTF or FTM, 14% identified as gender non-conforming, and reported a variety of alternative gender identities (Grant, Mottet, Tanis, Harrison, Herman & Keisling, 2011). Intersex individuals were also not represented in the literature.

Additional concern has been expressed regarding the under-representation of racial and ethnic minorities in both youth and adult samples (V. Paul et al., 2009). Because racialized sexual and gender minority individuals typically negotiate multiple marginalized identities - and are therefore more likely to experience psycho-social distress - several authors "have cautioned against the generalization of results among predominantly White LGB samples to racial minority LGB individuals" (Rosario, Schrimshaw & Hunter, 2004, cited in V. Paul et al., 2009). A study of 130 predominantly Black and Hispanic LGB youth identified elevated rates of substance youth, finding that 63% of participants reported using alcohol, and 14% had used cocaine in the previous 3 months, evincing rates substantially higher than those in the adolescent population, of whom 51% and 2% reported using alcohol and cocaine respectively during the preceding 3 months (Senreich, E., 2012). These disparities are likely more pronounced among gender minority youth, whose disproportionate exposure to violence, harassment and discrimination has been amply documented. As will be demonstrated later in this review, the psychological stress resulting from these experiences is often externalized through substance use.

Two-spirit and indigenous gender and sexual minority youth were also substantially under-represented in the literature. This is a particularly conspicuous omission, as indigenous populations have documented rates of AOD use substantially higher than those evinced by the general population. Likely attributable to the " ongoing effects of colonization, poverty, and forced acculturation strategies such as residential schools", indigenous respondents to a national survey conducted between 2008 and 2010 endorsed alcohol and drug abuse as the primary health concern encountered by on-reserve communities (Health Canada, 2011).

When considering the following information, therefore, it is important to consider the populations not represented in these studies. While researchers have provided a wealth of information regarding AOD use in gender and sexual minority populations, specific sub-demographics remain invisible. In the context of a literature review, we are limited to conveying ideas documented in existing research, and there will therefore be an under-representation of the communities mentioned above in the summaries that follow.

While the majority of data in the following section was derived from non-Canadian sources, several researchers have suggested that "in other large, relatively affluent countries such as Canada and Australia, disparities in LGB youth substance use are equal to those in the United States" (Marshal et al., 2008). Following this, we have limited our non-domestic sources to studies conducted in the United States and Australia. Further, citing several international reviews, the Canadian Centre on Substance Abuse concluded that "international comparisons of alcohol and cannabis use by young people indicate that Canada ranks among the leading countries for rates of prevalence and frequency" (Canadian Centre for Substance Abuse, 2007). Therefore, while Canadian institutions have not surveyed sexual orientation in the context of population-based studies, we have attempted to include relevant national data when comparing international convenience samples to population prevalence rates.

Similarly, although we have given priority to youth data sets, there is substantially more information available on AOD use in adult populations. In some instances, only non-youth data exists. However, Marshal et al. (2009) contend that the substance use disparities documented in gender and sexual minority adults "most probably begin in adolescence", when "youth may be less well equipped developmentally to cope with the challenges of having a minority sexual orientation in a stigmatizing environment". As well, latent curve models employed in the same analysis revealed that sexual minority youth, on average, reported higher initial rates of substance use, and increased their substance use more rapidly over time when compared to non-sexual minority youth (Marshal, et al., 2009). Further, in analyzing prevalence rates among youth (ages 12 – 24) and adults in the 2012 Canadian Alcohol and Drug Use Monitoring Survey (CADUMS) dataset, Health Canada found past year rates of illicit drug use by youth to be five times higher than those documented for adults (Health Canada, 2013). Therefore, divergences present in adult populations are likely

reflective of differences in youth AOD use, and have thus been included in this review.

1b) Population-Based Studies

Although "few epidemiological surveys have assessed participant sexual orientation", Cochran, Ackerman, Mays, & Ross (2004) utilized data from the 1996 National Survey on Drug Abuse - in which participants were asked supplementary questions regarding the gender of their sexual partners within the previous 12 months - to offer a preliminary indication of elevated rates of substance use in sexual minority populations. They found a lifetime prevalence of illicit substance use for men with male partners of 72.8%, compared to 54.6% for men with no previous year history of same-sex sexual behaviour. For women, 77.9% of those reporting a history of female partners endorsed lifetime use illicit substances compared to 42.3% for women indicating only male partners (Cochran, et al., 2004). Although not immediately comparable, the 2012 CADUMS Survey found the use of "at least one of five illicit drugs excluding cannabis [cocaine or crack, speed, ecstasy, hallucinogens or heroin] was reported by 2.0% of Canadians" (Health Canada, 2013).

Among the most frequently cited reviews of the past decade, a 2008 meta-analysis and methodological review examining sexual orientation and adolescent substance use across eighteen studies published between 1998 and 2006 quantified the odds of substance use for LGB youth as being, on average, 190% higher than for heterosexual youth. These results indicated elevated risks for specific sub-populations of LGB youth, including bisexual youth (340%) and females (400%). The research analyzed documented youth endorsing a sexual minority orientation, romantic attraction, or relationship to be 2-5 times more likely to report the use of substances. Precise odds varied across studies, likely because researchers alternatively defined LGB identity according to the three aforementioned variables, resulting in differing rates in each survey (Marshal et al., 2008).

As well, (from one of the few countries to assess sexual orientation in population-based surveys), Australian data offers further evidence of elevated rates of substance use in sexual minority communities. Specifically, the 2010 National Drug Strategy Household Survey (NDSHS) reported that:

- Non-heterosexuals had higher rates of risky drinking than heterosexuals (26.5% versus 16%)
- Non-heterosexuals were more likely than heterosexuals to have ever used illicit drugs (64% versus 39%)
- Non-heterosexuals were more likely to have used illicit drugs in the previous 12 months (36% versus 14%) (Lea, Reynolds, & de Wit, 2013b)

Comparing the results of heterosexual respondents from the NDSHS with a cross-sectional survey conducted at a youth LGBT festival in Brisbane, Australia in 2012,

Kelly, Davis, & Schlesinger (2014) found that while approximately one quarter of 18-29 year-olds in the NDSHS cohort reported drug use in the previous 12 months, half of the respondents in the Brisbane survey reported drug use in the previous 6 months. Among the general youth population, 77% of 12–15 year olds reported abstaining, while this was endorsed by 30% of gender and sexual minority participants. Hazardous drinking was also more frequently reported by LGBT youth when compared to the NDSHS sample, with particularly acute disparities documented during adolescence. While only 8% of 12-15 year-olds, 41% of 16-17 year-olds and 66% of 18-19 year olds in the general population reported hazardous drinking, rates among the LGBT sample were 60%, 56% and 79% respectively. The same trend was apparent in the use of illicit substances. Comparatively, the rates were as follows:

- 5% of 14-17 year olds in the NDSHS sample reported a lifetime history of illicit drug use versus 40% in the LGBT sample
- 25% of 18– 19 year olds in the NDSHS sample reported a lifetime history of illicit drug use versus 62% of the LGBT sample
- 28% of the NDSHS sample 20 and over had used illicit substances, versus 68% of the LGBT sample

The elevated rates of substance use among gender and sexual minority youth can be contrasted with those reported by the general youth population in Canada. The results of the aforementioned 2012 CADUMS report indicate that only 20.3% of youth ages 15 – 24 endorsed past year use of cannabis, with insufficient data available to report on other illicit substances, as their use was so infrequently endorsed. (Health Canada, 2013) Further, according to the Canadian Centre on Substance Abuse, " fewer than one in five teens in school have ever tried any drugs other than alcohol and cannabis", while an approximately equivalent proportion use these substances regularly, and even fewer have used "street drugs" such as heroin, cocaine, or methamphetamine. (Canadian Centre for Substance Abuse, 2007)

1c) Sub-Populations

To examine a variety of studies in more detail, we have divided the remainder of this section into specific sub-populations. As already mentioned, the research on which this review is based predominantly assesses sexual orientation – when based on self-identity – according to the categories of lesbian, gay, and bisexual. Even when operationalizing sexual minority identities according to attractions and/or relationships, these studies often only allow participants to identify their attractions/relationships according to same, both, or other-sex attractions and/or relationships, implicitly mandating participant adherence to binary gender options. With some reservations, therefore, we have organized the following sections according to assigned sex, and have further sub-divided according to other and both sex attractions.

Sexual Minority Men

Broadly, young men endorsing same or both-sex sexual orientations, attraction and/or relationships have rates of substance use higher than their heterosexual counterparts, including those that have not endorsed any cross-gender attractions and/or relationships. However, while research generally substantiates increased odds of AOD use within these populations, empirical support has not been universal. Studies providing no evidence of elevated rates of substance use in these sub-populations include a 2008 analysis of longitudinal alcohol use patterns among adolescents, which found no differences in drinking among gay, bisexual and heterosexual men (Corliss, Rosario, Wypij, Fisher, & Austin, 2008); and a 2012 survey of sexual orientation and substance abuse among young adults, which failed to document higher odds of substance use for males reporting exclusive same-gender as opposed to exclusively opposite-gender partners (Brewster, & Tillman, 2012). The majority of research, however, has documented increased AOD use in male sexual minority communities, and it is recommended that the above-mentioned results be viewed as deviations from a generally conclusive body of research.

Specifically, sexual minority men ages 18-25 participating in a cross-sectional online survey in 2010 were found to have the highest rates of club drug usage and dependence of all respondents, including heterosexual and sexual minority women.. Similarly, 69% of sexual minority male youth participants in a 2005 Los Angeles study reported having used an illicit drug. 90% of the sample reported a lifetime use of alcohol, 23% reported use of cocaine, and 20% reported use of crystal methamphetamine (Kipke et al., 2007).

While this survey used venue-based probability sampling, recruiting subjects from gay-identified licensed venues, so therefore cannot be assumed to be indicative of prevalence rates in the general male sexual minority population, it does indicate an increased use of club drugs within this population, and, further, gives credence to the concerns expressed by some researchers that increased AOD use may be associated with participation in the “gay scene” of licensed venues. Several authors have linked “higher levels of participation in the scene” with “recent and regular” AOD use in sexual minority men, particularly the use of 'club drugs' (methamphetamine, ecstasy, cocaine, GHB and ketamine) (Baiocco, D’Alessio & Laghi, 2010; Langhinrichsen-Rohling, Lamis & Malone, 2011). Specifically, a 2013 online survey found that “approximately twice as many young men reported ecstasy, cocaine, and speed use in lesbian and gay venues than in straight or mixed venues”, and, further, that “while regular attendance at licensed venues was associated with hazardous alcohol use and recent club drug use, regular attendance at the venues of the lesbian and gay scene was more strongly associated with hazardous alcohol use and club drug use than regular attendance at straight or mixed venues” (Flentje, Heck & Sorensen, 2014). Comparatively, the prevalence of past-year cocaine use in Canada was reported as approximately 1.1% in 2012, while 6.4% of participants in the 2004 Canadian Addiction Survey endorsed the lifetime use of amphetamines (Health Canada, 2013; Adlaf, Begin, & Sawka, 2005).

Among research explicitly exploring different dimensions of sexual identity, results indicate that youth who explicitly espouse a sexual minority identity have higher rates of substance use than those exclusively endorsing same-sex romantic attractions and/or relationships. Marshal et al.'s 2008 meta-analytic review found the correlation between sexual minority status and substance use to be strongest in studies using self-identification measures to assess sexual identity. Authors documenting similar results have attributed this phenomenon to the probability that youth self-identifying as gay or bisexual are more likely to have disclosed their sexual orientation to others, and are therefore more vulnerable to victimization, whose effects may be externalized through AOD use (Brewster, & Tillman, 2012). As well, on the basis of research correlating participation in gay nightlife and substance use, it may also be inferred that those who have explicitly endorsed a sexual minority identity are more likely to engage in licensed venues as a social outlet, which elevate their risk of AOD use.

Male sexual minority youth endorsing relationships with both sexes, as well those who that explicitly identify as bisexual, appear to have rates of AOD use higher than non-sexual minority youth, and equal to or higher than gay-identified male youth. Utilizing data from other male cohort, Marshal et al.'s 2008 meta-analysis also reported odds of substance use 4.4 times higher in bisexual adolescents and young adults when compared with heterosexuals.

Sexual Minority Women

Literature detailing AOD use among sexual minority women is subject to the same methodological constraints acknowledged in previous sections. Generally speaking, however, research documenting the prevalence of substance use in this population has offered more definitive results. Broadly, sexual orientation disparities in relation to substance use are believed to be larger in females than in males. That is, there appear to be greater differences between rates of AOD use in female sexual minority populations and non-sexual minority communities than have been reported to persist among sexual minority men and their peers. Specifically, utilizing data collected from the Growing Up Today Study, Corliss, et al. (2010) found that “when gender modified the relationship between sexual orientation and drug use, the elevated risk experienced by sexual minorities relative to heterosexuals was larger among females than males.” Similarly, Marshal et al.'s meta-analysis of research analyzing sexual orientation and adolescent substance use found that study results demonstrated a more/the most pronounced associations between sexual orientation and substance use for females.

Interestingly, while research indicates that adolescent males in the general population are more likely than females to report the use of substances, this tendency is reversed in sexual minority communities, such that sexual minority women are more likely to report substance use than sexual minority men. Brewster and Tilman's 2012 Sexual Orientation and Substance Use Among Adolescents and

Young Adults found that “females who identified as lesbian or bisexual, who reported at least some same gender attraction, or who reported sexual activity with partners of both genders had significantly higher odds of all forms of substance use” and, further, that bisexual females had the highest past-year prevalence of drug use amongst all groups for all drug categories except heroin. As well, utilizing a convenience sample of 137 self-identified lesbian and bisexual women ages 16-24, Herrick, Matthews and Garofalo (2010) found that 94% of respondents reported lifetime alcohol use and 68% reported using alcohol at least monthly.

Comparing these results to a heterosexual sample from the 2004 National Survey on Drug Use and Health revealed that these rates are substantially higher than those reported in the general population in which, according to the NSDUH sample, 76.5% of respondents reported lifetime alcohol use, and 46% indicated that they had used alcohol within the past month (Lea, et al., 2013a).

Sexual minority women who frequent sexual minority-specific night club venues similarly experience increased odds of AOD use. An online survey of 254 sexual minority women ages 18-25 found that 76% of respondents had AUDIT-C scores indicative of hazardous alcohol use, while 28% reported using club drugs in the preceding 6 months. Among those who had used club drugs during this time period, 26% of females had SDS scores indicative of “current dependence on at least one of these drugs” (Lea et al., 2013b). Among Canadians, Health Canada estimates that approximately 25% of the population engaged in alcohol consumption patterns characteristic of 'risky drinking' (“defined as more than four drinks per occasion monthly or more often in the past year for men or more than three drinks per occasion for women”) in 2012 (Health Canada, 2013).

Additional concerns have been expressed regarding the substance use behaviours of bisexual women, as well as heterosexual women indicating some level of romantic attraction to and/or sexual contact with same-gender partners. Specifically, an online survey of sexual minority young women ages 18-25 found that of the 49% of respondents that reported using illicit drugs in the previous six months, bisexual women were more likely than other participants to endorse using drugs, as well as reporting being younger upon initial use (Lea et al., 2013b). The same study also found that a higher proportion of lesbian and bisexual women had hazardous AUDIT-C scores when compared to gay and bisexual men. As well, Cochran et al. (2007) found bisexual women to be at elevated risk for the use of cocaine, methamphetamine and heroin when compared to other groups. The latter study further stated that that “sexual minority women presenting for publicly funded treatment, overall, have more severe drug use patterns” when compared to their non-sexual minority peers.

Gender Minority Populations

As aforementioned, the majority of studies documenting substance use prevalence rates in sexual minority communities explicitly exclude gender minority participants.

While some researchers have surveyed AOD use in gender minority communities, there is substantially less information available regarding these rates than those in sexual minority populations. Additionally, the majority of this research was undertaken between the mid-1990s and early 2000s, as American health departments conducted a series of needs assessments pertaining to HIV risk behaviours and interventions (Wolf, & Dew, 2012). In a review of 29 studies conducted between 1990 and 2003 (55% of which were conducted between 1996 and 1999), Herbst et al. (2008) found only five studies documenting AOD use, of which only one specifically surveyed youth participants. As well, because transwomen have documented rates of HIV infection higher than those reported by FTMs, much of this research has focused exclusively on the former population.

Despite these limitations, however, ample evidence indicates that AOD use in gender minority populations is more pronounced than those documented in cisgender populations, including rates recorded in sexual minority communities. As well, because behavioural patterns (related to substance use) exhibited by youth are likely to predict adult behaviour, results documented in adult studies can reasonably be applied to youth populations (Wolf, & Dew, 2012).

Comparing the results of three studies (Clements, Katz & Marks, 1999; Xavier, 2000; Valentine, 1998) with The 2002 National Survey on Drug Use (NSDU) measuring the rate of AOD use in the general population, Wolf and Drew (2012) identified the following disparities:

- 0.9% of NDSU respondents (and therefore the general population) reported the use of crack-cocaine, as opposed to between 7% and 21% of MTF participants across the 3 aforementioned studies
- 6.7% of NDSU respondents could be classified as 'heavy drinkers' (denoting five or more drinks on the same occasion on at least 5 different days in the past 30 days),compared to 24% - 37% of MTF respondents

Similarly, a 2006 survey of 229 MTF and 121 FTM participants found a past or current drinking problem reported by 23% of respondents.

Additionally, in perhaps the most comprehensive of data sets, the San Francisco's Transgender Community Health Project (1999) found that:

- Among MTF respondents, 66% reported lifetime use of cocaine, 57% reported lifetime use of speed, 48% reported lifetime use of crack, 24% reported lifetime use of heroin, and 34% reported a history of injection drug use
- Among FTM participants, 52% reported lifetime use of cocaine, 50% reported lifetime use of speed, and 18% reported a history of injection drug use (Clements, Katz & Marx, 1999)

There has, however, been some controversy regarding the prevalence of injection drug use in FTM communities. While three studies (Clements-Nolle et al. 2001; Conare et al. 1997; Kenagy & Bostwick, 2005) reported rates of non-hormonal injecting drug use ranging from 4% - 21%, neither Kenagy (2002) nor Xavier (2005) found that no FTM participants indicated having injected drugs.

In the only survey not to have dichotomized gender minority respondents according to MTF or FTM identity – preferring, instead, to categorize non-cisgendered participants as "gender diverse" - a 2012 Australian study of LGBT youth (13-24) found that a greater percentage of gender diverse respondents reported the use of stimulants, prescription medications and opiates, and were twice as likely to be poly-drug users when compared to cisgender respondents. (Kelly et al., 2014)

Finally, while little information exists regarding substance use in racialized gender minority communities, it is likely that AOD use is higher than the rates mentioned above. This phenomenon is often explained with reference to "syndemic theory", in which the interactions of multiple issues – particularly those that result from social inequity - are linked to a particular health outcome (Stall, Friedman & Catania, 2008, cited in Wolf & Dew, 2012). Because transwomen have to contend with social oppression related to multiple identity markers, and are often especially vulnerable to mistreatment resultant of any one of these various markers, they are more likely to experience adverse health outcomes. Substantiating this, the National Transgender Discrimination Survey found that "transgender racial minorities, particularly MTF transgender persons, fared worse than Whites in almost every category surveyed, including substance use" (Grant et al., 2011).

Indigenous Populations

While relatively little information is available regarding AOD use in indigenous gender and sexual minority communities, preliminary evidence indicates prevalence rates may be substantially higher within these populations. In 2010, researchers in Ontario published the Trans PULSE project - a community-based study of gender minority health – including the "first published data regarding the health of Aboriginal gender-diverse Ontarians" (Scheim, Jackson, James, Sharp Dopler, Pyne & Bauer, 2013). Of the 33 indigenous respondents, 23% indicated that they required services specific to their AOD use. As well, among a sample of 71 gender and sexual minority American Indian men in New York City, two-spirit respondents reported the highest levels of HIV risk behaviours, including substance use, when compared to heterosexual participants. These findings "parallel results of differences by sexual orientation among European American men" (Simoni, Walters, Balsam & Meyers, 2006).

Interestingly, the few studies documenting gender and sexual minority identities and behaviours in indigenous communities indicate that "American Indian youth have a higher prevalence of self-reported gay, lesbian, bisexual, and "unsure" sexual identities than non-American Indian youth" (Simoni et al., 2006).

2. Causal Explanations

Three primary theories have emerged in an attempt to explain elevated rates of AOD use in gender and sexual minority communities:

1. Authors have suggested that the extent to which LGBTTQQ2SIA social life is centred around attendance at licensed venues may increase participants' risk of alcohol and drug use (Lea et al., 2013a & 2013b; Baiocco et al., 2010; Kipke et al., 2007)
2. Gender and sexual minority individuals face stressors to which the general population is not subject – a construct broadly summarized as 'minority stress theory' – and are therefore vulnerable to elevated rates of psychological distress (Meyer, 1995 & 2003)
3. Internalized heterosexism, positing that the social stigma associated with gender and sexual minority identities may be assimilated into the belief systems of gender and sexual minority individuals, is hypothesized to result in guilt, shame, self-loathing, and consequent substance use (Barbara, 2002)

2a) Reliance on Licensed Venues

In part, the prevalence of substance use in gender and sexual minority communities is attributed to the extent to which the social lives of the aforementioned populations may be structured around bar spaces. (Lea et al., 2013a & 2013b; Baiocco et al., 2010; Kipke et al., 2007) Historically, the hostility to which gender and sexual minority identities have been subjected contributed to the emergence of licensed venues as one of the few contexts in which these populations could safely socialize. The development of community cohesion and connectedness have therefore been tied to these environments, a tendency that persists today. As a result, members of gender and sexual minority communities may be more likely to frequent bars and clubs “as a means of seeking community affiliation and social support”, thereby increasing “their exposure to environments where drug and alcohol use behaviours are highly prevalent” (Marshal et al., 2009).

While research suggests community involvement may function as a protective factor against myriad mental health and psycho-social concerns, increased attendance at sexual and gender minority specific licensed venues is also believed to augment the risk of AOD use (Lea et al., 2013a & 2013b; Deacon et al., 2013; Baioccoet et al., 2010; Langhinrichsen-Rohling, Lamis & Malone, 2011). Specifically, a survey examining club drug usage among young sexual minority men in Los Angeles found increased risk levels for substance use among those who frequented gay bars and nightclubs (Kipke et al., 2007). Further, a 2010 study identified regular attendance at venues specific to the “lesbian and gay scene” to be a predictor of hazardous alcohol consumption among 572 same-sex attracted young people in Sydney (Lea et al., 2013a). Interestingly, although the latter study found regular attendance at

licensed venues to be associated with hazardous alcohol consumption and recent club drug use, consistently frequenting sexual minority-specific venues was “more strongly associated” with these behaviours than was patronizing “straight or mixed” venues, prompting the authors to suggest that AOD use may be normalized in sexual minority communities (Lea et al., 2013a).

Particular concern has been expressed regarding the impacts of these social environments on gay men, with one author partially attributing lower abstinence levels of gay/bisexual study participants to “social and sexual factors in the male gay/bisexual sub-culture that encourage substance use that are not adequately addressed in treatment” (Senreich, E., 2009).

2b) Minority Stress

Defined by Meyer as circumstances in which the “stigma, prejudice, and discrimination [to which minority populations are subject] create a hostile and stressful social environment that causes mental health problems” (Meyer, 2003), Minority Stress encompasses three fundamental varieties of experience:

1. Objective events and conditions, such as discrimination and violence
2. Vigilance resulting from expectations of further mistreatment (alternatively referred to as 'stigma consciousness')
3. Internalizing of negative attitudes to which gender and sexual minorities are exposed

Minority stresses, therefore, are believed to exist along a continuum from objective events (including harassment, violence and discrimination) to subjective experiences (including vigilance and internalization). According to this model, “stress can be considered the mediator in the relationship between social status and addictive behaviours among people who belong to stigmatized minority groups” (Baiocco et al., 2010).

Objective Events

Ample evidence indicates that sexual and gender minority youth are disproportionately subject to instances of violence and discrimination when compared with their non-gender and sexual minority peers. In their meta-analysis of the victimization experiences of lesbian, gay and bisexual individuals, Almeida et al. (2009) found a school victimization rate of 33% across 31 studies. Similarly, data from the 2007 Washington, DC, Youth Risk Behaviour Surveillance (YRBS) system identified that 31% of youth endorsing a sexual-minority identity reported being bullied in the past year, compared to 17% of heterosexual youth (Almeida et al., 2009). Almost precisely mirroring these results, Burton et al. (2013) found that across 26 studies, sexual minority adolescents were 1.7 times more likely to report being assaulted at school than their heterosexual peers. Available evidence indicates that Canadian youth report similar levels of exposure. Specifically, 94% of

participants in a needs assessment surveying gender and sexual minority youth (15 – 26) in Simcoe County, Ontario reported hearing homophobic comments, while 87% reported hearing transphobic comments. Further, 46.9% of respondents indicated daily exposure to homophobia, and 31.7% endorsed daily exposure to transphobia (Ham & Byrch, 2012).

Significantly, sub-populations of gender and sexual minority communities experience varying levels of vulnerability to victimization. Research indicates that cisgender males endorsing sexual minority identities are more likely to experience violence than cisgender sexual minority females. This disparity is generally attributed to the mediating role of perceived biological/assigned sex as a mediating variable in victimization experiences related to gender non-conformity. Specifically, Kosciw, Diaz, & Greytak (2008) found that young people reported "hearing more negative remarks about gender nonconformity toward boys (53.8%) than girls (39.4%)" while "D'Augelli et al. (2006) found that male youth who were gender nonconforming were more likely to receive negative responses from parents than were gender-nonconforming female youth" (cited in Toomey et al., 2010). This has led a number of authors to conclude that " the more young people present as gender nonconforming, the more likely they will be victimized or abused at school" (Grossman, D'Augelli, Howell & Hubbard, 2005).

In a 2010 study of LGBT adolescent gender non-conformity, "both adolescent and young adult levels of gender nonconformity and LGBT school victimization were positively correlated", and further, victimization experiences were associated with higher rates of depression in young adulthood (Toomey et al., 2010). Therefore, experiences of victimization are theorized to mediate the relationship between gender non-conformity and young adult depression among sexual and gender minority youth.

This may partially explain why research regarding the victimization experiences of sexual minority females has been inconsistent across studies. While some research has found victimization to be correlated with psychological distress in cisgender sexual minority males and females, several studies have documented this relationship only for cisgender males (Almeida et al., 2009). This may be because, statistically, cisgender females tend to report lower levels of gender non-conformity (Toomey et al., 2010). As well, it may be that gender non-conformity is more socially permissible among those assigned female at birth, as this presentation does not constitute a betrayal of patriarchal masculinity, as it may in males. Further, because the above-mentioned study asked participants to describe their adolescent gender presentation "on a scale from 1–9, where 1 is extremely feminine and 9 is extremely masculine", it may be that lesser constraints regarding the performance of femininity (experiences of sexism and misogyny non-withstanding, as they were not assessed in this study) led cisgender females to report lower levels of gender non-conformity (Toomey et al., 2010). This does not mean, however, that cisgender females are not subject to sexual minority-specific victimization, nor that they do not experience adverse psycho-social consequences as a result. Rather, it indicates that this

relationship has not been adequately substantiated in the literature, particularly when associated with gender non-conformity among cisgender females.

The relationship between victimization and gender non-conformity alludes to the increased vulnerability of gender minority youth. School-based studies of gender minority adolescents, however, have been relatively scarce. In their meta-analysis of 39 studies published between 1999 and 2012, Collier, van Beusekom, Bos & Sandfort (2013) identified only 12 studies that included transgender participants, of which only four assessed their experiences independently of sexual minority youth. In research that has addressed only gender-minority experiences, rates of victimization are universally higher than those reported by cisgender heterosexual and sexual minority youth, indicating that gender-minority youth are at increased risk of peer-based victimization, and are therefore more susceptible to adverse psycho-social consequences. Notably, a 2005 study by Sausa found that 96% of transgender respondents reported experiencing physical harassment at school. McGuire, Anderson, Toomey & Russell (2010) similarly discovered that 82% of gender minority students reported regularly hearing negative gender-based comments at school, and in only 25% of cases did school staff intervene. Indeed, in a focus group conducted by Grossman & D'Augelli (2006) several transgender youth indicated that "their school experience was largely the most traumatic part of living with a gender-variant identity". Further, this treatment may be disproportionately directed at transwomen, who, by virtue of their birth assignment as male, experience increased vulnerability, particularly to physical violence. Because " biological males [birth-assigned males] are more often physically bullied" and "gender atypicality in the form of low masculinity in [birth-assigned] boys has been found to be a predictive factor for victimization" trans women are likely the demographic most vulnerable to peer-based victimization (Ignatavicius, 2013; Young & Sweeting, 2004).

While there is a relative dearth of information regarding the peer victimization experiences of gender minority youth, exposure to harassment, violence and discrimination have been amply documented in adult populations. While not ideal, these statistics can likely be extended to gender-minority youth, as many researchers believe reactions to gender non-conformity to be amplified during adolescence (Toomey et al., 2010). A 2009 study evaluating the impact of gender-related abuse in male-to-female transgender persons substantiates this claim. Surveying 571 MTF participants in New York City, researchers found that 78.1% of respondents had previously experienced gender-related psychological abuse, and one half had previously experienced gender-related physical abuse. The prevalence of both forms of abuse were especially high during early and late adolescence but subsequently declined across the remainder of each life course (Kuper, Nussbaum & Mustanski, 2012).

Most recently, results from the Virginia Transgender Health Initiative Study – a cross-sectional survey of 350 participants whose results were published in 2013 - indicated high rates of exposure to violence, with 38% of participants reporting that

they had been physically assaulted since age 13 (Bradford, Reisner, Honnold, & Xavier, J., 2013). Additionally, 31% of respondents indicated that their families were not supportive of their transgender identity, and 37% disclosed negative high school experiences, including hostility from peers, teachers, and school administrators. The study further emphasized that "being younger at age of first transgender awareness was significantly associated with discrimination," a finding substantiated by the above-mentioned New York study, in which authors partially attributed the comparatively high levels of distress during adolescence among the younger respondents to the increased public visibility of their transgender identity. (Bradford et al, 2013; Kuper et al., 2012) As well, in their review of 29 American HIV prevention literature surveying transgender populations, Herbst et al. (2008) found a history of physical abuse of 42.9% across studies (weighted mean), with 57.9% of MTFs reporting a history of violence in their families of origin. Participants further endorsed feeling uncomfortable (weighted mean, 60.4%) or unsafe (weighted mean, 76.6%) in public settings.

Although gender-minority populations are generally at heightened risk of exposure to harassment, violence, and discrimination, particular subsets of these communities are inordinately vulnerable to the aforementioned experiences. Specifically, birth assigned males and racialized gender minorities are documented to have increased exposure to maltreatment, such that the 2013 Transgender Health Initiative Study found that "being a racial/ethnic minority compared with being White" was associated with "increased odds of discrimination" (Bradford et al, 2013). Similarly, data from a study analyzing the substance use treatment experiences of gender minority adults found that "African-American transgender/transsexual participants reported the highest level of transphobic events in the past year", while the National Transgender Discrimination Survey demonstrated that " transgender racial minorities, particularly MTF transgender persons, fared worse than Whites in almost every category surveyed" (Lombardi, 2009, Grant et al., 2011). In Ontario, 92% of racial minority respondents in the Trans PULSE Project reported experiencing transphobia, while 90%indicated that they had been subjected to "racism or ethnicity-based discrimination" (Longman, Marcellin, Bauer & Scheim, 2013). Subsequent analyses indicated that "increases in experience of one type of discrimination had strongest effects on HIV risk when coupled with high levels of the other" (Longman et al., 2013).

Mediating Variables

Experiences of sexual and gender minority victimization are believed to mediate a variety of internalizing and externalizing behaviours indicative of psychological distress. Numerous authors analyzing this relationship have endorsed Meyer's minority stress model, identifying exposure to violence, harassment and discrimination to enhance risks of depression, anxiety, suicidality, self-harm behaviours and substance use. (Almeida et al., 2009; Toomey et al., 2010; Kelleher, 2009; Goldbach, Tanner-Smith, Bagwell & Dunlap, 2014; Burton et al., 2013). The precise nature of these relationships, however, has not been easily quantifiable.

While the majority of research has emphatically identified direct relationships between victimization and the aforementioned concerns, some studies have found no independent associations. This is likely attributable to:

1. The use of different measures across studies to analyze victimization experiences, depression, suicidality and risk behaviours (i.e. externalizing behaviours) (Collier et al., 2014)
2. Heterogeneous study samples, including those of distinct ages and demographic backgrounds (Collier et al., 2014)

Alternatively, Busseri, Willoughby, Chalmers & Bogaert (2008) have suggested an indirect relationship between experiences of harassment, violence and discrimination and the "higher levels of risk behavior observed in sexual-minority youth" (cited in Collier et al., 2014). That is, rather than directly impacting risk behaviour, the aforementioned experiences may function as a mediating variable impacting other dimensions of well-being, which may manifest in both internalizing and externalizing symptoms and/or behaviours (Collier et al., 2014).

Of the studies offering support to both direct and indirect relationships, Burton et al. (2013) used longitudinal mediation models to explore the influence of perceived discrimination on mental health disparities in self-identified lesbian, gay and bisexual youth, finding that sexual minority youth were nearly twice as likely to report suicidal ideation and more than three times as likely to report suicide attempts as their heterosexual peers. Further, according to Russell et al. (2011) "SMY [sexual minority youth] who experience higher levels of victimization are 2.6 times more likely to report depression and 5.6 times more likely to attempt suicide than SMY who experience lower levels of victimization", leading the authors of the former study to conclude that " elevated levels of sexual minority-specific victimization are partly responsible for the higher prevalence of depressive symptoms and suicidality in SMY" (Burton et al., 2013). Interestingly, several authors have suggested that gender and sexual minority adolescents evince more adverse health outcomes than non-gender and sexual minority youth victimized with the same frequency, indicating that the attribution of these experiences to gender or sexual minority status further increases the likelihood of psychological distress, thereby adding further support to Meyer's model (Birkett et al., 2009; Bontempo & D'Augelli, 2002; Espelage et al., 2008).

The same relationship appears to be present in gender minority experiences of victimization. Baiocco et al. (2010) found the relationship between gender non-conformity and depression to be mediated by experiences of school victimization, while an additional study noted that school victimization mediated the relationship between gender non-conformity and life satisfaction (Toomey et al., 2010).

If, as established above, gender minority individuals are more likely to experience discrimination, harassment and violence, and these experiences mediate psycho-social distress, it necessarily follows that gender minority youth are at greater risk of

adverse health outcomes when compared to both cisgender sexual minority and cisgender heterosexual youth. This is reflected in statistics quantifying psycho-social distress in gender minority communities, including:

- A 2010 study by Nuttbrock et al, which found that experiences of interpersonal violence, particularly during childhood and adolescence, "correlated with high rates of depression and suicidal ideation among MTF transgender persons"
- An analysis of independent predictors of attempted suicide among 515 transgender respondents in San Francisco, which found both gender minority discrimination and victimization to be "independently associated with attempted suicide" (Clements-Nolle, Marx, & Katz, 2006)

Finally, several authors report findings offering preliminary indications that substance use in gender and sexual minority communities may be attributable to experiences of violence and discrimination (Clements-Nolle et al., 2006; Bradford et al., 2013; Burton et al., 2013; Collier et al., 2013). Although not all authors tested the mediating relationships and causality cannot therefore be inferred, this data strongly suggests that victimization experiences can be correlated with substance use. For example, a meta-analysis of 15 studies exploring sexual minority stress and substance use among adolescents found that while available evidence could not substantiate a direct relationship between "sexual identity distress" and substance use, the authors did conclude that "both general measures of stress, as well as gay-related stress, were significantly and positively correlated with substance use among LGB youth", as well as identifying a "significant mean correlation between gay-related victimization (e.g., homophobic teasing) and substance use" (Goldbach et al., 2014). As well, a cross-sectional survey conducted at a youth (13-24) LGBT festival in Australia found that of the 98% of respondents who reported experiencing sexual or gender minority related violence or discrimination, 58% reported that these experiences had impacted their alcohol or drug use (Kelly, Davis, & Schlesinger, 2014).

This relationship appears to persist among gender minority individuals. Specifically, the National Transgender Discrimination Survey reported that while the National Institutes of Health estimated that only 7.3% of the general public will report a current or past dependence on alcohol and 1.7% abuses or is dependent on non-prescription drugs, 8% of survey participants reported currently using alcohol or drugs specifically to cope with the mistreatment they experienced as a result of being transgender or gender non-conforming (Grant et al., 2011). 18% also stated that they had done so previously, but did not report a current problem. Further, because this study asked only about use initiated specifically in response to maltreatment, general rates AOD use in these communities are likely significantly higher (see Section 2). As well, respondents who reported that they had been physically assaulted due to their gender minority status also endorsed increased rates of current alcohol or drug misuse (15%), as did those who reported being sexually assaulted for the same reason (16%) (Grant et al., 2011). These findings

appear to be more pronounced among transwomen, who, in a 2012 assessment of substance use risk factors, indicated a correlation between familial rejection and AOD use. Specifically, 32% of those indicating that had experienced rejection from their families also endorsed the use of alcohol or other drugs, while 19% of those who had experienced no such rejection reported use (Wolf & Dew, 2012).

As well, because there appears to be a relationship between the age at which individuals express gender variance and the severity of the mistreatment they experience – to the extent that younger individuals experienced more severe mistreatment – one could again expect elevated rates of harassment, discrimination and violence (and consequent substance use) among gender minority adolescents (D'Augelli, Grossman, & Starks, 2008). It is assumed that among both gender and sexual minority adolescents "a young person who is able to articulate their LGBT identity may have already 'come out' and been exposed to the negative impacts of homophobia, contributing to increased levels of AOD use" (Kelly et al., 2014). Substantiating this, Lombardi (2007) found that not only did participants endorsing a current problem with alcohol or drugs report higher levels of transphobic events in the past year, but, further, according to an analysis of the same data-set performed in 2009, "greater experiences of lifetime and past year transphobic events were correlated with the stress people experienced from transphobia" (Lombardi, 2009).

Stigma Consciousness

Comparatively little has been written regarding the relationship between anticipated maltreatment – grounded in an awareness of one's social position as a sexual or gender minority – and psycho-social distress. In one of the few studies to analyze this correlation, Kelleher (2009) found that "the greater the young person's expectation for rejection based on their sexual/gender identity, the more likely they are to report symptoms of anxiety, depression, and suicide ideation". These results substantiated earlier findings reported by Lewis, Derlega, Griffin and Krowinski (2003), in which perceived stigma was positively associated with symptoms of depression among lesbians and gay men (cited in Kelleher, 2009).

2 c) Internalized Heterosexism

According to Cochran & Cauce (2006), "the most prevalent explanation of the link between substance abuse and LGBT status is internalized homophobia [heterosexism]", or, alternatively, internalized cissexism. The third component of Minority Stress Theory posited by Meyer (1995), internalized heterosexism and cissexism, refers to the process by which a particular culture's negative beliefs regarding sexual or gender minority identities are assimilated into LGBTTQQ2SIA individuals' perceptions of themselves. Those internalizing these ideas are apt to experience shame, guilt and consequent psychological distress (Barbara, 2002). Thereby, "stress can be considered the mediator in the relationship between social structure/status and addictive behaviours among people who belong to stigmatized minority groups", and, further, is often assumed to be responsible for "the most

insidious effects of the minority stress processes upon the individual" (Baiocco, 2010). On this basis, increased levels of internalized heterosexism and cissexism are hypothesized to "correlate positively with substance abuse" in gender and sexual minority individuals (Cochran & Cauce, 2006).

In substance abuse literature, Kus (1988) appears to have been the first to posit a relationship between internalized heterosexism and high rates of alcohol abuse in gay men, conducting qualitative interviews with 20 sexual minority men in recovery from alcoholism. His findings, although not definitive, offered anecdotal evidence of the aforementioned relationship. However, although "popularly assumed" , the phenomenon has not yet been confirmed to account, in its entirety, for the elevated rates of alcohol and drug use in sexual and gender minority communities (Brubaker et al. 2009).

A 2009 methodological review of the relationship between IH and substance abuse among lesbian, gay and bisexual individuals identified 4 studies conducted between 2004 and 2010, of which 2 offer clear support, 1 offers partial support, and 1 no support (of the relationship) (Brubaker et al., 2009). Of those studies providing support to this theory, the first, researching HIV risk factors in 80 gay and bisexual men in New York, found "a positive link between IH and substance abuse mediated by symptoms of anxiety" (Rosario, Schrimshaw, & Hunter, 2006, cited in Brubaker et al., 2009). That is, while IH did not "directly positively correlate with substance abuse", pathway analysis demonstrated that "anxiety played a strong mediating role between these variables", to the extent that those with positive views of homo- and bisexuality exhibited fewer symptoms of anxiety, and that these individuals had lower rates of substance abuse (Brubaker et al., 2009). In 2008, Weber surveyed 824 self-identified lesbian, gay and bisexual individuals, finding " modest positive correlations between IH and alcohol abuse", as well as a small but "statistically significant, positive correlation between IH and drug abuse" (Brubaker et al., 2009). In both of the above-mentioned studies, sexual identity was limited to self-identification.

Of the studies demonstrating partial and no support, both were conducted by Amadio in 2006 and 2004 respectively. The former study revealed a statistically significant relationship between IH and heavy drinking among lesbian women but not among gay men, while the latter, surprisingly, identified a "statistically significant inverse relationship between IH and lifetime alcohol, marijuana, and cigarette use among women in their study". In both instances, however, convenience samples were recruited at Gay Pride festivities in two American cities, severely limiting the generalizability of these findings (Brubaker et al., 2009).

Therefore, despite the probable correlation between internalized heterosexism and substance abuse, as well as its continued invocation in academic literature, this relationship has yet to be empirically established. It is important to note, however, that Rosario's 2006 study providing support to the relationship between IH and substance abuse was the sole survey utilizing a youth sample, potentially indicating

that this correlation is more pronounced in youth populations. As summarized above, this coheres with young people's increased exposure to additional forms of minority stress, including violence, harassment and discrimination.

None of the studies summarized above, however, explore the experiences of gender minority individuals. Although included in Weber's study if they endorsed a sexual minority identity, the author stipulated that “transgender individuals may have unique experiences with bias and discrimination”, suggesting that these findings cannot be generalized to include gender minority populations (Weber, 2008).

Unfortunately, studies examining internalized cissexism and substance abuse have been effectively non-existent. Some researchers, however, have documented results indicating a potential correlation between internalized cissexism and substance abuse. Surveying 327 transgender women of colour in San Francisco, Sugano, Nemoto & Operario (2006) found self-esteem to be negatively correlated with exposure to transphobia, which may mediate rates of substance abuse. As well, individuals endorsing depressive symptoms had higher levels of exposure to transphobia, and, among participants 18-25, “those reporting higher levels of exposure to transphobia had a 3.2 times higher risk for engaging in URAI compared to those reporting lower levels” (Brubaker et al., 2009).

Indigenous Gender and Sexual Minorities

As a result of the colonial state in which indigenous communities currently live, experiences of victimization must be appropriately contextualized to avoid diminishing the importance of on-going structural violence with which these populations must contend (Simoni, Walters, Balsam, & Meyers, 2006; Burks, Robbins, & Durtschi, 2011; Scheim et al., 2013). Therefore, although we may assume that similar correlations between victimization and AOD use to be present within indigenous gender and sexual minority communities, subsuming these populations in the study samples referenced above would not be culturally appropriate.

Although indigenous communities have historically held positive attitudes towards gender and sexual minority behaviours and identities, “colonizing practices and missionary efforts have shifted traditional attitudes about sexual-minority people in many communities”. (Canadian Centre on Substance Abuse, 2007). The stigmatization of gender and sexual minorities as non-normative identities must be conceptualized as a colonial imposition, the legacy of which is reflected in high rates of victimization and AOD use among indigenous gender and sexual minority populations. Ample evidence suggests that “gender-diverse and two-spirit people were particular targets of violence in Canada’s history of colonization, due to the challenge they posed to European Christian worldviews” (Scheim et al., 2013), and Smith (2005) has established a correlation between the imposition of binary sex and gender categories as integral to the process of colonization.

Further, because "patterns in the prevalence of disease mirror broader patterns of social and economic inequity" among indigenous populations, colonization must be viewed " as a key determinant of health for Aboriginal communities" (Scheim et al., 2013). Among myriad historical indignities, indigenous communities in Canada have been "displaced from their lands, separated from their cultural traditions and languages, and forcibly removed from their families and communities through residential schools and the child welfare system" (Scheim et al., 2013). These atrocities are perpetuated by on-going structural violence ("and inequity"), necessitating that statistics regarding AOD use, victimization, and poverty be viewed from the perspective of on-going experiences of colonization (Simoni et al., 2006; Scheim et al., 2013).

Among indigenous participants in the 2010 Trans PULSE Project, 73% had experienced violence attributable to their gender minority status, 90 % had experienced transphobia, and 76% had contemplated suicide. Further, a 2011 study of the victimization experiences of two-spirit men found reported lifetime prevalence of both physical and sexual assault to be substantially higher than those indicated by non-indigenous sexual minority respondents (Walters, Simoni & Howarth, 2001, cited in Simoni et al., 2013). Similarly, a survey of HIV risk behaviours among indigenous gender and sexual minority men in New York City identified the "only significant correlates" of lifetime HIV risk behaviours as:

1. Experiences of victimization; and
2. Endorsing a two-spirit rather than heterosexual identity. (Simoni et al., 2013)

If, as described above, victimization mediates substance use among non-indigenous gender and sexual minority populations, the same processes are likely active among indigenous communities as well. Therefore, by virtue of increased exposure to both physical and cultural violence, indigenous gender and sexual minority youth likely experience heightened risk for AOD use.

3. Barriers to Service Access

Although it is generally assumed that gender and sexual minority individuals face significant barriers to service access, relatively few studies have empirically examined this idea. Research surveying substance use treatment seeking and service utilization among these populations are relatively rare, as gender and sexual identity are not habitually recorded by drug treatment services (Lea et al., 2013b). Contextually, however, there is sufficient information regarding the rate at which gender and sexual minorities access substance use services, as well as barriers endorsed in soliciting health services generally, to discern the primary impediments to treatment access among these populations.

3a) Proportion Accessing Services

In 2002, Finnegan & McNally estimated the percentage of clients in “mainstream” (i.e. those without gender or sexual minority-specific groups or program content) treatment programs to be approximately 1% (cited in Rowan & Faul, 2011). Similarly, in their 2006 study of LGBT clients receiving publicly funded treatment in Washington State utilizing information derived from the TARGET Database (a digital reporting system for publicly funded substance use services utilized by approximately 525 agencies), Cochran & Cauce identified an LGBT subset of 2.46%, or 269 of the 24,792 people in the entire study sample. Considering the elevated rates of substance use in sexual and gender-minority communities, these statistics are indicative of an under-utilization of services.

Additionally, a 2010 online survey of sexual minority youth ages 18 – 25 found that only 6% of their 572 respondents had sought treatment, despite exhibiting a 70% frequency of AUDIT-C scores indicative of hazardous alcohol use. Comparatively, 22% of an Australian population sample with alcohol use disorder reported accessing treatment (Lea et al., 2013b).

3b) Barriers Endorsed

In his 2007 analysis on sexuality, gender identity, social bias and mental health, Burgess found that gender and sexual minority respondents were more likely to indicate a need for mental health care services, and more frequently endorsed not having accessed services when compared to non-gender and sexual minority participants. Burgess further identified gender minority respondents as the most under-served sub-population. His research indicates that experiences of discrimination, in addition to being a life stressor that likely precipitates significant psycho-social distress, also increases the likelihood that individuals will avoid seeking needed mental health care services. That is, discriminatory experiences may bring about expectations of institutional degradation in historically marginalized demographics, thus rendering them loathe to expose themselves to anticipated maltreatment.

Gender minority youth may report additional barriers unique to their social positioning, as well as increased exposure to discrimination in service provision contexts. Significantly, results from the Virginia Transgender Health Initiative Study identified health care as the most common context in which discrimination was reported (Bradford et al., 2013). This survey also found that racial minority respondents recorded increased odds of discrimination. As well, 28% of those participating in the National Transgender Discrimination Survey reported postponing medical care when they were sick or injured due to discrimination (Grant et al., 2011. An equivalent percentage reported experiencing harassment in medical settings, while 19% indicated that they were refused care due to their gender minority status. The survey also found that the likelihood of experiencing discrimination increased when providers were aware of the respondent's gender minority identity.

Finally, a survey of transgender patient perceptions of stigma in health care contexts identified previous negative experiences with healthcare, fear of treatment and stigma concerns to be the most frequently endorsed barriers related to seeking mental health services. Respondents' descriptions of maltreatment "coalesced around 6 themes: gender insensitivity, displays of discomfort, denied services, substandard care, verbal abuse, and forced care" and "71% of the sample reported at least one instance of mistreatment in health care contexts" (Kosenko, Rintamaki, Raney & Maness, 2013).

Although the majority of research has explored explicit experiences of discrimination and/or violence and their impact on service access, these may not be the sole barriers with which gender minority populations must contend. Specifically, the utilization of gender as an administrative category to structure service access may create additional vulnerability for those whose identities do not correspond to these assumptions (Spade, 2011). This is particularly relevant to substance use treatment, in which programs are frequently segregated according to sex. Gender minority individuals attempting to access these services may encounter institutions whose admission policies and program streams do not accommodate their unique subjectivities.

The problem, according to Hartley and Whittle (2003), "lies with the uncritical use of sexed and gendered categories in the development of services and policy issues." Although the influence of these organizational classifications has not yet been studied, it is unlikely that individuals will access services that do not appear to acknowledge their identities, and that they may assume that these environments will be manifestly unsafe.

Indigenous Gender and Sexual Minority Populations

Indigenous gender and sexual minority populations probably face additional barriers to health care access. Beyond the barriers explicitly related to gender and/or sexual minority status (noted above), indigenous communities may be legitimately distrustful of governmental organizations/services, and experience the marginalization of indigenist health practices in modern medical contexts (Burks, Robbins, & Durtschi, 2011).

Among indigenous Trans Pulse respondents, 61% reported at least one unmet health care need within the previous year, with a substantial proportion of participants indicating that they required, but were unable to obtain addiction services during the same period (Longman Marcellin et al., 2013). Similarly, participants in a 2011 survey of HIV risk factors among sexual minority American Indian men endorsed "mistrust of the current healthcare system" as one of the primary barriers to service access (Burks et al., 2011).

4. Experiences in Service Provision Contexts

Significant concern has been expressed regarding the substance use treatment experiences of gender and sexual minority clients. Gender and sexual minority clients have consistently been found to have poor treatment outcomes, including lower levels of abstinence (when required) and program completion, when compared to heterosexual and cisgender populations (Cochran & Cauce, 2006; Senreich, 2009, 2010a, 2010b & 2011; Lea et al., 2013b).

Several authors have suggested that treatment environments may replicate hetero- and cissexist social dynamics on both institutional and interpersonal levels (Cochran & Cauce, 2006; Senreich, 2009, 2010a, 2010b & 2011; Lea et al., 2013b). This may manifest in in homo- bi- queer- or transphobic comments from treatment staff and/or peers, and may culminate in explicit acts of violence (Lombardi, 2009). In a survey of treatment providers' attitudes toward LGBT individuals among a sample of 46 substance abuse treatment counselors, "15.2% believed that substance abuse treatment was more effective for heterosexuals, 26.1% found it difficult to relate to the specific problems that LGBT individuals present in treatment, and 17.4% believed all clients should see the nuclear family as the ideal social unit" (Cochran, Peavy, & Cauce, 2007). To the extent that AOD use in gender and sexual minority communities may be evidence of adaptive coping in response to social maltreatment, these environments may reinforce rather than ameliorate these behaviours.

The literature also reveals that treatment counselors in 'mainstream' (i.e. those without culturally specific program content) programs will not have received sufficient training in gender and sexual minority-specific care, and will therefore not provide adequate support to gender and sexual minority clients (Senreich, 2010b). If, ultimately, there are culturally specific reasons as to why gender and sexual minority individuals use substances, these issues must necessarily be addressed in treatment environments if interventions are to be successful.

Surveying the gender and sexual minority awareness of substance use treatment providers in Chicago, Eliason & Hughes (2004) found a dearth of expertise. 56% of respondents reported little to no familiarity with gender and sexual minority-specific familial issues, 47% lacked knowledge of internalized homophobia, and 38% were unfamiliar with the 'coming out process'. This is particularly troubling, as several authors have suggested correlations between counsellor knowledge base and client satisfaction (Israel et al., 2008; Rachlin, 2002). Corliss, Beizer, Forbes & Wilson (2007) found, in a qualitative study of health and social service utilization among 18 transgender youth, that negative experiences of service provision were associated with providers perceived to lack understanding of transgender issues and a lack of validation of participant identities.

Consequently, it is inferred that in the presence of hetero- and cissexist social norms, and lacking culturally relevant support, gender and sexual minority clients will not feel sufficiently comfortable to address the issues that precipitated their substance use (Senreich, 2010a). Experiences of gender and sexual minority specific maltreatment constitute significant traumas, and thus necessitate the implementation of specific coping mechanisms. Such responses, of which substance use is one, may be either productive or destructive. Consequently, it is imperative that these experiences and their ramifications be addressed in the therapeutic context. However, when such traumas are incurred in the clinical environment, their resolution becomes an impossibility.

Additionally, several authors have noted the tendency of substance use treatment providers to individualize the issues with which clients present in treatment. This propensity may be especially pronounced within facilities adhering to the disease model of addiction, in which substance use disorders are viewed as “primary” (i.e. they are not caused by anything else) (Klein, & Ross, 2014). This perspective, often utilized to encourage personal accountability, may ultimately obscure the genesis of victimization experiences embedded in larger social contexts. Eliason (1996) noted that human service providers are often trained in “equal treatment” models of care. That is, they are instructed to regard each client as isolated individuals in need of repair, with no consideration of contextual factors that may influence substance use (cited in Eliason & Hughes, 2004).

Therefore, treatment programs often address individual deficiencies without regard for the larger social context. Despite the “growing recognition that substance user and misuser treatment models based on the experiences of white, heterosexual men have limited applicability to many types of clients”, many treatment facilities lack training in cultural competence and fail to address the distinct intersections of marginalized identities (Eliason & Hughes, 2004). This may be especially dangerous for gender and sexual minority populations, whose experiences of substance use are often correlated with socially sanctioned exposure to harassment, violence and discrimination. According to Eliason and Hughes “this model minimizes group and individual differences”, and, although there may be some value in the recognition of shared experiences habitually promoted in treatment environments, “being a ''substance abuser' does not override the social inequalities created by racism, sexism, classism, and heterosexism” (Eliason & Hughes, 2004).

Several studies over the past decade have evaluated the differential substance use treatment experiences of gender and sexual minority populations. Utilizing a convenience sample of 120 gay, lesbian and bisexual former clients of traditional substance abuse programs (including outpatient, residential, inpatient and methadone maintenance programs), Senreich (2009) compared the perceptions, reported abstinence and completion rates of lesbian, gay, bisexual, and heterosexual clients in substance abuse treatment, finding that:

- Gay and bisexual respondents of both genders had lower mean scores for all four perception variables (feelings of connection, therapeutic support, ability to be open/honest, treatment satisfaction) than heterosexual respondents
- Gay/bisexual respondents were significantly less likely to have completed treatment and more likely to have left treatment due to their needs not being met or their being discharged
- Being gay/bisexual was a significant negative predictor of both "abstinence at end of treatment" and "current abstinence"
- Gay and bisexual men reported the lowest abstinence rates at the end of treatment and at the current time (approximately 50% and 58% respectively) of any cohort, including lesbian and bisexual women
- In open-ended responses, 57% of participants reported that their sexual minority identity negatively impacted their treatment experiences. Four central themes emerged: experiencing homophobia from heterosexual clients, difficulty being honest and open about gay/bisexual issues, feeling vulnerable and unsafe, and feeling alienated and not understood"

Similarly, a 2010 comparison treatment experiences of gay and bisexual men in traditional treatment programs, gay and bisexual men in culturally specific treatment, and heterosexual men in traditional treatment found that:

- Heterosexual men and gay/bisexual men in LGBT specialized treatment had more favorable results than did gay/bisexual men in traditional programs
- No significant differences in abstinence rates existed between heterosexual men and gay/bisexual men in LGBT specialized treatment
- Heterosexual men were significantly more likely to report that they had completed treatment than were gay/bisexual men in traditional treatment, but there were no significant differences in completion rates between heterosexual men and gay/bisexual men in LGBT specialized treatment (Senreich, 2010b)

The presence of disparities in treatment experiences and outcomes between gay/bisexual men in traditional treatment but not between gay/bisexual men in culturally specific treatment and heterosexual men in traditional treatment is likely indicative of the efficacy of culturally specific program components.

Further, in a qualitative study of 3 lesbian women and 10 gay men who attended substance abuse treatment programs in Ontario, respondents endorsed six themes in relation to their treatment experiences: "feelings of isolation, feelings of not being understood by staff and clients, fear of being open about their sexual orientation, having their sexual issues ignored, hearing hurtful comments by both staff and clients regarding their sexual orientation, and being the recipient of hurtful actions (including physical abuse)." Respondents also endorsed the development of LGBT-specific programming for substance use (Cullen, 2004).

As is evident in the above-mentioned studies, the majority of research evaluating treatment experiences of gender and sexual minority populations often centre on the experiences of gay and bisexual cisgendered males. Comparatively little research has explored the specific treatment needs of sexual minority women or gender minority populations. Interestingly, research indicates that sexual minority women are more likely than heterosexual women to seek treatment for alcohol and drug related issues. While this is an encouraging suggestion considering the elevated rates of alcohol and drug use among sexual minority women, it is surprising that they do not appear to be subject to the same deterrents as sexual minority men. This may be a function of their differential exposure to sexual minority-based victimization (see Section 3), but there is not sufficient research to substantiate this inference.

As well, relatively few studies have examined the substance use treatment experiences of gender minority populations. Even among sexual minority samples, several studies have explicitly excluded gender minority participants – stating that they were not the target of a particular project – while others have found gender minority samples to be too small "to conduct meaningful comparisons of transgender and cisgender individuals" (Flentje, Heck, & Sorensen, 2014). Existing research, however, indicates that low completion and abstinence rates, as well as negative treatment experiences, are prevalent among gender minority clients. Extracting data from a larger study examining the substance use treatment experiences of sexual minority clients, Senreich (2011) found that the 11 transgender participants reported significantly lower levels of feelings of therapeutic support, connectedness and satisfaction with treatment when compared to both cisgender and sexual minority respondents. Similarly, transgender participants reported less than half the rates of current abstinence and treatment completion than cisgender and sexual minority respondents. In open-ended questions, several gender minority respondents stated that their treatment experiences "made me (feel) isolated and afraid" and were "not helpful because I was not able to be totally honest about my personal problems" (Senreich, 2011).

And, perhaps most disturbingly, a US study conducted in 2008 surveying the residential treatment experiences of 90 transgender participants found that:

- 20% reported being verbally abused by treatment staff
- 11.8% had been physically assaulted by fellow clients
- 33% reported being prevented from discussing trans issues
- 60% reported being required to use inappropriate sleeping and shower areas

Respondents indicated that they were more frequently victimized/harassed by treatment staff than fellow clients or participants in self-help programs. A subsequent statistical analysis revealed that a greater number of transphobic encounters with treatment staff was associated with drug use within the past 30 days (Lombardi, 2007).

There remains some controversy regarding the relationship between disclosure of sexual identity in treatment contexts and consequent success therein. Typically, authors endorsing concerns regarding sexual and gender minority experiences in substance use treatment suggest that these clients will not feel sufficiently comfortable in disclosing their sexual and/or gender identities, and will therefore report lower levels of treatment satisfaction and program completion. Although apparently self-evident, this correlation has not been adequately documented in the literature. Several recent studies have, in fact, recorded no relationship between "honesty and openness" and reported abstinence (Senreich, 2009 & 2010a). Habitually, the absence of disclosure is assumed to be associated with the presence of internalized heterosexism, such that those who opt not to disclose their sexual or gender identities are thought to experience increased shame and guilt associated with those identities. Disclosure, therefore, is presumed to be integral to the establishment gender and sexual minority identities, and posited to enhance emotional well-being. Several studies, however, have documented a positive correlation between disclosure and AOD use (Rosario, 2006). A 2005 study of young (18-22) sexual minority men, for, example, found that "respondents who had disclosed their sexuality to all or most of their family members were also at greater risk for recent club drug use" (Kipke et al., 2007).

In 2009, however, Rosario, Schrimshaw, & Hunter, undertook a more thorough examination of the relationship between disclosure of sexual orientation and subsequent substance use among lesbian, gay, and bisexual youth. Utilizing a longitudinal analysis to analyze the results of a survey of 156 LGB youth ages 14-21, they found that:

- The number of people to whom youth disclosed their sexual orientation was not associated with substance use
- The number of rejecting reactions to disclosure were positively correlated with substance use
- While accepting reactions were not directly related to substance use, "youth with more accepting reported a consistently low/moderate level of alcohol use, regardless of the number of rejecting reactions experienced"

The implications of this research are twofold, suggesting

a) That it is reactions to disclosure, rather than their volume, that impacts substance use
b) Accepting reactions may moderate the negative effects of rejecting reactions

Further, these reactions were demonstrated to have deleterious long-term effects, such that rejecting reactions prior to the commencement of the study were associated with substance use 3-4 years later.

Therefore, while habitually associated with increased shame and internalized heterosexism, the decision not to disclose one's sexual orientation "can be viewed

as adaptive under some circumstances". On this basis, researchers have suggested that the failure to disclose is "not an essential component of internalized homophobia" , and, further, that the reduction of internalized homophobia should be on self-acceptance rather than the promotion of disclosure (Brubaker et al., 2009).

While no studies have explicitly evaluated the relationship between internalized cissexism and substance use in gender minority communities, research has suggested correlations between peer and familial rejection and psychological distress. Among the participants in Ryan, Russell, Huebner, Diaz & Sanchez's 2010 study, those who "experienced parental rejection reported suicidal ideation and attempts three times higher than those who felt accepted by their parents" (cited in Ignatavicius, 2013). As well, "Family rejection correlated with a higher rate of AOD use (32%), whereas family acceptance correlated with a lower AOD rate (19%)" (Eliason, & Hughes, 2004). These implications, in fact, may be especially relevant to gender minority youth, who are disproportionately exposed to peer and familial rejection and/or violence. "In a study by Grossman and D'Augelli (2007), up to 73% of transgender youth experienced verbal abuse by their parents for their nonconforming gender expression, some of which occurred in front of others; and up to 36% of transgender youth experienced physical abuse by their parents" (Ignatavicius, 2013)

5. Recommendations

As evidenced by the articles reviewed above, gender and sexual minority youth soliciting support services related to AOD use are likely to present with treatment concerns distinct to those evinced by heterosexual and cisgender populations. Because, according to Rainbow Health Ontario, "substance use may be related to LGBT-specific stresses", it is necessary that culturally specific services be provided to this population. Indeed, several authors have indicated that "targeted interventions may be more effective than universal interventions in reducing substance use in this population" (Kelleher, 2009; Goldbach & Steiker 2011). Substantiating this, in each of the eight studies surveying the treatment experiences of gender and sexual minority clients, respondents indicated that they believed that the provision of culturally specific content would have enabled more effective interventions (Senreich, 2009, 2010a, 2010b, 2011 & 2012; Cullen, 2004; Cochran & Cauce, 2006: Lombardi, 2007).

Although gender and sexual minority individuals comprise a heterogeneous population, they will likely share certain experiences as a result of their marginalized identities (Cochran et al., 2007). Consequently, there are treatment considerations of which service providers developing interventions for these populations should be aware; the implications of these are summarized below.

Sexual Minority Clients

Following Meyer's Minority Stress Model described in Section 2, it is integral that substance use interventions developed for sexual minority populations address the impact of sexual minority-specific victimization and its correlates, as well as the potential presence of internalized heterosexism.

Due to the elevated rates of exposure to violence, harassment and discrimination, culturally appropriate programming should incorporate a trauma-informed framework that actively integrates the management of various psycho-social stresses into treatment planning. Clinicians should expect program participants to present with internalizing and externalizing behaviours consistent with exposure to sexual minority specific victimization, including depression, anxiety, self-harm and suicidality. This may be especially true of racialized sexual minority youth, who may use substances to cope with exposure to racism as well as heterosexism (Beatty, Madl-Young, & Bostwick, 2006; Finnegan & McNally, 2002; Senreich, 2012).

Further, as clients will likely continue to be at risk for ongoing experiences of victimization, “researchers have stressed the importance of substance abuse treatment for this population incorporating relapse prevention strategies that can counter these factors during and after treatment”. That is, because

a) Victimization has been found to mediate the relationship between sexual identity and substance use, and
b) Sexual minority clients are at increased risk of violence, harassment and discrimination, the experience of which is not contingent on levels of AOD use,

successful interventions must facilitate the development of alternative coping mechanisms (Senreich, 2012).

Additional attention must be given to alleviating internalized heterosexism, but providers must exercise caution in assuming the absence of sexual identity disclosure to be indicative of this phenomena. Several recent studies have, in fact, indicated that opting not to disclose one's sexual identity may be advantageous when disclosure reactions are likely to be negative (Brubaker et al., 2009; Rosario et al., 2009; Baiocco et al., 2010). As per Rosario et al.'s Disclosure Reaction Hypothesis, the number of negative reactions to disclosure is theorized to correlate positively with substance use (Rosario et al., 2009). In a service provision context, the implications of this theory are threefold, suggesting

a) That those soliciting services are more likely to have experienced negative disclosure reactions
b) That an internal acceptance of one's identity will manifest differently depending on the circumstances of the individual
c) That prioritizing disclosure as emblematic of self-acceptance may negatively impact clients' attainment of their recovery goals

Consequently, several authors have modified existing models of identity development, advocating that assuaging internalized heterosexism be focused on "self-acceptance rather than self-disclosure and membership identity" (Rosario et al., 2009).

Similarly, clients will likely have varying needs regarding familial relationships. While substance use treatment often emphasizes the importance of reconciling with one's family of origin, this may be not be feasible – or safe – for clients endorsing a sexual minority identity. Much has been written regarding the development of a "chosen family" among marginalized communities, through which the support assumed to be characteristic of biological relationships is replicated among non-kinship networks (Sugano et al., 2006; Baiocco et al., 2010; Ignatavicius, 2013; Flentje et al., 2014). Treatment providers, therefore, should validate non-traditional definitions of family, and incorporate these arrangements into the treatment planning process when possible. As well, because "connectedness with family has repeatedly been found to be highly protective against drug use" it is anticipated that many sexual minority individuals experiencing substance dependence are more likely to be alienated from their families of origin (Kipke et al., 2007).

Further, while research suggests that community connectedness may minimize risk of AOD use, increased involvement in sexual minority-specific licensed venues is also believed to augment risk for substance use (Lea et al., 2013a; Deacon, et al., 2013). It is therefore suggested that clinicians provide alternative means for service users to engage with their chosen communities, and develop relapse prevention strategies "targeting the relationship between the use of substances and social aspects of being gay, lesbian, or bisexual" (Senreich, 2010a).

Studies examining the mental health symptomatology of sexual minority clients accessing substance use treatment found this demographic to be more likely to endorse current or past treatment of mental health concerns when compared to heterosexual clients (Cochran & Cauce, 2006). Consequently, Cochran et al. (2007) suggested that " integrated mental health treatment could greatly augment the services being provided to LGB[T] clients in substance use treatment". This does not imply, however, that sexual minority identity is predictive of pathology; rather, it indicates that disproportionate exposure to psycho-social trauma may manifest in symptoms consistent with mental illness, and that the resolution of these concerns is integral to successful substance abuse treatment.

Gender Minority Clients

While gender minority individuals navigate similar experiences of victimization, these communities are subject to increased social marginalization, and therefore experience more adverse health outcomes. Consequently, these populations are more likely to exhibit mental health symptoms, the presence of which "does not necessarily indicate chronic mental health issues." Rather, these tendencies are

likely the cumulative result of myriad psycho-social stresses, and, “in the overwhelming majority of cases, mental health symptoms have psychosocial causes” (Bockting, Knudson, & Goldberg, 2006). On this basis, successful interventions with gender minority individuals “require[s] an understanding of the multifactoral issues that commonly drive transgender individuals’ addiction”, including “attempted suppression of transgender feelings, management of historical violence/trauma, self-medication for physical or mental illness” (Bockting et al., 2006).

Successful counselling of gender minority substance abusers necessarily involves viewing gender difference as “an integral part of the client’s identity, not as pathology” (Pazos, 1999). Therefore, effective therapeutic support must acknowledge the client’s inalienable right to self-determination. Practically, this involves the validation of any form of gender variance expressed by the client as manifest in a demeanour that is “respectful, sensitive, accepting, affirming, empathic, compassionate, and supportive” (Raj, 2002).

Those developing interventions for these populations should also be aware that those actively espousing a gender minority identity are likely at increased risk of victimization (Bradford et al., 2013). This, to some extent, constitutes a central difficulty in navigating gender minority experiences: while identity affirmation and connectedness to a gender minority community are cited as “critical factors in mental health functioning”, the social expression of that identity elevates one's risk of victimization (Blumenstein, Nuttbrock, & Rosenblum, 2002). Encapsulating this contradiction, Blumenstein et al. (2002) suggest that although “affective symptomatology in this population is viewed as significantly affected by the extent to which transgender identity is successfully incorporated into social relationships”, a 2009 study by Lombardi inferred that the number of friends to whom participants had disclosed a gender minority identity was positively correlated with exposure to “transphobic events”.

Therefore, while actively affirmation their clients' gender identities, clinicians must also incorporate the development of specific coping strategies to be employed in response to experiences of victimization. Programs should additionally emphasize the cultivation of protective and resilience factors, including:

- Pride, in one's gender identities
- The “ability to identify, acknowledge, and assertively navigate through instances of discrimination”
- Access to community organizations and support groups (Ignatavicius, 2013)

Similarly, in their qualitative study of transgender resilience, Singh, Hays and Watson (2011) identified seven central themes endorsed by participants, recommending that they be utilized to develop interventions for gender minority populations: “(a) evolving a self-generated definition of self, (b) embracing self-

worth, (c) awareness of oppression, (d) community support, (e) cultivating hope, (f) social activism, and (g) being a positive role model" (cited in Wolf & Dew, 2012).

Further, although some youth may be "clear about the level of medical intervention they require" others may be actively navigating alternative approaches while attempting to address their AOD use (Bockting et al., 2006). Wolf and Dew (2012) therefore suggest that the "administration of hormones...be incorporated into long-term treatment planning." Some concern has been expressed, however, that therapists assuming a dual role as counsellor and 'gatekeeper' may negatively impact the quality of the therapeutic relationship (Hunt, 2014). It is therefore recommended that a psychiatrist "be part of a multidisciplinary treatment team", ensuring that program participants retain access to necessary medical care without impeding their ability to engage with those providing support related to AOD use (Corliss et al., 2007).

Regarding familial relationships, several authors have suggested that "transgender individuals may also be more reliant than cisgender individuals on communities that are non-family", as gender minority populations evince high rates of rejection from their families of origin (Cochran & Cauce, 2006; Factor & Rothblum, 2008; Grant et al., 2011). Notably, results from an epidemiological study of transgender women of colour in San Francisco revealed that 54% of respondents reported moving away from their families as a result of responses to their gender identities, "suggesting separation from traditional sources of social support" (Sugano et al., 2006). Similarly, a 2007 study by Grossman and D'Augelli found that 73% of gender minority youth were verbally abused by parents unsupportive of their gender minority status, while 36% reported experiences of physical abuse. In addition to acknowledging the legitimacy of non-tradition family arrangements, providers must also be aware of the impact that these losses may have on self-esteem and depressive symptomatology. Namely, participants in a 2010 study by Ryan, Russell, Huebner, Diaz, & Sanchez who experienced parental rejection "reported suicidal ideation and attempts three times higher than those who felt accepted by their parents" (cited in Ignatavicius, 2013).

Several authors have indicated additional concerns with which gender minority individuals may present when soliciting counseling services (Goldberg & Lindenberg, 2004; Bockting et al., 2006; de Vries, Cohen-Kettenis, Delemarre-van de Waal, White Holman, & Goldberg, 2006). Although it may not be feasible to address all of these concerns in the context of substance abuse interventions, providers should be aware of the psycho-social issues with which gender minority individuals must contend, and integrate their resolution into long term treatment planning:

- Gender dysphoria and body image issues
- Marginalization in a variety of social spheres, including employment, housing, education and interpersonal relationships
- Disclosure of transgender status to relationship partners

- Cumulative grief and loss of familial relationships, friendships, and separation from ethnocultural/religious communities
- Low self-esteem and social isolation resultant of suppression of transgender feelings

Additionally, because gender minority individuals have documented rates of HIV infection substantially higher than those reported in the general population, it is quite possible that gender minority clients may present with specific health care needs. Participants in the 2011 National Transgender Discrimination Survey reported a rate of HIV infection 4 times higher than that documented in the general population (Grant et al., 2011). Elevated rates, however, appear to be exclusive to transwomen, as transmen reported rates .51% lower than the general population. Similarly, in their 2008 meta-analysis of HIV prevention literature, Herbst et al. found an aggregated infection rate of 11.8% across 29 studies, with substantially higher rates evinced by studies that provided HIV testing to respondents. In these instances, MTFs recorded an aggregated infection rate of 27.7%. Additionally, these rates are substantially higher among racial and ethnic minority populations, with 24.9% of African-Americans, 10.92% of Latino/as, 7.04% of American Indians, and 3.70% of Asian-Americans participating in the National Transgender Discrimination Survey reporting being HIV positive (Grant et al., 2011). Comparatively, estimated infection rates in the general American population are t2.4% for African Americans, .08% Latino/as, and .01% Asian Americans.

Insidious Trauma and Microaggressions

While the majority of the research discussed above has emphasized psychological distress as a correlate of exposure to explicit instances of violence and discrimination, this framework may be insufficient when describing the marginalization of gender minority populations. When discussing the psycho-social trauma experienced by gender minority individuals, researchers habitually conceptualize trauma according to the DSM-4 Criterion A definition of a 'stressor', in which:

“The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence” (American Psychiatric Association, 2000).

Although explicit incidents of gender minority- specific violence are undoubtedly important, this model is, of itself, a limited conception whose exclusive emphasis on intentional, individualized negative action ultimately obscures structural cissexism. That is, while equating gender minority marginalization with transphobia may be useful in understanding the motivations underlying the actions of individuals, the tendency to prioritize the effects of individual acts has contributed to the obscuration of the more systemic nature of gender minority marginalization.

On this basis, critical trauma theorists are re-conceptualizing oppression as traumatic, emphasizing that when working with historically marginalized populations the assumption that a person has experienced trauma only if they have been subject to or witnessed a physical violation is unnecessarily narrow, as it does not describe the effects of repetitive structural violence and victimization. (Burstow, 2003) An alternative framework emerging from the field of ethnic minority psychology, Insidious Trauma posits that the insults of daily life, taken cumulatively in the lives of members of marginalized groups, constitute a traumatic stressor for those populations (Burstow, 2003; Bryant-Davis & Ocampo, 2005; Bryant-Davis 2007; Edmund & Bland, 2011). Thereby, rather than limiting the definition of a traumatic stressor to a single event or experience, Insidious Trauma suggests that repeated exposure to micro-aggressions – the brief, subtle, everyday and often non-verbal exchanges that send denigrating messages to members of marginalized groups – may cause the insidiously traumatized person to develop symptoms of post-traumatic stress when the apparent psychosocial stressor appears relatively small and non-threatening (Bryant-Davis, 2007). Specifically, a 2010 study of nearly 7,000 youth ages 9-16 by Copeland Keeler, Angold, & Costello found that 47.9% of the low-magnitude stressors (including moving to a new home and the loss of a friendship or romantic relationship) reported by participants were related to subclinical symptoms of PTSD (cited in Ignatavicius, 2013).

This may be relevant to the stigma awareness described by Meyer as the second component of minority stress. As stated by Danieli (1998):

“In oppressed communities, trans-generational trauma is the norm....The trauma is historical in the sense that it is attached to historical events and conditions. Historical trauma arises from identity and shapes identity, and it is the lens through which current events are understood and current trauma experienced” (cited in Burstow, 2003)

Therefore, if identity development is a process “where individuals’ narration of their personal experiences interacts with, and becomes anchored by, larger conceptualizations of what it means to be a member of a sexual minority within society”, then the awareness of social stigmatization develop therein may lead those endorsing marginal identities to anticipate social maltreatment.

Although this maltreatment may be experienced as physical violence and interpersonal harassment or discrimination, the identities of gender minority individuals are also implicitly invalidated by social systems that do not acknowledge the legitimacy of those identities. This includes sex-segregated treatment programs, the use of binary gender options as administrative classifications, and myriad other indignities. Therefore, policies and procedures genuinely conducive to an inclusive therapeutic environment must, rather than maintaining the ascendant status of established cultures, be formulated to secure the rights of emergent groups (Hartley, C.F. & Whittle, S., 2003). Additionally, the aforementioned practices cannot assume a singular category of gender variant individual or identification. Practically, “those

policies that force trans[gender] people to conceal their identity or prohibit diversity of gender expression must be amended, and existing harassment and diversity policies must be made inclusive of trans[gender] people" (Goldberg, J., & Lindenberg, D., 2004).

Indigenous Populations

While the above recommendations are largely relevant to indigenous gender and sexual minority individuals, these populations have distinct cultural needs that are often neglected in service provision contexts.

Primarily, researchers have suggested the use of indigenist and post-colonial approaches, as well as culturally tailored interventions delivered by community members (Simoni et al., 2006. Providers working with indigenous gender and sexual minority youth will have to suspend Euro-American conceptions of gender, sexuality and health, and should be aware that these individuals will have unique experiences of historical trauma, as well as cultural specific approaches to healing. While it would be inappropriate for us, as non-indigenous individuals, to suggest specific interventions, a number of indigenous organizations are actively developing health programs reflective of their diverse communities, and should be consulted regarding any further proposals in this area.

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Appendix 2 – List of Agencies Surveyed

Aids Committee of Toronto – SPUNK
Bellwoods
Breakaway Addiction Services
CAMH: Child, Family and Youth Program
Outpatient Addiction Services including Rainbow Program
SAPACCY (Substance Abuse Program for African Canadian and Caribbean Youth)
Youth Addiction and Concurrent Disorders Program
Covenant House
Delisle Youth Services
East Metro Youth Services
EGALE
Eva's Initiatives
Griffin Centre
LOFT
Maggies
Ossington Withdrawal Management Centre
Planned Parenthood Toronto
Renascent
Salvation Army Harbour Light
Sherbourne Health Centre SOY Program
Sketch
Toronto East General Hospital Withdrawal Management Centre Aboriginal Day Program
Triangle Program
TRIP
Turning Point Youth Services
West Scarborough Neighbourhood Program
Youthlink
Yonge Street Mission Evergreen Centre

Appendix 3 – Agency survey responses

1. What types of services do you provide?

ACT – Spunk
The Aids Commission of Toronto created the SPUNK program, which includes intervention and education for substance use and sexual health. SPUNK is harm-reduction focused and the methodology is motivational interview style.
Their clients are mainly young queer men dealing with social determinants of health and substance use risk factors. They co-ordinate a large team of volunteers for outreach to the queer community in bars, clubs and bath houses.

Bellwood Health Services
Bellwood provides addiction treatment for individuals and families experiencing problems with alcohol and drugs, or behaviours relating to sex, gambling and eating. They have 54 private beds and 12 OHIP beds. Stays range from 21 to 69 days and there is a two month waitlist for the OHIP beds. They see clients from all across Canada.

Their programming covers a range of topics, and they have specialized streams for post-traumatic stress disorder, sex addiction, eating disorders, and a health care professional stream for people that have access to drugs. Programming is abstinence based and Bellwood's treatment model allows for concurrent treatment for clients with multiple addictions.

Breakaway Addiction Services
Breakaway provides a variety of harm reduction and addiction services including support groups and individual counselling, distributing safer-use supplies, street outreach, and auricular acupuncture to help with anxiety and withdrawal symptoms.
The Family and Youth Initiative is a non-residential program developed to meet the needs of youth, age 12 to 25, and their family members and friends who are struggling with substance use concerns. The program offers assessments and referrals as well as individual and family therapy.
The Supportive Housing program is available to individuals 16+ who have problematic substance use and require stable housing. The program is offered in partnership with Regeneration Community Services.
They have a collaborative classroom-based program which serves 10 youths from the ages of 14-18 who live in the GTA and who are experiencing both mental health and substance use problems.
They don't have any specific LGBT services/programming so they tend to refer this population to more specific services/agencies.

Covenant House
Covenant House is Canada's largest shelter for youth 16-24. They have 94 beds: 58 male and 36 female. They provide a 24/7 crisis shelter and transitional housing on-site and in the community along with comprehensive services, including

education, counselling, health care, food and clothing bank, employment assistance, job training and aftercare.
They have an in-house high school which offers youth 16-20 (residents and non-residents) the chance to earn credits in compulsory subjects.
They have a day program called Arts and Minds, for youth with mental health issues.
They do community programming which opens services to non-residents as well as school presentations to link students to resources in their local communities.

CAMH – Child, Youth and Family Services; Rainbow Services; SAPACCY (Substance Abuse Program for African Canadian and Caribbean Youth); Youth Addiction and Concurrent Disorders Program;
The Child, Family and Youth Services provides intensive and specialized services for young people with mental health and/or addiction problems.

Rainbow Services provides counselling to lesbian, gay, bisexual, transgender, transsexual, two-spirit and intersex people who are concerned about their use of drugs and alcohol. These services are available to individuals with a variety of goals, including those who want to try to quit, cut down, or who would just like to gain more awareness about their drinking or drug use.

SAPACCY provides support and counselling to Black youth and their families who are dealing with problem substance use. The programs include individual therapy, group therapy and early intervention and prevention.

The Youth Addiction and Concurrent Disorders Service offers treatment to youth (14 to 24 years) who have substance use challenges/concerns with or without concurrent mental health concerns, and to their families.

Delisle Youth Services
Delisle Youth Services offers many programs including counselling, a group home, day treatment programs, in school programs, a queer youth program, an art gallery, and a youth centre. They do residential case management for teens with complex special needs.

They act as a single point of entry into residential services in the GTA for children and youth with mental health issues or complex special needs. CARS is the system access program that does centralized intake and matches clients to the most appropriate services.

They provide mental health services and system level services, with mental health outpatient counseling for youth 13-21.

SESSIONS is a 10 session drug info program developed by a former service user, which they now deliver to other agencies. They are no longer LGBT specific .

East Metro Youth Services
East Metro Youth Services (EMYS) is an adolescent mental health and addictions centre. They offer counseling services, walk-in services, and residential services. They also do school based programs, a violence intervention program, a youth justice group, and SESSIONS (see above). They have youth outreach workers and sex worker support. They also have an LGBT drop-in.

EGALE
EGALE is Canada's only national charity promoting lesbian, gay, bisexual, and trans (LGBT) human rights through research, education and community engagement. They offer walk-in counseling, case management, and advocacy: letters to housing, OW & ODSP. They also have a drop-in program which offers food, coffee, shelter and informal counseling. They have community kitchen programming with a professional chef.

They operate from a harm-reduction standpoint but don't have specific policies or objectives. Substance use is not considered a priority because they're a new agency and still sorting things out.

Eva's Initiatives
Eva's Initiatives operates three unique facilities in Toronto, providing safe shelter and diverse programs and services to help homeless and at-risk youth. The three shelters – Eva' Place, Eva's Satellite, and Eva's Phoenix – engage and support 114 homeless youth (aged 16-24) each night, and are designed to help youth transition out of homelessness and on to independent living.

Eva's Place is a 32-bed emergency shelter. This emergency shelter helps homeless youth connect to a community that can support them as they move forward.
Eva's Phoenix provides housing for 50 youth, aged 16 to 24 years, for up to a full year. Eva's Phoenix uses an integrated, holistic approach to provide youth with the skills they need to find and maintain housing and employment.

Eva's Satellite describes itself as Toronto's only harm reduction shelter, where youth receive counselling, life skills training and recreation programs. They have services provided by Inner City Health Associates, and partnerships with Central Toronto Youth Services and other community agencies.

Griffin Centre
Griffin Centre is a multi-service mental health agency providing services to youth, adults and their families. They also deal with substance use. Programming consists mainly of community based services for youth 12-18 years of age, some up to 24. They offer 11 separate day programs, including 3 for youth. They have a range of programming from one-on-one support to case management to art space harm reduction. They collaborate with other organizations such as Breakaway and TRIP. Their reachOUT program is specifically for LGBTQ youth or youth labelled with disabilities. It's mainly counselling for youth 12-18. They also have a program called

Helping Youth Through Solutions, which is a program for mental health and substance use problems with a focus on harm reduction. The program has a capacity of 8 students and can provide high school credits.

LOFT
The LOFT Transitional Age Youth Program (TAY) seeks to fill the significant gaps that exist between youth and adult services sectors, and between hospital and community-based services. TAY serves about 200 at-risk youth a year, both male and female, aged 16 to 26. This program offers support and case management for youth mental health issues and youth addictions, and assists homeless youth in finding safe and affordable housing.

They provide case management for 130 people, treatment groups with 7 different groups, funding for enhanced navigation staff for managing clients with complex needs. They work on a variety of life skills.

They've received funding for their CAMPUS program with U of T, Ryerson and York, which consists of housing for youth with a focus on abstinence, harm reduction and mental health. They currently have 9 youth houses and can't keep up with demand.

Maggie's
Maggie's: The Toronto Sex Workers Action Project is an organization run for and by local sex workers. Their aim is to empower sex workers to work safely, and their programming includes access to information, kits, and resources for substance use. They have people and groups come in and do workshops as well as a drop-in centre three days a week.
They serve women, men and the trans population. They see a lot of youth.

Ossington Withdrawal Management Program
The Ossington Men's Withdrawal Management Centre provides withdrawal support to men, 16+ who are in an acute state of intoxication or withdrawal from alcohol or other substances and whose condition can be safely managed in a non-medical residential setting. They provide assessment, referral, group and individual counseling and support.

Since there are no specific LGBT services, they try to direct this population to more specific services.

Planned Parenthood
The Planned Parenthood Toronto clinic provides youth health services including primary care, sexual and reproductive health care and mental health services. For clients 16-29 they offer a sexual health clinic with doctors, nurses and a social worker.
They also offer community programs, and their TEACH program trains youth 15-20. In the program, volunteers work on sharing narratives, covering topics like anti-

oppression and gender and sexuality. They deliver LGBT workshops around 150 schools.

Renascent
Renascent offers residential treatment. They provide continuing care for 15 weeks with the focus of early stage recovery on reinforcing principles and relapse prevention. They work with all substances. The program is for addicts both actively using and not. For addicts, the intensive program is intended to stabilize them, get them enough info and help them continue. They offer continuous intake. They offer gendered programming as well as a children's program to help children develop strategies for coping. They approach addiction as a family disease; the family program targets adult family members, including the client's "chosen family".

Salvation Army - Harbour Light
Salvation Army - Harbour Light is a ministry unit offering residential addiction and mental health treatment for self-identified men. They have 98 units for transitional housing for both genders. Other services from other organizations are brought in to help newcomers. They also have a long term residence for women in the west end. All of their services are for adults, and they have a separate youth shelter in Sutton.

Sherbourne SOY (Supporting Our Youth)
SOY is a health program run by Sherbourne Health which offers programs and activities for LGBT youth aimed at building an inclusive, welcoming community. SOY programs and activities include arts, social, cultural and recreational activities, mentoring, skill building and employment support.

They also have supportive housing programs and programs for specific populations including newcomer/immigrant youth, black queer youth, youth of colour, bisexual youth, homeless and street-involved youth and trans youth.

Sketch
Sketch is a community artist initiative that works with marginalized and homeless youth. They offer a lot of programming including visual arts, community artist leadership training, ceramics, movement and performance, textiles and silk screening, music recording arts and culinary and enviro-arts. One example is Krafty Queers which allows LGBT youth to connect with other LGBT and ally youth while crafting in textiles, silkscreening and painting.

Toronto East General Hospital (TEGH) Withdrawal Management Services (WMS) Aboriginal Day Program
TEGH WMS Aboriginal Day Program offers a day program with a community withdrawal worker and a case manager. TEGH WMS also has residential services. They do continuous intake and it's an ongoing program with no set length. They have a continuing care group, an Aboriginal family group and they also do individual counseling with youth.

The program blends mainstream information with traditional teachings. They deal with gambling, internet, sex and the whole spectrum of addiction, including both long and short term effects.

Triangle Program
The Triangle Program is one of three programs that make up Oasis Alternative Secondary School. This is a full-time TDSB high school program for LGBT youth. They offer academic and applied curriculum that addresses the interests, concerns, literature, science and history of the LGBTTQQ2SIA communities whenever possible.

They have social supports through social workers, child and youth counsellors, and through connections to community organizations. They provide students a free nutritious meal every day at lunch, which is prepared by community volunteers. They also offer TTC fare (to those who qualify) so transportation is not a barrier.

TRIP
TRIP provides safer sex and drug information and supplies to people in Toronto's electronic music communities. TRIP provides several services to the dance community and beyond. The project is known for its onsite outreach booths, a vendor-style setup staffed by 2-3 TRIP workers and volunteers, which offers a display of safer drug use and safer sex information and supplies.

All TRIP staff and volunteers are trained in basic counseling, crisis intervention, how to handle drug-related emergencies, and CPR. TRIP also provides workshops on safer drug use, safer sex, and safer partying to other organization and schools.

Turning Point
Turning Point Youth Services is a multi-service children's mental health centre. They provide a range of mental health, counselling and support services to at-risk and vulnerable youth age 12-24 and their families. They offer food and basic needs, a community support worker and a housing worker. Their day programming is voluntary, with community members coming into the shelter.

They do a drug awareness group with Delisle Youth Services for harm-reduction, they have legal representatives to connect youth with legal services, and employment services come in and do presentations. They have CTYS groups on coping strategies to help stress, and a program called ‘Connects’ for support with concurrent disorders. For this program they bring in a MSW clinician, a youth worker and a psychiatrist.

West Scarborough Neighbourhood Community Centre
WSNCC is a community centre offering restorative justice and employment services for youth. They are also home to the Boys and Girls Club which is a community organization for children and youth up to 18.

YouthLink
YouthLink offers counselling services, co-op housing, residential services and community services in Scarborough.

YAAHA (Young advocating anti-homophobia) is a group that meets weekly and takes on different projects based on grant funding. Previously, they produced a magazine based on their feelings of being queer or trans in Scarborough. Now they are working on wellness based initiatives, as well as skills for navigating school, families and community. As well as LGBT+ programming they do walk-in and ongoing counseling for youth.

The YouthLink Residence is a specialized group setting for young women who need intensive support, as they are unable to live with their family, a foster family or in a group home. The program combines treatment for mental health concerns with life-skills training and emphasizes diversity and inclusiveness. Youth in the program are required to attend school or have a job.

Yonge Street Mission (YSM) – Evergreen
YSM – Evergreen offers a continuum of care, starting with drop-in, food and space to hang out. This is primarily for street and at-risk populations.
They offer addictions counseling from Breakaway and YSAP, CTYS, mental health and LGBT counseling services as well as art programming. They have a dialogue about sex and life that attracts LGBT+ people, which is led by a doctor.
They also provide legal services, employment services, a health ID clinic, a nursery for parents and a baby food bank.

2. Do LGBTTQQ2SIA, youth from 16-29 years old or people that use substances access your services? If so, how many of these people do you see on a monthly basis? What percentage of your caseload is this population?

Agency	LGBTTQQ2SIA	Youth 16-29	S.U.	Response
ACT - Spunk	x	x	x	
Bellwood Health Services	x	x (19+)	x	
Breakaway Addiction Services	x		x	
Covenant House	x	x		25% of youth is self-identified as LGBT at Covenant House but could potentially be higher
CAMH	x	x	x	SAPACCY: the population is more prone to identify mental health as an issue than substance use (they don't see SU as a problem, more as "something that happens to them in their environments")

Agency	LGBTTQQ2SIA	Youth 19-29	S.U.	Response
East Metro Youth Services	x	x		8 consistent youth attending LGBT drop-in with other teens attending regularly. In residential setting in last year at least 4 LGBT clients. Over 20 clients from this pop. have come through in the past year. Youth are 12-19 generally but they do walk-in counseling up to 29. Substance use is not a big concern.
EGALE	x			Less than 10 conversations about substance use in a month. Most clients are trans with 60%, fairly even with LGBT.
Eva's Initiatives	x	x	x	Around 10-15% LGBT. More trans people are identifying but don't see higher. Also have youth that are not identifying. Numbers are not higher because of safety and comfort, as it's an emergency shelter with the focus on stabilization and support.
Griffin Centre	x	x	x	
LOFT	x	x	x	27% of people identify as LGBT+ and a lot of youth identify as "gender neutral". TAY serves about 200 at-risk youth a year, both male and female, aged 16-26
Maggie's	x	x	x	80 people per month at the drop-in and 15-20 people each night age 14-18 with different backgrounds, gender identity. 40 are LGBT, including lots of trans people
Ossington Detox	x	x	x	20-30% of clients are LGBT. They've only seen 3 trans people in 10 years
Planned Parenthood	x	x		20% of clients are LGBT+ Substance use less of an issue
Renascent	x	x	x	Over the past year they have had 4 trans clients, all under 29. They think they may have 1-2 gay/lesbian client per month. Regarding youth, 6% are under 24.
Salvation Army-Harbor Light	x		x	Currently 2/35 people under 30 in Harbourlight. All services are for adults., with the youth shelter in Sutton. One man in treatment now who is queer.

Agency	LGBTTQQ2SIA	Youth 16-29	S.U.	Response
Sketch	x	x		Under representation of LGBT community historically, combination of societal homophobia and geography and geographical setting. In terms of substance use, unknown
TEGH WMS/Aboriginal Day	x	x		No idea about LGBT because it's not asked during intake, guesses are 20% Trans residents yes but cannot ask about sexual orientation and no specific policies in place. Lots of gay, transgender people and 2-spirit people. Youth about 20-25%
Triangle Program		x	x	About 30 students in program; 5 of them use everyday
TRIP		x	x	
Turning Point	x	x	x	They don't ask about LGBT. Option to identify as transgender during intake procedure No specific transgender policy but would fall under "anti-discriminatory" policy and falls under shelter standards Substance use pretty high.
West Scarborough Neighbourhood CC	x	x	x	Not much of a sense, but 10% would be LGBT in some way. 60 clients on caseload, 3 are openly gay, and all of them have substance use issues.
YouthLink	x	x		They don't see substance use
Yonge Street Mission - Evergreen	x	x	x	Estimate over 25% of clients are LGBT. Assessment in 2011 said about 99% of clients had some sort of substance use issue. Age limit is 16-25

3. Do any of your staff have lived experience as a LGBTTQQ2SIA person, a person that uses substances or a person in recovery from addiction?

Agency	LGBTTQQ2SIA	Substance use	Response
Bellwood Health Services		x	
Breakaway Addiction Services	x	x	With substance use, staff can't answer because of privacy. Yes they have lived experience but they can't give numbers.
CAMH	x		SAPACCY: 0.5 of a staff position is devoted to the LGBTQ population, and the staff represents the population
EGALE			Not a mandate to have lived experience so therefore don't know. Feel it's incredibly important to youth to see it reflected in staff.
Griffin Centre			It is important that service providers have lived experience or cultural experience.
LOFT	x	x	Both, between staff and peers.
Maggie's			Lived experience helps break down barriers.
Ossington Detox			Not sure about staff but some of the older clients will take the younger ones under their wing and pass on experience.
Planned Parenthood			Peer to peer education, someone that has similar or recent experiences that are really relevant to you.
Renascent		x	All staff have lived experience being in recovery
Sherbourne SOY	x		It is a priority to hire LGBT people, mentor and do a lot of intergenerational work
Sketch	x	x	Yes. They don't know the percentage of staff with lived experience but definitely people with history of substance use, definitely some gay and lesbian staff The benefit of staff with lived experience is commonality and helps build trust and helps to build connections.
TEGH WMS/Aboriginal Day			Unclear, definitely not a priority
Triangle Program	x	x	Yes, some staff with lived experience
TRIP		x	Peer work makes the project relevant and good to be able to pay people.
Turning Point	x	x	A number of staff with lived experience but definitely not a requirement.
West Scarborough Neighbourhood CC	x		In the whole agency there are only 2 gay staff. No info re. lived experience with substance use
Yonge Street Mission - Evergreen		x	Currently no LGBT staff but there are staff with previous substance use in the past

4. Do you believe your services are accessible to LGBTTQQ2SIA people? People that use substances? Youth? If so, why or why not?

Agency	LGBTTQQ2SIA	Substance users	Youth	Why or why not
ACT - Spunk	x	x		Their mandate is for queer men, but they try to involve women as well. Recruiting is the hardest part
Breakaway Addiction Services	x	x	x	
CAMH	x	x	x	SAPACCY: Initially, staff went and met with the population and identified key sites and went there. They have the flag on their brochure as a specific statement. They've organized forums including "One Love" for parents, offered both in Scarborough and downtown Rainbow Services: although we take self-referrals, people have to be quite motivated to go through the assessment process, show up for groups etc. (could be hard for youth to display this level of motivation)
Covenant House	x		x	Yes, absolutely. Staff training done and looking to more training for peers. Zero tolerance for any discrimination. Policy for housing trans residents
East Metro Youth Services			x	Have representation of staff and feel like they are doing a good job. Working on changing the culture in services. However, lack of LGBT services here

Agency	LGBTTQQ2SIA	Substance users	Youth	Why or why not
EGALE	x		x	Yes to LGBTThe vibe is super great and non-judgmental, open to youth. Substance use no because they just don't have the "buy in" or the outreach to access the people actually struggling because of focus on housing.
Eva's Initiatives	x	x	x	The youth are quite supportive with each other
Griffin House	x	x	x	Yes, diversity is a valued part of the agency
LOFT		x	x	Sense is yes but no groups specifically for queer and trans
Maggie's	x	x	x	
Ossington Detox	x			Yes to LGBT people, same as everybody else. Guidelines tolerate no discrimination.
Planned Parenthood	x			Our program is very queer and trans friendly
Renascent				Not particularly for LGBT people, no specific programming. Bottom line, it's mainstream.
Salvation Army-Harbor Light	x	x		We think it is, but clients may have different opinion.
Sherbourne SOY	x	x	x	They have a Respect agreement developed in collaboration with youth, anti-oppression framework at the core Programming incorporates queer and trans identity with specific programming. Substance users feel safe, operate from harm-reduction, and communicate

Agency	LGBTTQQ2SIA	Substance users	Youth	Why or why not
Sketch			x	For LGBT accessibility they don't know much about the topic. Strive to but don't know. In terms of substance users, individually people try to be welcoming and understanding.
TEGH WMS/Aboriginal Day			x	Absolutely for youth Not specifically accessible to LGBT, discrimination is unacceptable
Triangle Program				No Response
TRIP		x	x	Really meeting them where they are at and focusing on reducing stigma
Turning Point		x	x	
West Scarborough Neighbourhood CC			x	If you have an employment program, how do you make your services LGBT friendly?
YouthLink			x	
Yonge Street Mission - Evergreen	x	x	x	Yes but the only thing that hinders it is the other clients. Most LGBT people feel comfortable free. Staff have some training and some do not, supervisor has training but looking for more training.

5. Are there sub demographics among LGBTTQQ2SIA youth that use substances that may face additional barriers? If yes, what demographics and what types of barriers?

Five (5) service providers identified a sub demographic of people that have survived trauma such as violence or sexual abuse. In this case trust and feelings of safety are a huge barrier to this group accessing services.

Five (5) service providers identified the sub demographic of homeless LGBTTQQ2SIA youth that use substances. The transient nature of their living situation and priorities (basic needs) would be barriers to this group accessing services.

Five (5) service providers identified the sub demographic of those suffering from mental health issues. This group was identified by 5 different service providers. A concurrent mental health issue would obviously act as an additional barrier to this group accessing services.

Four (4) service providers identified a sub demographic of new immigrants, people from other cultures, or people of a visible minority as a group that may face additional barriers accessing services. One explanation offered for this was that they are coming from cultures with higher levels of homophobia and transphobia and this creates an additional barrier for this group.

Another sub demographic identified by three (3)service providers were students. For this group, experiencing homophobia and trans phobia at the hands of other students and even teachers acts as a barrier for them going to school. This in itself may not create barriers for accessing services but it definitely makes them more vulnerable to joining the other sub demographics of trauma survivors, homeless youth, or someone with a concurrent mental health issue.

Two (2) service providers also identified those living in more isolated areas as a sub demographic that may face additional barriers in accessing services. The lack of services in close proximity and the travel involved to access these services would certainly create an additional barrier for this group
Finally, one (1) service provider identified sex workers as a sub demographic that may face additional barriers in accessing services.

6. **How has your agency taken steps to ensure that your services are accessible? For example, do you have LGBT policies and procedures, do you have anti-oppressive training for staff or do you have staff with lived experience?**

ACT – SPUNK
No response

Bellwoods
They're accredited so there are discrimination policies. They have racial, gender and sexual diversity, which is well accepted and valued. No violence and no abuse. Staff are very respectful and treat all clients with dignity. However they admit that if someone was a minority for any reason, it might be challenging, as services are gendered. Intake covers sexual history, works to help develop treatment plans that may make more specialized services for LGBT.

Breakaway
In terms of being accessible, they've modified forms in order to be more inclusive. They've had recent conversations about creating space for difference for all. They don't try to reinvent services but instead refer to other LGBT services. They also had ACT come in for a day of training.

CAMH
Not enough time to discuss this issue.

Covenant House
They've had staff training done and are looking to get more training for peers. Zero tolerance for any discrimination. They want to create a safe space for everyone living here. They also changed some forms to make them not just male and female to include more options.

Delisle Youth Services
There has been immense shift for 5 years to being LGBT positive. They have staff with lived experience but want more training. Substance users feel comfortable coming into the space because there are representative staff with necessary experiences and deep understanding of substances. Drug use won't be stigmatized.

East Metro Youth Services
They have a focus on LGBT relevant training and speakers for staff, a focus on harm reduction training, and there's also a new comer group and youth workers that can also get this training. They have training by Rainbow health Ontario and they're also having a speaker from EGALE. They are represented at East Side Pride community events.

EGALE
They do volunteer training to help them assist LGBTTQQ2SIA clients.
For clients, trans and gender education is done. For some lesbian, gay and bi do trans 101 to be more trans inclusive.

Eva's Initiatives
Eva's have developed and LGBT toolkit which will be put out shortly and they've also done research with staff and clients. They work form anti-oppression framework, have an inclusive statement and a visible pride flag but there still exists bullying.

Griffin Centre
Griffin Centre has workers who are reflective of the community they are serving. They have workplace policies and supports, they do intersectionality training, disability training, and accessibility training. They do check-ins with clients, and travel to clients where they want to be seen.

LOFT
LOFT has anti-oppression training for everyone as well as staff with lived experience. They do a lot of staff training and are constantly trying to learn how to better support clients. They also try to keep it as safe as possible for youth.

Maggie's
Maggie's has always been queer people and the board reflects this. It was started by queers and has always had a large representation of queer people. Not as much men. Very diverse and lots of queer and trans people.
Maggie's also does a lot of peer outreach to different organizations.

Ossington WMC
In terms of accessibility for LGBT people, they are treated the same as everybody else. Their guidelines tolerate no discrimination. A couple of years ago had an LGBT workshop, and they would be interested further workshops or training for staff. They make a lot referrals to CAMH Rainbow, Alpha House. In terms of specific accommodations, for trans clients to use gender neutral terms for them and provide accommodations to the client. If the client has specific needs they'll state it and the staff will support them.

Planned Parenthood
Planned Parenthood's TEACH program trains youth volunteers covering topics like anti-o, gender and sexuality, and answering tough questions in order to deliver LGBT workshops around 150 schools. The program is very queer and trans-friendly. Volunteer presenters in schools become a point of reference with LGBT visibility to other queer and trans folks. They've also done multiple trans awareness training sessions and have a trans access working group. They're also doing continuous survey and feedback.

Renascent
All staff have lived experience being in recovery. Not that accessible for LGBT clients because they don't offer specific programming.

Salvation Army Harbor Light
The 519 came in to do training and came in to look at policies. When homophobia occurs, staff intervenes and tells clients it's not okay. The program is certainly trauma informed which is important for this population. Another step is using inclusive language, self-identification language, and having positive space signage.

Sherbourne SOY Program
It is a priority to hire LGBT people, mentor and do a lot of intergenerational work, in terms of staff and volunteers. This creates a sense of safety and a sense of community. They have a respect agreement developed in collaboration with youth, with an anti-o framework at its core. They are careful with pronouns with check-ins and have programming incorporate queer and trans identity. They do offer specific LGBT/trans programming. Substance users feel safe because staff operate from a harm-reduction perspective and communicate well with clients.

Sketch
Staff at Sketch try to operate from an anti-oppression framework overall. They have staff with lived experience and the benefit is commonality with clients which helps to

build trust and connections. They have specific queer programming with Krafty Queers and specific trans programming with Chrysallis. They haven't had any training but there is a consciousness among staff to be LGBT positive. Sketch rules include harm-reduction perspective with the client's decision to use or not but if it affects others there are issues. They are having crisis training coming up and becoming better equipped.

TEGH WMS & Aboriginal Day Program
Discrimination towards LGBT clients is not acceptable; however, the program is not specifically accessible to LGBT people.

Triangle Program
The program has staff with lived experience.

TRIP
TRIP is accessible to youth, LGBTTQQ2SIA and substance users because of their unique position of doing outreach for the EDM/rave community. All TRIP coordinators have been peers and volunteers. They do workshops at youth high schools and agencies to talk about drugs and real harms. Volunteer training is important to their health centre and getting clients connected to the centre.
They operate from a harm reduction and very client centered approach.
Staff/volunteers don't make any judgments and let clients figure out for themselves what information they want to access, including prevention and treatment stuff.
In the rave scene they see a lot of queer people, exploring gender and sexuality. In the all ages scene they see a lot of street involved youth.

Turning Point
Turning Point has a number of staff with lived experience. They have a lot of staff training, including Toronto hostel trainings and 519 training for team meetings a couple of years ago. They have no specific transgender policy but this would fall under their "anti-discriminatory" policy.

West Scarborough Neighbourhood Centre
They are getting trained a lot to help youth know and for youth to feel safe, but still indicated the need for more training especially to help staff talk to people about LGBTTQQ2SIA issues.

Youthlink
They have staff with lived experience, and in addition have been able to incorporate trans youth into women only residence.
They have a weekly group YAAHA (Young advocating anti-homophobia) that does different projects based on grants.

YSM-Evergreen
They feel they are accessible to all 3 groups. They have done some staff training but also indicated the need for additional training.

7. **What types of circumstances are barriers for LGBTTQQ2SIA people, youth and people that use substances to accessing services? At your organization? In general (personal, organizational and systemic)?**

The biggest barrier was the lack of specific services for LGBTTQQ2SIA youth that use substances. This is a systemic barrier and was identified by 17 different service providers. Without specific services this group is much less likely to access traditional services for fear of homophobia, judgment, and even violence. Five (5) different service providers identified fear of violence as a barrier for this group accessing services.

Related to the lack of specific services, three (3) different service providers identified the stigma, fear and shame that is sometimes experienced by LGBTTQQ2SIA clients when they are attempting to access traditional services. This is a personal barrier for the individual accessing services but it is also a systemic barrier in that there are a lack of specific services for this group.

One organizational barrier that was identified by four (4) different service providers was a lack of training among staff or a lack of lived experience among staff. Another systemic barrier identified by four (4) different service providers was the difficulty of navigating the system and gaining access to appropriate services. The location of services was also identified as a systemic barrier by 2 different service providers. More specifically there is a concern that all services are located downtown and are less accessible to people in Scarborough, for example.

The cost of services and waiting lists for shelters or beds were each identified by one (1) service provider as systemic barriers to LGBTTQQ2SIA youth or youth that use substances accessing services.

As an organizational barrier, Salvation Army Harbor Light were concerned that since they are a Christian organization the religious aspect might act as a barrier to potential clients who might not know what to expect from them.

One (1) organization identified the abstinence model as a possible barrier, as people would then have to ditch their queer friends who use (which is a huge loss). “The normative experience within the community regarding substance use influences their participation in treatment”

8. **What recommendations do you have for engaging LGBTTQQ2SIA youth that use substances?**

Six (6) service providers recommended that staff be non-judgmental, engage, listen and understand the clients, joining with them “where they are at”. The relationship with clients is most important, having mutual respect and treating them with dignity.

Five (5) service providers identified the importance of meeting clients wherever they are. This means doing outreach in communities with different cultures, outreach to street-involved youth and outreach in the party scene. "In terms of the utility of creating culturally specific spaces, this opens up the possibility for them to receive services, because they see themselves culturally represented within the service organization. There is then more opportunity for engagement right through to treatments. However, with queer clients (within the SAPACCY population), there is a tension because of the community context from which they come (their community doesn't deal well with LGBTQ issues)".

Five (5) service providers recommended finding ways to help meet basic needs, including food and free transportation with TTC tokens.

Three (3) service providers recommended having an inclusive space as a way to draw in LGBTTQQ2SIA youth that use substances.

One (1)service provider recommended using social media to connect with the youth.

9. What types of services do you think would be beneficial to LGBTTQQ2SIA youth that use substances?

The most popular recommendation was to offer specific programming for LGBTTQQ2SIA youth that use substances; this was recommended by 15 different service providers.

Seven (7) service providers recommended that youth LGBTTQQ2SIA that use substances have some say in terms of what programming is offered. They thought it was important that there is an element of self-determination and there is a lot of input from the clients who will actually be accessing the services.

Seven (7) service providers recommended that harm-reduction services be offered as this may be more effective than pushing for abstinence.

Four (4) service providers pointed out the importance of staff being properly trained and supported to help this population, or the importance of staff having lived experience themselves.

Trauma counselling was recommended by two (2) service providers, because many LGBTTQQ2SIA substance using youth have also experienced trauma in some form. Three service providers recommended that multiple services and programs be offered under one roof for LGBTTQQ2SIA youth, a type of one-stop-shop (as one service provider described it).

Two (2) service providers recommended 1-on-1 counselling, believing that group discussions might act as a barrier to some LGBTTQQ2SIA youth that use substances opening up in the same way that they would in a 1-on-1 situation.

Two (2) service providers recommended that there be a mix of designated spaces and open spaces, as well as a mix of specific programming and closed programming with open, general programming.

Three (3) service providers recommended that programming should include life skills and educational components. They felt it was important for clients to develop tools and skills that they could use in different contexts when they're not actually in the program.

Two (2) service providers recommended networking with other service providers to get an idea of what everyone is doing well. This should lead to more referrals, and to clients having an easier time finding and accessing appropriate service.

Two (2) service providers recommended having family support services in place in addition to programming aimed at clients.

Two (2) service providers recommended having programming take place during the day and also in the evening to attract more clients.

One (1) service provider recommended doing after-care or follow-up services with clients once they are out of the program.

One (1) service provider recommended having drop-in services.

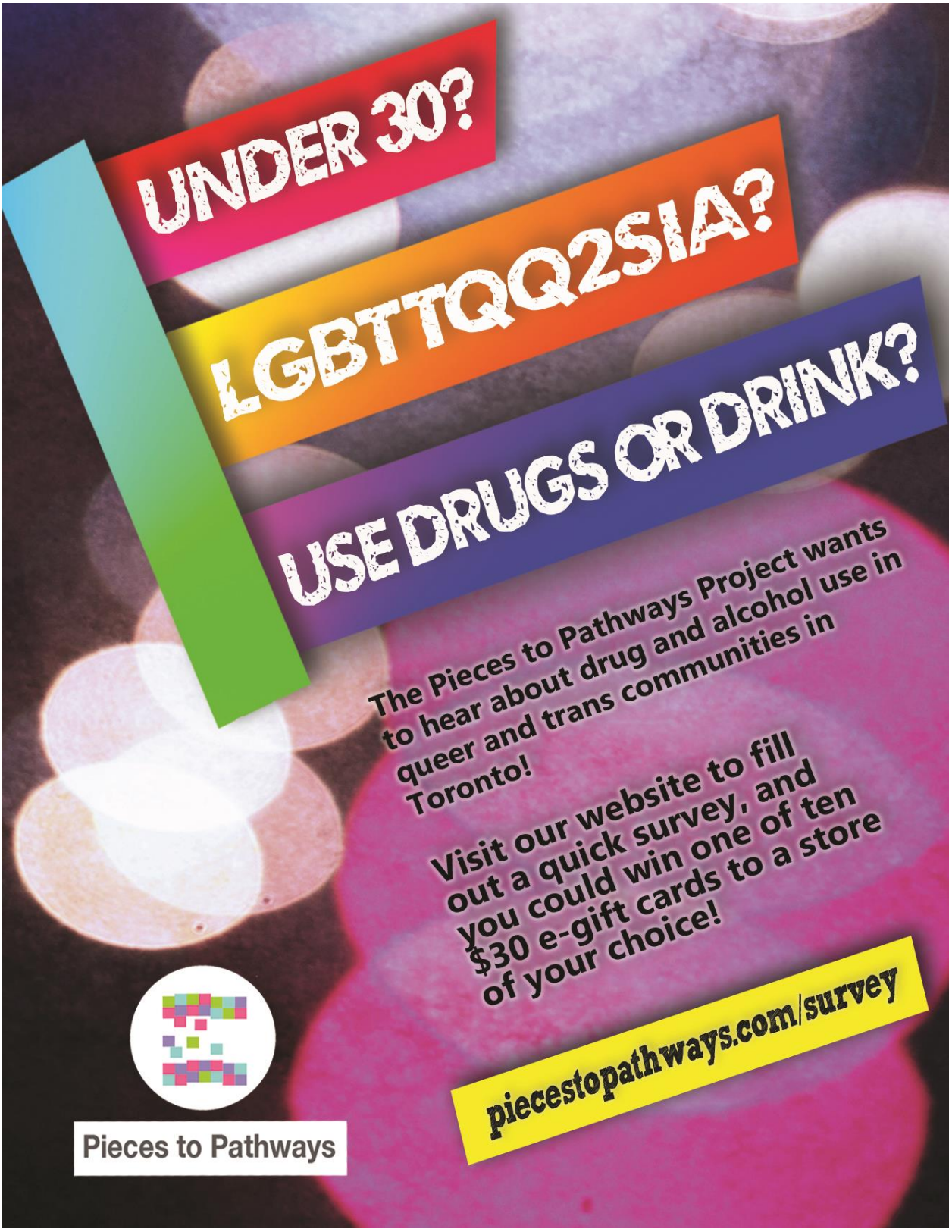
One (1) service provider recommended creating place-based services e.g. in Scarborough.

One (1) service provider recommended debunking myths about what constitutes substance abuse e.g. it's not just using heroin and meth.

One (1) service provider recommended considering clients' emotional ages when developing programs.

One (1) service provider recommended focusing on empowering clients and creating an environment where they can feel successful.

Appendix 4 – Flyer used to promote online survey



Appendix 5 – Venue/Event in which population survey was promoted/administered

Come as You Are
EGALE
Glad Day
Good For Her
Harm Reduction Open House (TRIP, Central Toronto CHC and the Works)
Health and Human Rights Conference at University of Toronto
Homo Hop
I'd Tap That: Crush TO
Now Magazine
Oasis Aqua Lounge
Out in the Night at the Bloor Cinema
Queer Cab at Buddies in Bad Times Theatre
Rhubarb Festival at Buddies in Bad Times Theatre
Sketch
The Steady
Turning Point
Xtra Magazine
Yes Yes Y'all
YSM Evergreen
Youthlink

Appendix 6 - Alcohol and Other Drug Use Survey: LGBTTQQ2SIA Youth (16-29)

Thank you so much for taking the time to do this survey!

We at Pieces to Pathways are young queer and trans people who have accessed support in relation to our drug and alcohol use. Our hope is to ensure that our communities have access to whatever support they might feel that they need. We want to make sure that those affected by the current lack of LGBTTQQ2SIA-specific services are involved in creating the kinds of supports they would want to see. The information that you provide will help us develop recommendations as we try to set up an LGBTTQQ2SIA-specific substance use support program.

Because we want to get a sense of alcohol and other substance use in these communities as a whole, it doesn't matter how much experience you have with substance use - whether you drink infrequently, or think you might have a problem with substances - the information you provide is valuable, and we want to hear from you!

Everything that you say in this survey is anonymous and confidential. We won't know who said what, and won't ask you for any information that could be used to identify you. **If at any time you feel uncomfortable with a question - or the survey as a whole - feel free to skip the question, or opt out of the survey entirely.** Your sense of safety is more important than anything else, and you're not obligated to finish the survey if you're uncomfortable.

To get started, we have a couple of questions to make sure that you're eligible to complete the survey.

Do you identify as LGBTTQQ2SIA? ☐ *Yes* ☐ *No*
* "A" is for asexual NOT ally

Do you live or access services in Toronto? ☐ Yes ☐ No

Are you 16-29 years old? ☐ Yes ☐ No

Self-Perceptions of Alcohol and Other Drug Use

These questions ask about how you feel about your use of alcohol and/or other drugs. We've separated drugs and alcohol because people often have very different relationships to these things. When you look at the options below, please select the statement that best applies to you for each section.

Drug Use:

O I'm **fine** with my drug use.
O I'd like to **cut down on using *some* drugs**, but I haven't yet.
O I'd like to **stop using *some* drugs**, but I haven't yet.
O I'm trying to cut down on using *some* drugs.
O I'm trying to stop using *some* drugs.
O I've stopped *some* drugs.
O I'm trying to cut down on using *all* drugs.
O I'm trying to stop using drugs *completely.*
O I've stopped *all* drugs.

Alcohol Use:

O I'm **fine** with my alcohol use.
O I'd like to **cut down**, but I haven't yet.
O I'd like to **stop** drinking, but I haven't yet.
O I'm trying to **cut down**.
O I'm trying to **stop** drinking.
O I've **stopped** drinking.

Previous Experience Accessing Formal Support

This section asks about any experiences you may have had with service providers around alcohol and other drug use. **If you've never accessed support for these things, go right ahead and skip these questions by going to the next page.**

What kind(s) of service(s) have you accessed related to alcohol and other drug use? Please check all that apply.

O Harm reduction services (stem kits, safe injection kits, safety tips)
O Individual Counselling
O Group Counselling
O Detox (Withdrawal Management Services)
O Outpatient Day Program
O Residential Program
O 12-step support groups (Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous)

Anything we missed?

_____
_____
_____

Below, we've created a list of different factors that often influence how people feel about the services that were provided to them. Please select "YES" or "NO" to each statement if it applies to you. If you do not identify as a racialized, non-white or mixed person or a person with a disability, please skip parts "B" & "C" of this page. We've also left some space at the bottom in case we missed something about your experience that you'd like to share with us.

A. On the basis of my identity as a LGBTTQQ2SIA person…
   I did not feel safe disclosing my identity **YES / NO**
   I felt that staff did not accept me **YES / NO**
   I was mistreated by staff **YES / NO**
   I felt the that clients did not accept me **YES / NO**
   I was mistreated by clients **YES / NO**
   The service(s) did not meet my needs **YES / NO**

B. On the basis of my identity as a racialized, non-white or mixed person…
I felt that staff did not accept me **YES / NO**
I was mistreated by staff **YES / NO**
I felt the that clients did not accept me **YES / NO**
I was mistreated by clients **YES / NO**
The service(s) did not meet my needs **YES / NO**

C. On the basis of my identity as a person with a disability…
I felt that staff did not accept me **YES / NO**
I was mistreated by staff **YES / NO**
I felt the that clients did not accept me **YES / NO**
I was mistreated by clients **YES / NO**
The service(s) did not meet my needs **YES / NO**

Anything we missed? Please share your greatest concerns.

_____
_____
_____

Barriers to Support

Sometimes people feel that they'd like to get support, but decide not to for a lot of different reasons. This section asks about why you may not have accessed services related to alcohol or other drug use before. Please select all that apply to you. If you have accessed services, you can go ahead and skip this section.

O I don't know what's available.
O There aren't any services in my area.
O I don't know if I need support.
O I don't know if the staff will understand me.
O I have other obligations that prevent me from accessing services.
O I've been discriminated against before, and don't want to be in that position again.

O I don't know if the staff will accept me as an LGBTTQQ2SIA person.
O I don't know if the clients will accept me as an LGBTTQQ2SIA person.
O I don't think the services available will meet my needs as an LGBTTQQ2SIA person.

O I don't know if the staff will accept me as a racialized/non-white/mixed person.

O I don't know if the clients will understand me as a racialized/non-white/mixed person.
O I don't think the services available will meet my needs as a racialized/non-white/mixed person.

O I cannot physically access the space due to my disability.

O I don't know if the staff will accept me as a disabled person.
O I don't know if the other clients will treat accept me as a disabled person.
O I don't think the services available will meet my needs as a disabled person.

Anything we missed?

_____
_____
_____

If you picked several items, could you let us know which 3 are the most important?
1. _____
2. _____
3. _____

If you're comfortable, could you tell us more about those 3?

_____
_____
_____

Service Preferences

Which publically available services would be the most helpful to you? Please check all that apply.

O Safer injection sites
O Methadone or suboxone (substitution therapy)
O Detox (Withdrawal management services)
O Individual counselling
O Group counselling
O 21 day outpatient treatment program
O 28 day outpatient treatment program

O Short term residential treatment program (21-28 day rehab)
O Medium term residential treatment program (3-6 months rehab)
O Long term residential treatment program (More than 6 months rehab)

O 12-step support groups (Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous)

Anything we missed?

_____
_____
_____

What types of service would you prefer? Please check all that apply.

O Harm-reduction focus
O Abstinence focus
O Harm-reduction and abstinence focus
O Gender specific services
O LGBT+ specific services
O Trans* specific services
O Services delivered by LGBT+ people
O Services delivered by Trans* people
O Services delivered by LGB people
O Peer led services
O Programming that explores gender
O identity and sexual preferences

Anything we missed?

_____
_____
_____

What types of additional resources would support your alcohol and other drug use goals? Please check all that apply.

O Access to medical transition support (assessment, hormones, surgery)
O Sexual health services (medical doctor, nurse)
O Stop smoking support (stop smoking aids like gum, patch or medication)
O Mental health support (counselling, case management, medication)
O Sex work advocacy and support (peer support, safety tips)
O Trauma support (counselling)
O Housing support (case management, transitional housing, permanent housing)
O Shelter services
O HIV/AIDS Services (prevention, testing, medication, peer support)
O Legal services
O Support for leaving abusive situation(s)
O Crisis counselling
O Anger management
O Family counselling

Anything we missed?

_____
_____
_____

If you picked several items, could you let us know which 3 are the most important?

1. _____
2. _____
3. _____

If you're comfortable, could you tell us more about those 3?

_____
_____
_____

What kind of recommendations do you have to improve services for LGBT+ youth 16-29 years old who use substances/alcohol?

_____
_____
_____
_____
_____

Alcohol and Other Drug Use Frequency

*** If you have previously used alcohol and/or others drugs and currently do not use any alcohol and other drugs, please skip this chart and answer the question below the chart.**

If you are currently using alcohol and/or other substances, please fill out this chart. This question asks about your use of a whole bunch of different drugs, including alcohol. For each drug listed, please circle one number under the category that best describes your use pattern.

	Never Used	Tried but stopped	Several Times a Year	Several Times a Month	Weekends Only	Several Times a Week	Daily	Several Times a Day
Alcohol (beer, cider, wine, liquor, mouthwash, rubbing alcohol)	0	1	2	3	4	5	6	7
Marijuana (weed, hash, oil, bud, pot, dope, ganja, mary jane)	0	1	2	3	4	5	6	7
MDMA (e pill, ecstasy, E, molly, X)	0	1	2	3	4	5	6	7
Hallucinogens (mushrooms, mush, shrooms, LSD, acid, DMT, 5-Meo DMT, Peyote, mescaline)	0	1	2	3	4	5	6	7
Amphetamines (speed, adderall, dexadine, dex, ephedrine, methylone)	0	1	2	3	4	5	6	7
Methamphetamine (meth, crystal, jib, crystal meth, ice, Tina, crank, glass)	0	1	2	3	4	5	6	7
Powdered cocaine (coke, chach, yeyo)	0	1	2	3	4	5	6	7
Freebase cocaine (crack, rock)	0	1	2	3	4	5	6	7
Heroin (dope, smack, junk, china white, black tar, H, chasing the dragon)	0	1	2	3	4	5	6	7
Prescription opiates (morphine, oxycotin, oxys, oxycodone, 80s, dilaudid, fentanyl, codeine, percocet)	0	1	2	3	4	5	6	7
Ketamine (K, cat food, kitty, special k)	0	1	2	3	4	5	6	7
Phenethylamines (2CI, 2CB, 2CT-7)	0	1	2	3	4	5	6	7
Benzodiazepines (benzos, xanax, ativan, valium,)	0	1	2	3	4	5	6	7
Anything we missed?	0	1	2	3	4	5	6	7

If you have previously used alcohol or others drugs and have not used alcohol or other drugs for over a month now, what services and supports helped you make this change?

_____
_____
_____

Demographics

Age: _____

Gender (please select all that apply):

O Man
O Woman
O Genderqueer
O Non-binary
O Transgender
O Transsexual
O Trans woman
O Trans man
O Cis man
O Cis woman
O Two-Spirit
O Genderfluid
O Agender
O Cisgender
O Intersex
O Transmasculine
O Transfeminine

Anything we missed?

_____
_____

Sexual preference (please select all that apply):

O Gay
O Lesbian
O Bisexual
O Queer
O Asexual
O Pansexual
O Man that has sex with men
O Questioning
O Demisexual
O Heterosexual
O Straight

Anything we missed?

_____
_____

O Race and Ethnicity (please select all that apply):

O Black
O East Asian
O Hispanic/Latin@
O Indigenous
O Middle Eastern
O South Asian
O South East Asian
O White

If you identify with a particular ethnicity, what would it be?

_____
_____

Demographics

If you consider yourself to belong to a particular neighbourhood in Toronto, what would it be?

_____
_____

What type of environment are you currently living in? Please select all that apply right now.

O Apartment
O House
O Shelter
O Friend's place
O Relative's place
O Street
O No fixed address

Anything we missed?

_____
_____

Do you have a formally diagnosed or self-diagnosed disability, mental health or medical condition?

_____
_____
_____