Addressing Opioid Use Disorder among LGBTQ Populations

JUNE 2018

NATIONAL LGBT HEALTH EDUCATION CENTER
A PROGRAM OF THE FENWAY INSTITUTE

Introduction

Opioid use disorder has reached an alarming rate in the United States. As a population disproportionately affected by substance use disorders (SUDs), the lesbian, gay, bisexual, transgender and queer (LGBTQ) community has not been spared from the opioid epidemic. According to the 2015 National Survey on Drug Use and Health, LGB men and women across all age brackets were significantly more likely to have misused prescription pain relievers in the last year compared to heterosexual adults (Figure 1), and had almost three times greater risk of opioid use disorder compared to heterosexual adults.[1] Although little is known about opioid use among transgender people, the few studies that do exist have found an elevated prevalence of illicit drug use in this population.[2,3]

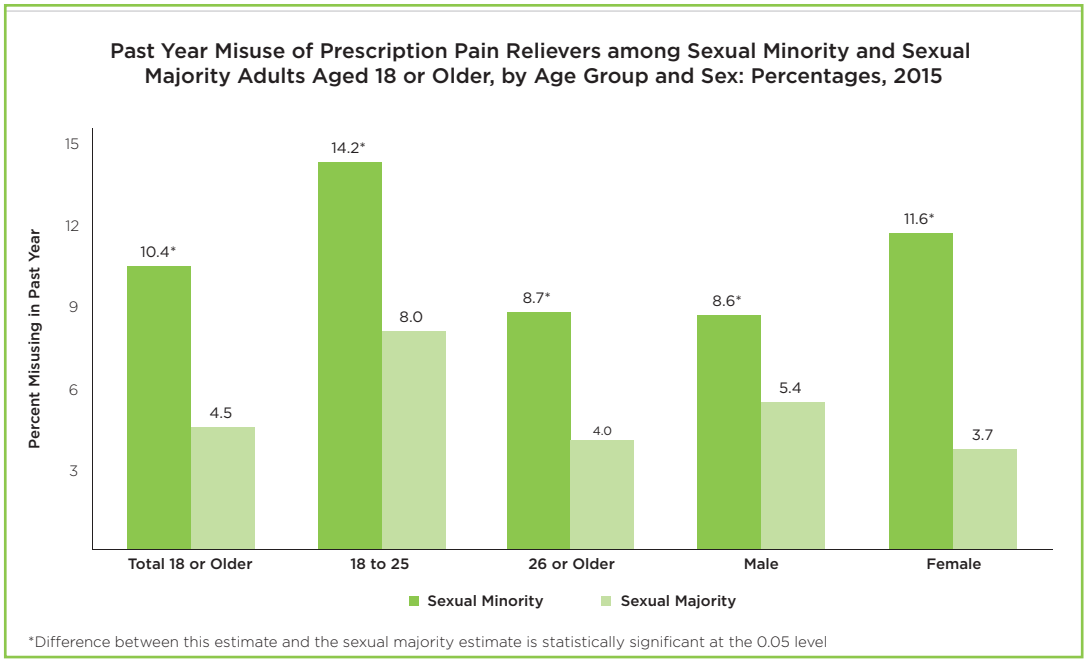

Figure 1. Past Year Misuse of Prescription Pain Relievers among Sexual Minority and Sexual Majority Adults Aged 18 or Older, by Age Group and Sex: Percentages, 2015 (Adapted from SAMHSA National Survey on Drug Use and Mental Health 2015)[1]

Minority Stress and Opioid Use

The higher prevalence of SUDs, including opioid use disorder, among LGBTQ people can best be understood within the framework of minority stress. Starting at a young age, LGBTQ people live with everyday discrimination, marginalization, and victimization based on their sexual and gender minority statuses. The stress caused by such high levels of external stigma can disrupt an individual's psychological processes, such as the ability to cope adaptively, regulate emotions, and achieve positive interpersonal relationships. External stigma can become internalized, leading to identity concealment, self-hate, feelings of worthlessness, and fear of rejection. To escape or mute these challenging emotions, some LGBTQ people turn to opioids and other substances that provide a sense of euphoria or relief. These behavioral coping mechanisms can lead to worse mental and physical health outcomes, such as physiologic dependence and addiction; depression and other mental health disorders; and HIV and other sexually- and intravenously-transmitted infectious diseases. [4,5,6]

LGBTQ youth in particular may turn to opioid use to cope with stigma-related stressors. One study found that sexual minority youth are more likely to initiate opioid misuse early in life compared to sexual majority peers.[7] Other studies have found associations between stress and higher opioid use among young men who have sex with men (MSM),[8] and specifically Black MSM.[9] A large survey of transgender Americans found that 35% of those who experienced school-related harassment or assault reported using substances to deal with the mistreatment.[10]

Medical Opioid Use in LGBTQ Populations

In medical settings, LGBTQ people are exposed to opioids at disproportionate rates as well. According to recent Massachusetts Behavioral Risk Factor Surveillance System (BRFSS) data, 58% of sexual and gender minority respondents between 35-44 years of age report ever being prescribed an opiate by a medical professional, compared with just 35% of their sexual and gender majority counterparts.[11] Certain clinical situations place LGBTQ people at increased risk of opioid exposure in medical settings. For example, though not all transgender people pursue surgical methods for gender affirmation, recent data from the American Society of Plastic Surgeons suggest that gender affirmation surgery is on the rise.[12] As opioid therapy is by far the most common form of post-surgical pain management, and opioid dependence is correlated with frequency of opioid exposure, each of these procedures places transgender patients at increased risk of developing opioid dependence. Additionally, both transgender people and older people living with HIV have increased prevalence of chronic pain, and up to one-fifth report taking an opioid-based pain medication.[13,14] Taken together, these clinical situations suggest that certain subpopulations of the LGBTQ community are at increased risk of developing opioid use disorder and signal the need for special care in prescribing opioids in these and other LGBTQ populations.

Opioid Use and Sexual Risk

Substance use is known to mediate the relationship between life stress and sexual risk, and opioid use in particular has the potential to increase HIV risk via sexual and injection drug behaviors.[15] For example, non-medical opioid use among MSM was associated with increased risk of condomless sexual intercourse, increased number of sexual partners, and sharing syringes.[16–18] Additionally, opioid use may compromise obtaining and giving sexual consent. It may also specifically place transgender people at risk of acquiring HIV via other needle sharing for hormone therapy, though little is known about the complex interplay of these risks.[19] Furthermore, treatment for opioid use disorder has been shown to be associated with a reduction in certain high-risk sexual and injection-drug behaviors and an increase in condom use,[20] bolstering the case for addressing opioid use disorder in LGBTQ populations.

Best Practices for Addressing Opioid Use Disorder among LGBTQ People

As with all patients suffering from an opioid use disorder, medication assisted therapy (MAT), in combination with counseling and behavioral health interventions, is the mainstay of treatment for LGBTQ people with opioid use disorder. However, given the multifactorial nature of opioid use in LGBTQ people and the complex medical needs of this population, certain concerns and considerations may arise during the course of opioid use disorder treatment. For example, how will treatment affect adherence to hormone therapy for transgender patients, to antiretroviral therapy (ART) for sexual and gender minority people living with HIV, and to pre-exposure prophylaxis (PrEP) for those at risk of acquiring HIV? How might MAT, such as buprenorphine and methadone, interact with hormone therapy, ART, and PrEP in these patients, and what are patients' beliefs about potential medication interactions that could impact their treatment adherence? What models of behavioral health interventions will be most efficacious for LGBTQ populations, and what adaptations should be made? Here we provide a framework and resources for addressing some of these pressing concerns.

Opioid Use Disorder Treatment and Medication Interactions

Opioid agonists, including treatments such as methadone and buprenorphine, have known interactions with certain ART medications, particularly efavirenz, and with hormone-modulating medications, such as spironolactone.[21,22] Known or perceived interactions between these and other medications may deter some patients and providers from initiating potentially life-saving treatment for opioid use disorder; we strongly caution against this fear. Co-prescription of these medications is safe and feasible with appropriate monitoring and follow up. Though a full discussion of these medication interactions is outside the scope of this clinical brief, resources for prescribers are available.[23] Of note, buprenorphine is thought to be safer and have fewer drug-drug interactions than methadone or other opioids.

Trauma-Informed Care

The co-occurrence of SUDs, including opioid use disorder, with posttraumatic stress disorder (PTSD) is common in the general population.[24,25] Having an SUD is associated with increased treatment costs, decreased treatment adherence, and worse physical and mental health outcomes for those with PTSD. Posttraumatic stress can occur as a result of an identifiable traumatic incident (such as sexual violence, assault, other hate crimes, etc.) but is also believed to occur after chronic, insidious minority stress, which many LGBTQ people experience throughout their lives. Though substance use is a common avoidance strategy for posttraumatic stress, treatment for SUDs that also targets trauma and stress in an integrated fashion has proven acceptable and efficacious in community addiction treatment programs.[26,27]

The Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Trauma-Informed Care offers excellent resources for organizations on best practices for providing trauma-informed care for SUD treatment, which can be broadly applied to LGBTQ people with opioid use disorder. According to SAMHSA, a trauma-informed service organization:

- Realizes widespread impact of trauma and understands potential paths for recovery
- Recognizes signs and symptoms of trauma in clients, staff, and others involved with the system
- Responds by fully integrating knowledge about trauma into policies, procedures, and practices
- Seeks to actively promote a sense of safety and resist re-traumatization.[28]

Several evidence-informed treatments designed to improve posttraumatic stress symptoms are emerging, including models for people living with HIV.[29] Trauma-informed approaches to opioid use disorder among LGBTQ people should incorporate the following:

- Development of a trauma-sensitive practice environment, including:
    - o training for clinical and administrative staff to ensure a sense of safety in all staff interactions with patients.
- Identification of trauma and its mediators, including:
    - o screening patients for trauma history, particularly populations with a higher risk of prior trauma and intimate partner violence,
    - o screening for sequelae of posttraumatic stress, including poor adherence to treatment and high-risk behaviors, among others.
- Education for patients about the connection between trauma and its negative behavioral and physical health outcomes.
- Linkage to suitable resources and referrals for more specialized treatment as needed.

Tools are available from the SAMHSA Center for Trauma-Informed Care to assist health centers and other healthcare organizations in adapting these approaches. However, implementation of these strategies to target the effects of trauma on health has been limited and inconsistent. Importantly, the framework of trauma-informed care has recently gained more national traction with increasing concerns about consequences of posttraumatic stress among veterans, presenting more opportunities for synergistic efforts by health centers.

Adapting Behavioral Health Addiction Treatment Frameworks for LGBTQ Populations

Cognitive behavioral therapy (CBT) has been shown to improve treatment outcomes for patients receiving MAT for opioid use disorder,[30,31] and cognitive processing therapy (CPT) has been shown to be efficacious in treating trauma-based stress disorders.[32,33] We believe that these frameworks can be applied to LGBTQ people with an opioid use disorder mediated by posttraumatic stress symptoms and may be even more effective with certain adaptations (Table 1). Providers ought to help patients recognize the adverse impacts of minority stress, as LGBTQ people often attribute these effects to personal failures as opposed to external stressors. Other strategies for providers include: facilitating emotional awareness, regulation, and acceptance; empowering assertive communication; restructuring harmful minority stress cognitions; validating the unique strengths of LGBTQ people; and fostering supportive relationships with the LGBTQ community and allies.[34]

Cognitive Behavioral Therapy		Cognitive Processing Therapy	
Basic Principles for Opioid Use Disorder[30]	***Tailoring for LGBTQ Populations***	***Basic Principles for PTSD[32-33]***	***Tailoring for LGBTQ Populations***
• Coping with craving (triggers, managing cues, craving control) • Shoring up motivation and commitment (clarifying and prioritizing goals, addressing ambivalence) • Refusal skills and assertiveness (substance refusal skills, passive/aggressive/ assertive responding) • All-purpose coping plan (anticipating high-risk situations, personal coping plan) • HIV risk reduction	• Minority stress-specific triggers for cravings (e.g. nonconformity-related discrimination and victimization, expectations of rejection, identity concealment, and internalized homophobia/ transphobia) • SUDs as barriers to personalized goals of adequate PrEP adherence or consistent condom use • For transgender patients: assertive substance refusal with non-transgender sex partners; HIV risk from hormone and silicone self-injections; SUDs as barriers to personalized goal of successful gender affirmation	• Education about posttraumatic stress • Writing an Impact Statement to help understand how trauma influences beliefs • Identifying maladaptive thoughts about trauma linked to emotional distress • Decreasing avoidance and increasing resilient coping	• Focus on how LGBTQ-specific stigma causes posttraumatic stress (e.g. avoidance, mistrust, hypervigilance, low self-esteem) • Attributing challenges to minority stress rather than personal failings • Impact Statement on how discrimination and victimization affect beliefs (e.g. expecting rejection, concealment needs, internalized homophobia/ transphobia) • Decreasing avoidance (e.g. isolation from LGBTQ community or health care) • Impact of minority stress on PrEP adherence or condom use

Table 1. Adapting Cognitive Behavioral Therapy and Cognitive Processing Therapy for LGBTQ people with an opioid use disorder. Modeled after a previously established minority stress framework.[34]

Behavioral Health Integration into Primary Care

Opioid use disorder and other SUDs rarely occur in isolation, and this is certainly true for LGBTQ populations. More commonly, these disorders exist within a complex interplay of other mental health problems, polysubstance use disorders, and co-occurring physical health problems. As such, integrated models of behavioral health and primary care services have emerged as effective, comprehensive programs for addressing these health issues. Integrated behavioral care exists along a spectrum, from simple coordinated care among separate facilities to fully-integrated, merged practices.[35] Integration of behavioral health services with primary care for LGBTQ patients with opioid use disorder and other SUDs may offer many benefits, including improving the patient experience of care, improving the health of larger populations, and reducing costs.[36]

Improved experience of care

The patient experience of care within an integrated behavioral health care program may improve by reducing the stigma of SUDs, including the dual stigma of addiction and LGBTQ minority status.[37] It improves an individual's access to behavioral health interventions, SUD treatment, and medical care, and has been shown to improve health outcomes.[38] It reduces patient care fragmentation and cultural barriers among medical and behavioral health providers. Finally, it offers opportune moments to address opioid use disorder while patients are currently receiving treatment for other mental and physical health problems.

Improved population health

Integration of behavioral health services within primary care increases the uptake of a variety of universal screening programs, such as screening, brief intervention, and referral to treatment (SBIRT),[39] and intimate partner violence screening.[40] It also allows for robust prevention and early intervention efforts. It can be structured as outcome-driven with a focus on quality and performance measures. Finally, it can serve as a tool for collecting mental and physical health outcomes data on sexual orientation and gender identity in medical settings.

Reduced per capita health care costs

From a systems-level perspective, integrated medical-behavioral health care capitalizes on synergistic health efforts and economies of scale, and is expected to lead to long-term cost savings. Annual estimates of these cost savings range from $26.3 to $48.3 billion nationally.[41] This is particularly important for behavioral health providers, since behavioral health care is poorly reimbursed in a fee-for-service model. Looking forward, these cost savings will also be critical as payers continue to move towards capitated payments and other risk-sharing payment models.

Fenway Health Model: An Example of an LGBTQ-Focused Integrated Opioid Use Disorder Program

Fenway Health is an LGBTQ-focused health center, research institute, and advocacy organization in Boston, Massachusetts. Collectively, Fenway cares for over 700 patients with opioid use disorder, most of whom have co-occurring physical and psychiatric disorders. Fenway utilizes a unique two-pronged approach to treating opioid use disorder that integrates addiction treatment with behavioral health and primary care services. The first component is the Addictions and Wellness Program, which is housed within Fenway's Behavioral Health Department and consists of individual and group therapy work rooted in a minority stress framework. This program, combined with the Behavioral Health Department's Violence Recovery Program, leverages LGBTQ community solidarity as a source of resilience and self-efficacy, and includes group therapy specifically for patients with both addictions and trauma. The Addictions and Wellness Program offers buprenorphine treatment in a weekly clinic staffed by a psychiatrist, during which the buprenorphine-prescribed support group meets with therapists specializing in addictions who utilize key contingencies and behavioral reinforcement paradigms for ongoing buprenorphine management. The second prong of Fenway's model is housed within Fenway's Primary Care Medical Department. This program, which follows a harm-reduction model, is led by an experienced nurse practitioner and requires few behavioral contingencies for ongoing buprenorphine management. Thus patients at Fenway may gravitate towards whichever of the two buprenorphine treatment programs more effectively supports their sobriety from opioids, while taking advantage of true integration of behavioral health services into primary care.

Conclusion and Next Steps

The opioid epidemic is devastating communities across the United States. Though little is known about the specific burden of the opioid epidemic on LGBTQ populations, other substance use disorders are disproportionately prevalent in the LGBTQ community, and data exist to suggest the same is true for opioid use disorder. Minority stress is a likely contributor to this increased burden and also serves as a helpful framework in understanding and addressing the opioid epidemic in LGBTQ populations. Though medication-assisted therapy with buprenorphine or methadone remain critical to addressing opioid addiction among LGBTQ people, adaptations of behavioral health interventions to the specific needs of this population will likely be important to curb the epidemic. Still, there is much work to do to better characterize the burden of this epidemic, to implement and evaluate the efficacy of integrated LGBTQ-focused behavioral health interventions, and to explore other LGBTQ-specific considerations related to the opioid epidemic.

Other Resources

SAMHSA-HRSA Center for Integrated Health Solutions: Integrating Behavioral Health into Primary Care: https://www.integration.samhsa.gov/integrated-care-models/behavioral-health-in-primary-care

Addiction Technology Transfer Center Network White Paper: Building Capacity for Behavioral Health Services within Primary Care and Medical Settings: http://attcnetwork.org/advancingintegration/ATTC_WhitePaper5_10_16Final.pdf

Substance Abuse and Mental Health Services Administration Center for Trauma-Informed Care: https://www.samhsa.gov/nctic

SAMHSA Buprenorphine Waiver Management: https://www.samhsa.gov/programs-campaigns/medication-assisted-treatment/training-materials-resources/buprenorphine-waiver

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This publication was written by Michael P. Girouard in collaboration with the National LGBT Health Education Center.

This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under cooperative agreement number U30CS22742, Training and Technical Assistance National Cooperative Agreements (NCAs) for $449,994.00 with 0% of the total NCA project financed with non-federal sources. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS, or the U.S. Government.

NLHEC-24