NATIONAL LGBT HEALTH EDUCATION CENTER

A PROGRAM OF THE FENWAY INSTITUTE

Addressing Opioid Use Disorders among LGBT People through Trauma-informed Care and Behavioral Health Integration

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Our Roots

Fenway Health

- Independent 501(c)(3) FQHC
- Founded 1971
- Mission: To enhance the wellbeing of the LGBT community as well as people in our neighborhoods and beyond through access to the highest quality health care, education, research and advocacy
- Integrated Primary Care Model, including HIV services

The Fenway Institute

- Research, Education, Policy

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- Program Faculty: Alex Keuroghlian, MD MPH
- Current Position: Director of Education and Training Programs at The Fenway Institute; Assistant Professor of Psychiatry, Harvard Medical School
- Disclosure: No relevant financial relationships. Presentation does not include discussion of off-label products.

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LGBT Education and Training

The National LGBT Health Education Center offers educational programs, resources, and consultation to health care organizations with the goal of providing affirmative, high quality, cost-effective health care for lesbian, gay, bisexual, transgender and queer (LGBT) people.

- Training and Technical Assistance
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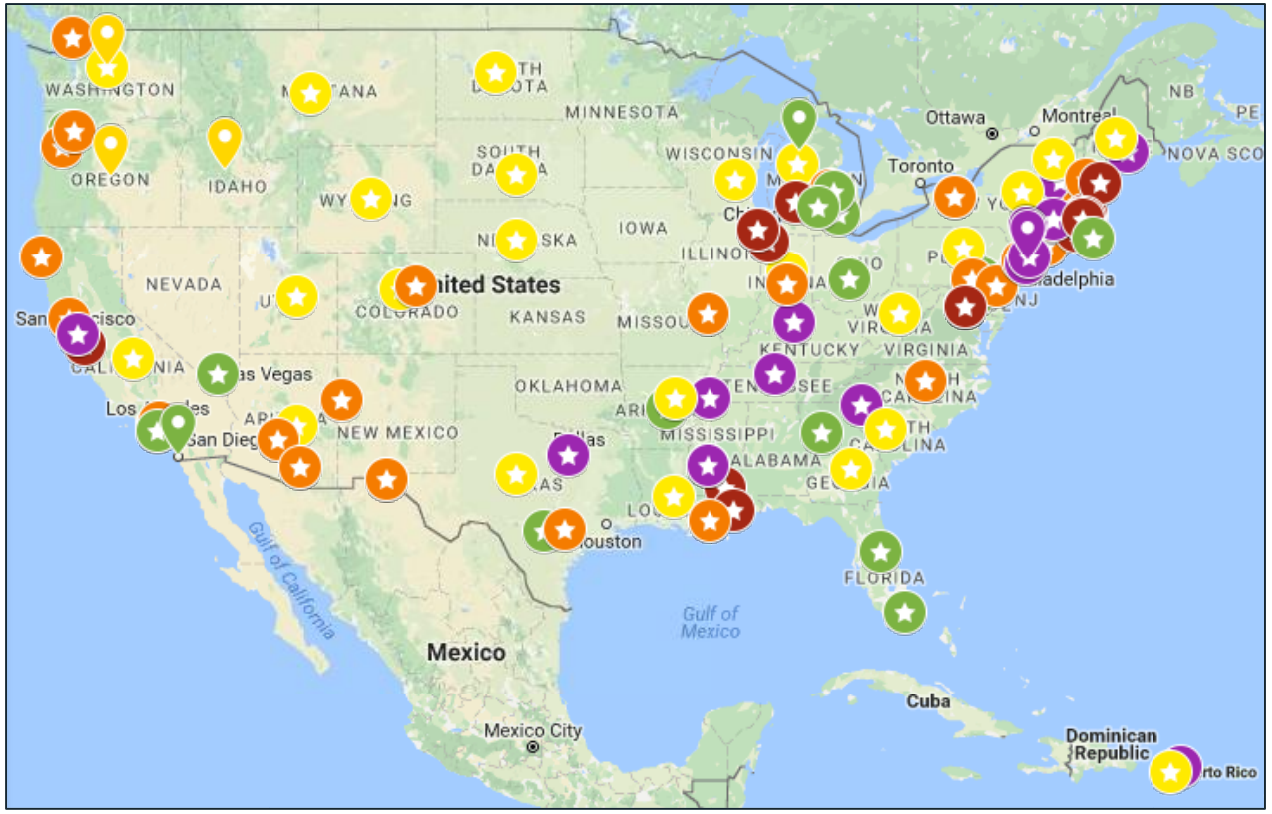


Training and Technical Assistance in 43 states, plus Washington D.C. and Puerto Rico

Learning Objectives

This session will enable participants to:

1. Describe the epidemiology of opioid use disorders in the LGBT population.
2. Identify LGBT subpopulations at increased risk.
3. Implement best practices in addressing opioid use disorders among LGBT people.

Opioids

- Class of drug that includes:
  - Heroin
  - Synthetics (e.g., fentanyl)
  - Prescription pain medications (e.g., oxycodone, codeine, morphine)
- Interact with opioid receptors on nerve cells in body and brain
- Prescription opioids intended for short-term use
- Regular use can lead to dependence, and misuse can lead to overdose and death

https://www.drugabuse.gov/drugs-abuse/opioids

Opioids

- Opioid overdose can be reversed with the drug naloxone if given right away.
- Effective medications exist to treat opioid use disorders: methadone, buprenorphine, and naltrexone.
- Every day, more than 90 Americans die of an opioid overdose.
- Economic cost of prescription opioid misuse alone in U.S. is $78.5 billion annually.

https://www.drugabuse.gov/drugs-abuse/opioids/opioid-overdose-crisis#one

Minority Stress Framework

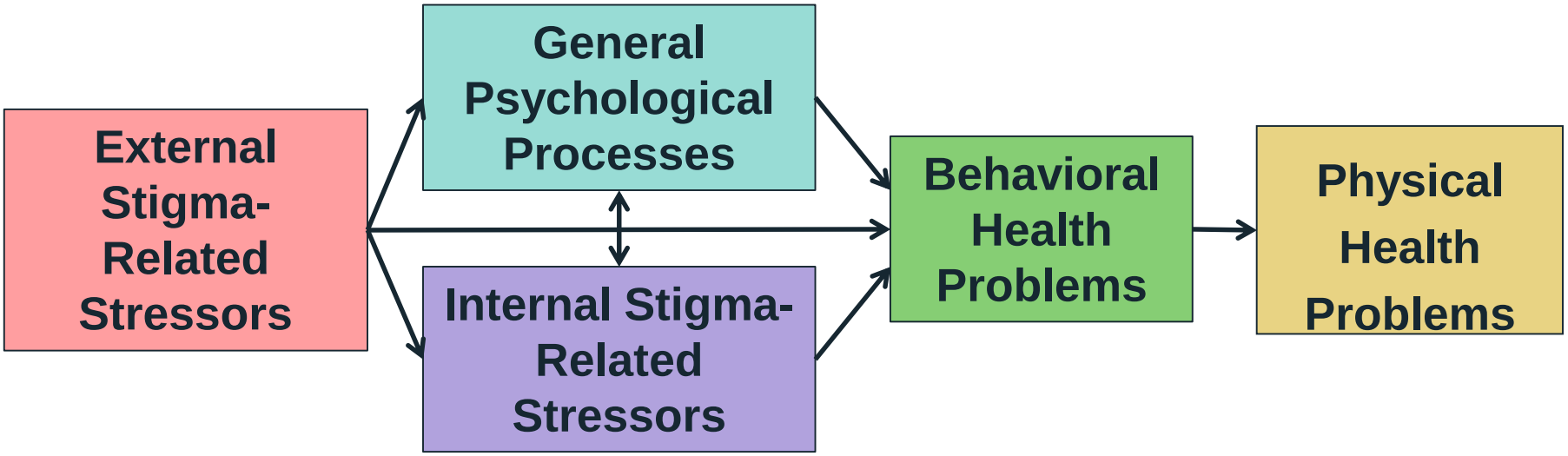
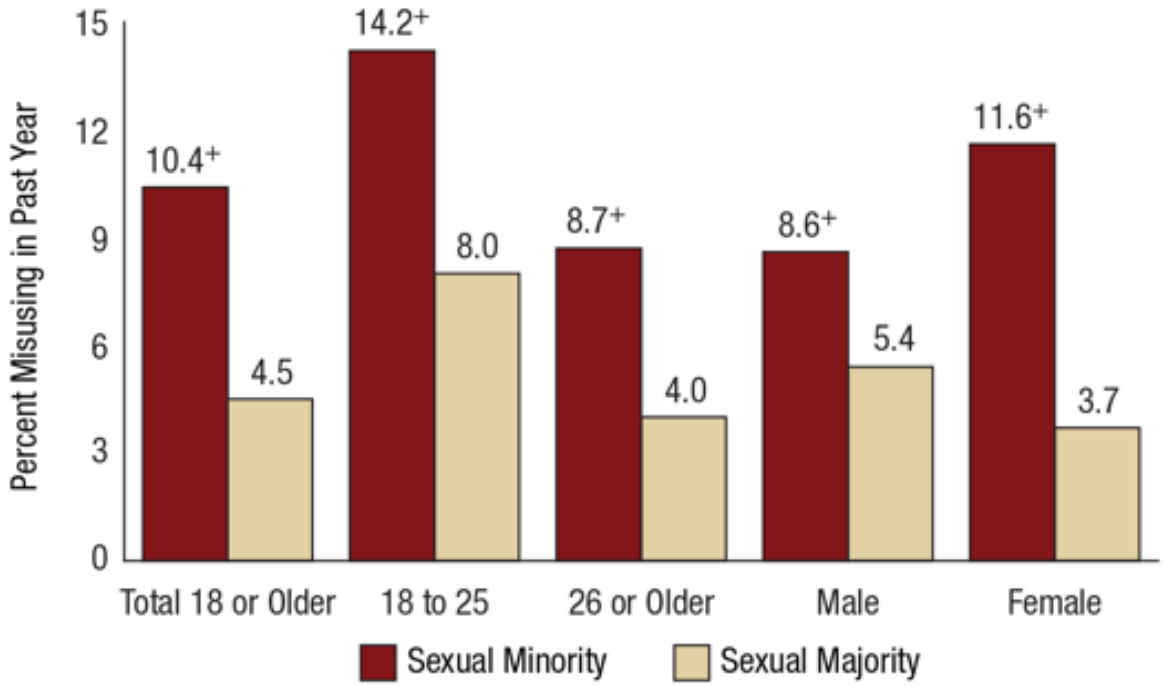


Fig. 1: Adapted from *Hatzenbuehler, 2009*

2015 National Survey on Drug Use and Mental Health

Figure 5. 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



D

+ Difference between this estimate and the sexual majority estimate is statistically significant at the .05 level.
Note: Sexual minority adults identified as being lesbian, gay, or bisexual. Sexual majority adults identified as being heterosexual or straight.

SAMHSA, 2015

Opioid Use Disorders among Sexual Minority Groups

- Sexual minority youth aged 16 to 25 are more likely to initiate prescription opioid misuse early in life compared with their sexual majority counterparts (Kecojevic et al., 2012).

- Among young men who have sex with men (MSM) aged 18 to 29, higher perceived stress is associated with higher opioid misuse (Kecojevic et al., 2015).

Opioid Use Disorders among Sexual Minority Groups

- Higher life stress among young Black MSM in Chicago was associated with greater odds of prescription opioid use (Voisin et al., 2017).

- Nonmedical opioid use among MSM is associated with increased risk of condomless sexual intercourse and sharing syringes (Zule et al., 2016).

Minority Stress and Substance Use Disorders

- LGBT people have disproportionate substance use disorder (SUD) prevalence as a downstream effect of minority stress (Nuttbrock, 2013; Pachankis, 2015).

- Substance use mediates the relationship between life stress and sexual risk (Hotton, et al., 2013).

A Closer Look: Addictions among Transgender People

- Studies examining substance use disorders (SUDs) among transgender people are rare (Flentje, et al., 2015).
- Reporting of gender identity data (e.g., transgender status) in SUD-related research is limited.
- In the few studies that exist, transgender people have elevated prevalence of illicit drug use compared with the general population (Nuttbrock et al., 2013; Rowe et al., 2015).

Gender Minority Stress and Substance Use among Transgender People

- 35% of transgender people who experienced school-related verbal harassment, physical assault, sexual assault, or expulsion reported using substances to cope with transgender- or gender nonconformity-related mistreatment (Grant et al., 2011).
- Psychological stress of health care access disparities faced by transgender people is believed to contribute to worse mental health, including disproportionate substance use as a coping strategy.

Substance Use Disorders among Transgender Adults

- Among 452 transgender adults, increased odds of SUD treatment history plus recent substance use (including opioid use disorders) were associated with:
  - intimate partner violence
  - PTSD
  - public accommodations discrimination
  - low income
  - unstable housing
  - sex work
- SUDs increasingly viewed as downstream effects of chronic gender minority stress

Keuroghlian et al., 2015

Substance Use and Posttraumatic Stress

- Co-occurrence of SUDs with posttraumatic stress symptoms is highly prevalent (McCauley, 2012):
  - Associated with increased treatment costs, decreased treatment adherence, and worse physical and mental health outcomes
- Substance use is a common avoidance strategy for posttraumatic stress

26 McCauley, Jenna L., et al. "Posttraumatic stress disorder and co-occurring substance use disorders: Advances in assessment and treatment." *Clinical Psychology: Science and Practice* 19.3 (2012): 283-304.

Integrated Treatment for Addictions and Trauma

- Recent shift in focus toward trauma-informed care created a favorable environment in community SUD treatment settings for evidence-based integrated therapies that also target trauma and stress (Killeen et al., 2015; McGovern et al., 2015; Roberts et al., 2015; Institute of Medicine, 2008).
- Integrated treatments for SUDs and posttraumatic stress are well tolerated and improve both SUDs and PTSD.

Definition of Trauma-informed Care

- According to the Substance Abuse and Mental Health Services Administration (SAMHSA, 2014), 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 resist re-traumatization.

Trauma-informed Care: An Emerging National Priority

- Emergence of several evidence-informed treatments designed to improve posttraumatic stress symptoms (Brezing and Freudenreich, 2015).
- Implementation of these strategies to target effects of trauma on health has been inconsistent, including at health centers.
- This issue has recently gained more national prioritization with increasing concerns about consequences of posttraumatic stress among veterans.

Trauma-Informed Care

- Trauma-informed approach should incorporate the following (Brezing and Freudenreich, 2015):
  - A trauma-sensitive practice environment
    - Trainings to ensure a sense of safety in all patient interactions with staff members, including clinical and administrative staff
  - Identification of trauma and its mediators
    - Sequelae of posttraumatic stress, including poor adherence to treatment and high-risk behaviors
  - Education for patients about connection between trauma and its negative behavioral and physical health outcomes
  - Linkage to suitable resources and referrals for more specialized treatment as needed

National Center for Trauma-Informed Care

- In 2005, SAMHSA developed the National Center for Trauma Informed Care:
  - Promotes awareness and implementation of best practices
  - Disseminates resources for and referrals for trauma-focused treatments
  - Defines trauma-informed care as an organizational approach rooted in principles that focus on being mindful of and responding to people who have experienced or may be at risk of trauma; rather than a particular set of rigid procedures

SAMHSA, 2014

Trauma-Informed Service Environment

- Priority is to promote a sense of safety
- Prior traumatic experiences influence reaction in subsequent interactions, such as the process of seeking care
- A history of interpersonal trauma can contribute to mistrust of caretakers and increased likelihood of being re-traumatized
- Retention in care for patients with trauma histories requires engagement through collaboration, transparency, trust, and consistent supportiveness

Brezing and Freudenreich, 2015

Screening for and Identifying Trauma and Its Mediators

- Screening all patients for a trauma history
  - Extra attentiveness for subpopulations with an even higher risk of trauma, who may have heightened sensitivity;
  - Screening for intimate partner violence.
- If trauma is identified, care team ought to assess specifically for posttraumatic stress symptoms
  - Hypervigilance; avoidance, numbing, re-experiencing through intrusive thoughts, flashbacks, nightmares; psychological dissociation, including amnesia, depersonalization, and derealization.

Brezing and Freudenreich, 2015

The Primary Care PTSD Screen (PC-PTSD)

Exhibit 1.4-5: PC-PTSD Screen

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, *in the past month*, you…

1. Have had nightmares about it or thought about it when you did not want to?
   YES NO
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?
   YES NO
3. Were constantly on guard, watchful, or easily startled?
   YES NO
4. Felt numb or detached from others, activities, or your surroundings?
   YES NO

Source: Prins et al., 2004. Material used is in the public domain.

SAMHSA, 2014

Intimate Partner Violence Screening Tool

Exhibit 1.4-4: STaT Intimate Partner Violence Screening Tool

1. Have you ever been in a relationship where your partner has pushed or Slapped you?
2. Have you ever been in a relationship where your partner Threatened you with violence?
3. Have you ever been in a relationship where your partner has thrown, broken, or punched Things?

Source: Paranjape & Liebschutz, 2003. Used with permission

SAMHSA, 2014

Minority Stress Treatment Principles for Clinicians Treating Opioid Use Disorders

- Normalize adverse impact of minority stress (Pachankis, 2013):
- Facilitate emotional awareness, regulation, and acceptance
- Empower assertive communication
- Restructure minority stress cognitions
- Validate unique strengths of LGBT people
- Foster supportive relationships and community
- Affirm healthy, rewarding expressions of sexuality and gender

Cognitive-behavioral Therapy for Substance Use Disorders

- Adapting selected topics and practice exercises from the manual by Carroll (1998):
- Focus:
  - 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.

Cognitive-behavioral Therapy for Substance Use Disorders

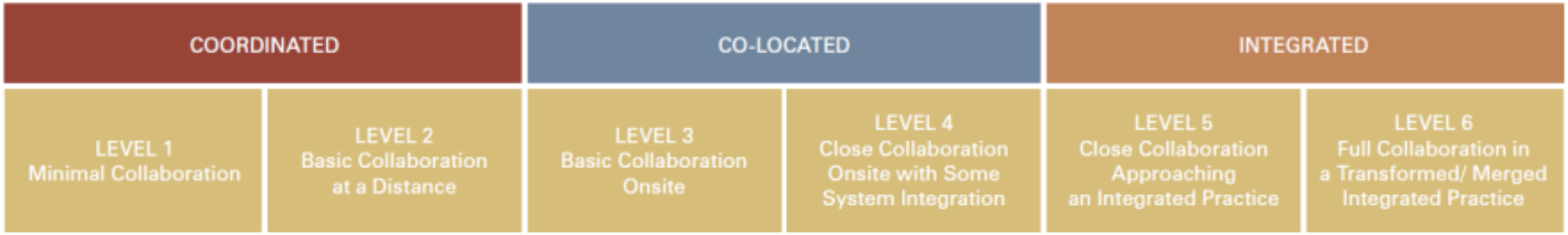
- Tailoring for LGBT patients:
  - Minority stress-specific triggers for cravings (e.g. nonconformity-related discrimination and victimization, expectations of rejection, identity concealment, and internalized homophobia/transphobia);
  - SUDs as barriers to personalized goals of adequate PrEP adherence 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.

Behavioral Health Integration (BHI)

What are the Types of BHI?

Spectrum (Heath et al., 2013):

- Coordinated
- Co-Located
- Integrated



Coordinated

- Separate systems and facilities, issue driven
- Level 1
  - Minimal Collaboration
- Level 2
  - Basic Collaboration at a Distance

Co-Located

- Level 3
  - Basic collaboration on-site
  - Same facility, separate system
- Level 4
  - Close collaboration on-site with some system integration
  - Same facility, some shared systems
  - Driven by complex patients, regular face-to-face interactions, basic understanding of culture

Integrated

- Level 5
  - Close collaboration approaching an integrated practice
  - Same facility, some shared space, toward same team
- Level 6
  - Full collaboration in a transformed/merged integrated practice
  - Sharing all the same space within same facility
  - One integrated system of team care, roles and cultures blended

Why BHI?

1. Improving experience of care
2. Improving health of populations
3. Reducing per capita costs of health care

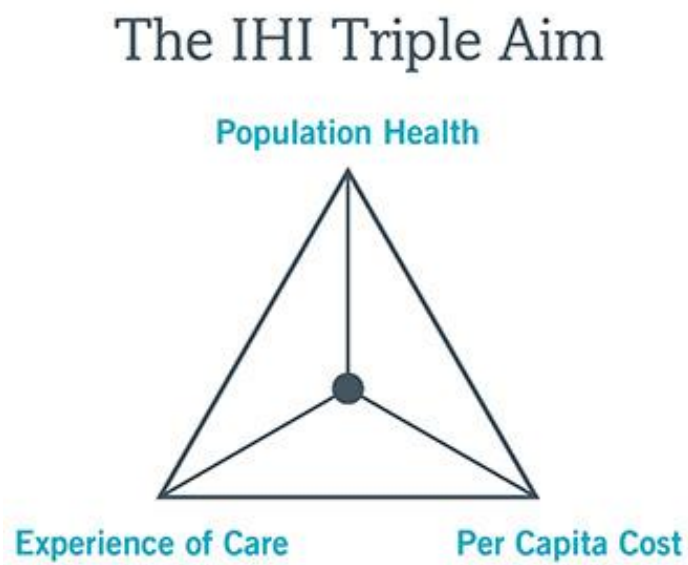


Fig. 3: Diagram from Institute for Healthcare Improvement[56]

56 Source: http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx

1. Patient Experience

1. Improving the patient experience
   - Reducing stigma (including dual stigma of addiction and LGBT minority status)
   - Mind-body holistic approach to health

2. Improving access to care
   - Primary care clinics are more accessible
   - Reducing operational inefficiencies
   - Reducing cultural barriers among medical and behavioral health providers
   - “Striking when the iron is hot”

2. Population Management

- Universal screening
- Prevention and early intervention
- Managing co-occurring disorders
- Outcome-driven with performance measures
- A long-term goal of sexual orientation and gender identity data collection

3. Cost

- BHI expected to lead to cost savings (Melek, 2014):
- Estimated $26.3-48.3 billion nationally
- Important since behavioral health care is poorly reimbursed in a fee-for-service model

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

Evidence-based practice to identify, reduce, and prevent problematic alcohol and drug use (Babor et al., 2007):

1. Screening

2. Brief Intervention

3. Referral to Treatment

Co-occurring Opioid Use and Psychiatric Disorders: Fenway's Model

- Over 700 Fenway patients with an opioid use disorder, mostly alongside other psychiatric disorders
- Dual diagnosis approach to treatment
- Integration of addictions treatment with behavioral health services

Co-occurring Opioid Use and Psychiatric Disorders: Fenway's Model

- Fenway's model: Addictions and Wellness Program (800 patients) within Behavioral Health (BH) Department

- Individual and group therapy programs rooted in a minority stress framework

- Leveraging LGBT community solidarity as a source of resilience and self-efficacy

Co-occurring Opioid Use and Psychiatric Disorders: Fenway's Model

- Addictions and Wellness Program includes group therapy specifically for patients with both addictions and trauma

- Addictions and Wellness Program integrated with Violence Recovery Program for LGBT patients
  - Both programs housed within BH Department

Fenway's Two Models of Buprenorphine Treatment

- Buprenorphine clinic in BH department
  - Weekly clinic with psychiatric prescriber, buprenorphine group meets concurrently
  - Leverages treatment contingencies and behavioral reinforcement paradigms
- Harm reduction model for buprenorphine in primary care
  - Initiated in Fall 2017 in response to opioid epidemic
  - Led by nurse practitioner based in medical department

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The Education Center is a part of The Fenway Institute, the research, training, and health policy division of Fenway Health, a Federally Qualified Health Center, and one of the world's largest LGBT-focused health centers.

Advice from one health care provider to another.
JANUARY 18, 2017

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