National Center for Medical Education, Development and Research

Communities of Practice Webinar:
Addressing Opioid Use Disorders among LGBT People through Trauma-informed Care and Behavioral Health Integration
August 13, 2018 11:00am – 12:00pm CST

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Reminders….

- Please mute your microphone.
- The webinar is being recorded.
- We will address questions during the Q&A section.
- Thank you for joining the webinar.

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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 the evaluation and treatment of opioid use disorders among LGBT people.

National Center for Medical Education, Development and Research

*The aim of the Center is to address the needs of persons who are LGBTQ, Homeless, Migrant Farm Workers (vulnerable populations).

*Translate research findings into Medical Education curriculum and clinical practice into primary care training and practice guidelines.

Patricia Matthews-Juarez, PhD
Project Director

Paul Juarez, PhD
NCMEDR Director

Katherine Y. Brown, EdD
Director, Communities of Practice

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Today's Speakers

Katherine Y. Brown, EdD, OTR/L
Director, Communities of Practice
National Center for Medical Education,
Development and Research

R. Lyle Cooper, PhD, LCSW
Assistant Professor Department of Family and
Community Medicine
Researcher: National Center for Medical Education,
Development and Research

Alex S. Keuroghlian, MD, MPH
Director, The National LGBT Health Education Center
Assistant Professor of Psychiatry, Harvard Medical School

Leandro Mena, MD, MPH
Professor and Chair of Population Health Science, John D. Bower School of
Population Health and Professor of Medicine, University of Mississippi School of Medicine
Consultant: National Center for Medical Education, Development and Research

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R. Lyle Cooper, PhD, LCSW

Dr. Cooper has over 20 years of experience as a behavioral interventionist working with persons with Substance Use Disorders (SUD), and those at risk of HIV. He started his career as an outreach worker for the NIDA funded indigenous street outreach worker model studies, bringing HIV and SUD intervention to consumers where they are. This clinic to community approach has continued to influence all of his research academic, and clinical work. He has since served as a therapist and program manager in programs focused on opioid misusers including preventive programming such as syringe services programs and HIV/HCV testing for drug users. He has been in academia for the past 15 years, where has served as was the director of a substance abuse counseling certificate, developed the clinical course section of the Doctorate in Social Work Program at the University of Tennessee, and is currently developing an addiction curriculum for family medicine residents. His research is currently focused on testing low resource, primary care delivered opioid treatment models, and tailoring substance abuse treatment models to the needs of LGBTQ consumers in the South. He has published over 20 articles addressing SUD and mental health treatment, HIV prevention and care, as well as the experience of LGBTQ consumers in the receipt of these services.

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Opioid Use and LGBTQ Patients

- Rates of opioid misuse are higher among sexual minorities than the general population.[1]
- Co-occurrence of trauma with opioid use is frequent.[2-6]
- Opioid use is associated with increased sexual risk behavior and syringe sharing.[7,8]
- Survival sex.

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Treating Opioid Misuse among LGBTQ Patients

- Trauma informed care
- Evidence based behavioral trauma treatments
- Evidence based substance abuse treatments
- Medication assisted treatment
- Linkage to other services

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Our Approach (primary care integration)

- Integrated treatment approach including MAT and naloxone training distribution
- CBT
- Seeking Safety
- Chronic pain self-management training
- Case Management Services
- Partnership with emergency departments
- Partnership with substance abuse treatment
- Partnership with HIV/HCV clinic
- Partnership with CBOs doing prevention outreach and SSP

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Keynote Speaker

Alex S. Keuroghlian is the Director of Education and Training Programs at The Fenway Institute and Assistant Professor of Psychiatry at Harvard Medical School (HMS). He directs the National LGBT Health Education Center, a HRSA-funded cooperative agreement to improve health care for LGBTQ people at health centers. Dr. Keuroghlian concurrently directs the Evidence-Informed Interventions Coordinating Center for Technical Assistance, also funded by HRSA, to implement effective and culturally-tailored interventions nationally for people living with HIV. He is the Public and Community Psychiatry Curriculum Director for the Massachusetts General Hospital (MGH)/McLean psychiatry residency program and clerkship director for the fourth-year elective in LGBTQ health at HMS.

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Continuing Medical Education Disclosure

- 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.

It is the policy of The National LGBT Health Education Center, Fenway Health that all CME planning committee/faculty/authors/editors/staff disclose relationships with commercial entities upon nomination/invitation of participation. Disclosure documents are reviewed for potential conflicts of interest and, if identified, they are resolved prior to confirmation of participation. Only participants who have no conflict of interest or who agree to an identified resolution process prior to their participation were involved in this CME activity.

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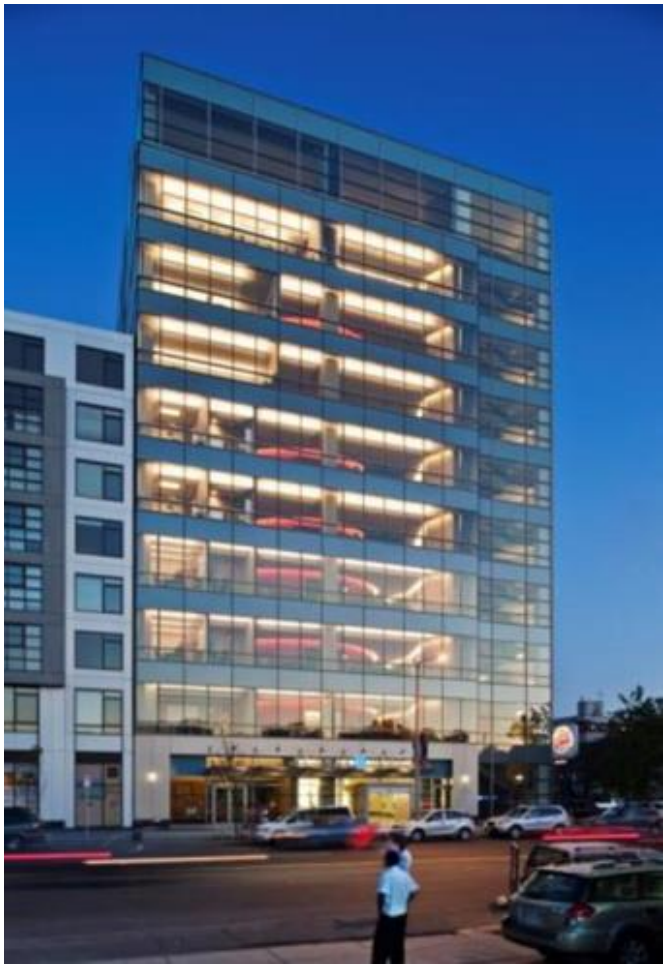
The Fenway Institute

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 and transgender health

The Fenway Institute

- Research, Education, Policy



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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
- Grand Rounds
- ECHO Programs
- On Line Learning
  - Webinars and Learning Modules
  - CE, and HEI Credit
- Resources and Publications
- www.lgbthealtheducation.org

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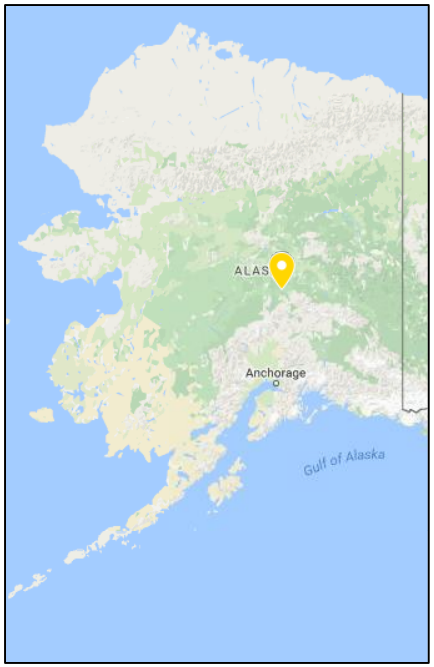
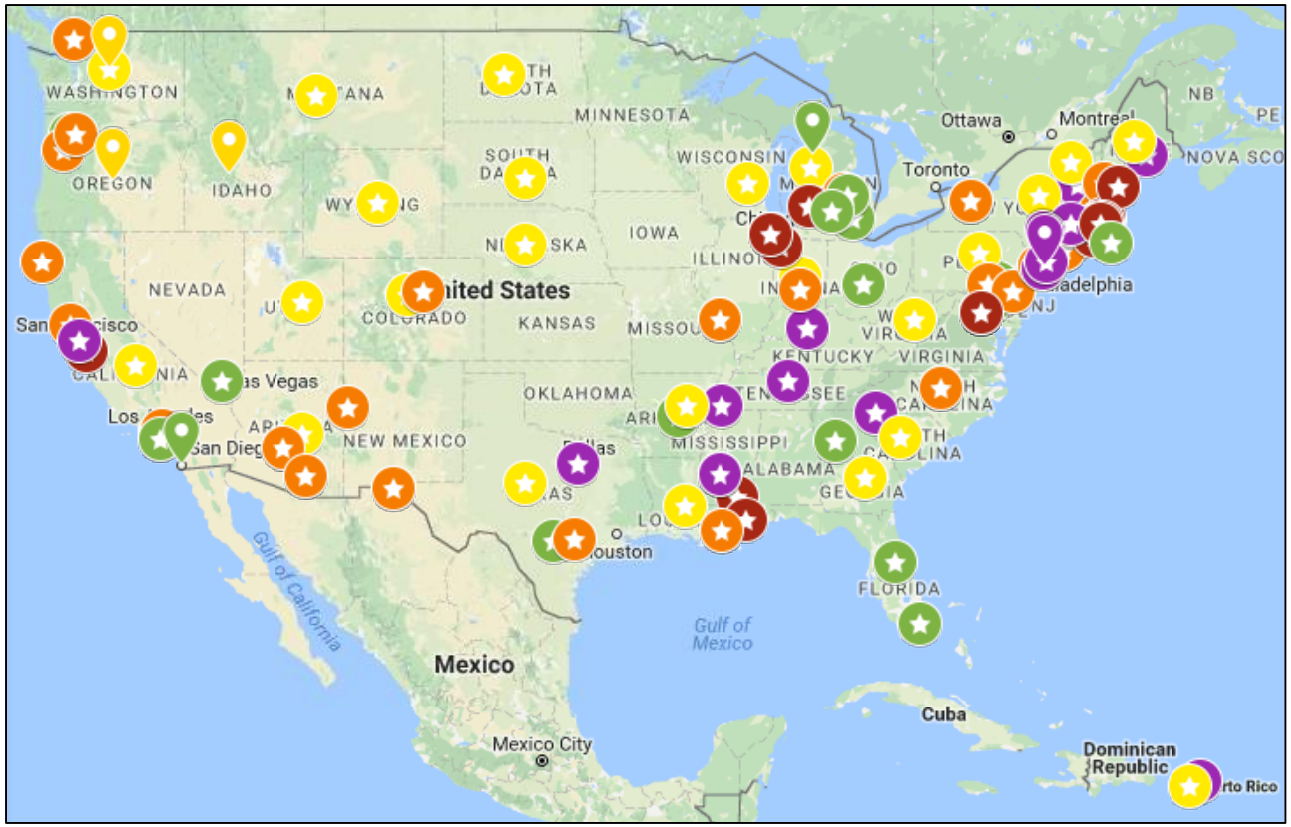
The National LGBT Health Education Center





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

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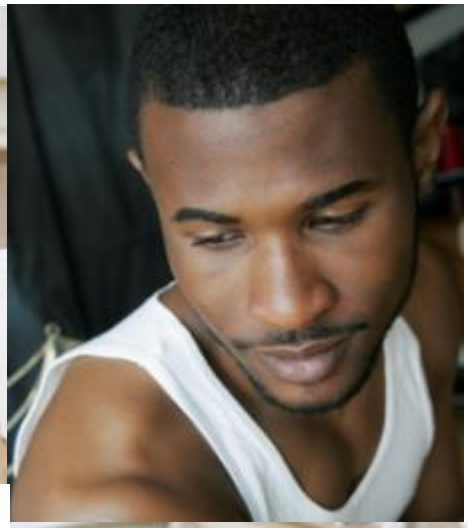
L,G,B,T,Q Concepts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Sexual Orientation and Gender Identity are Not the Same

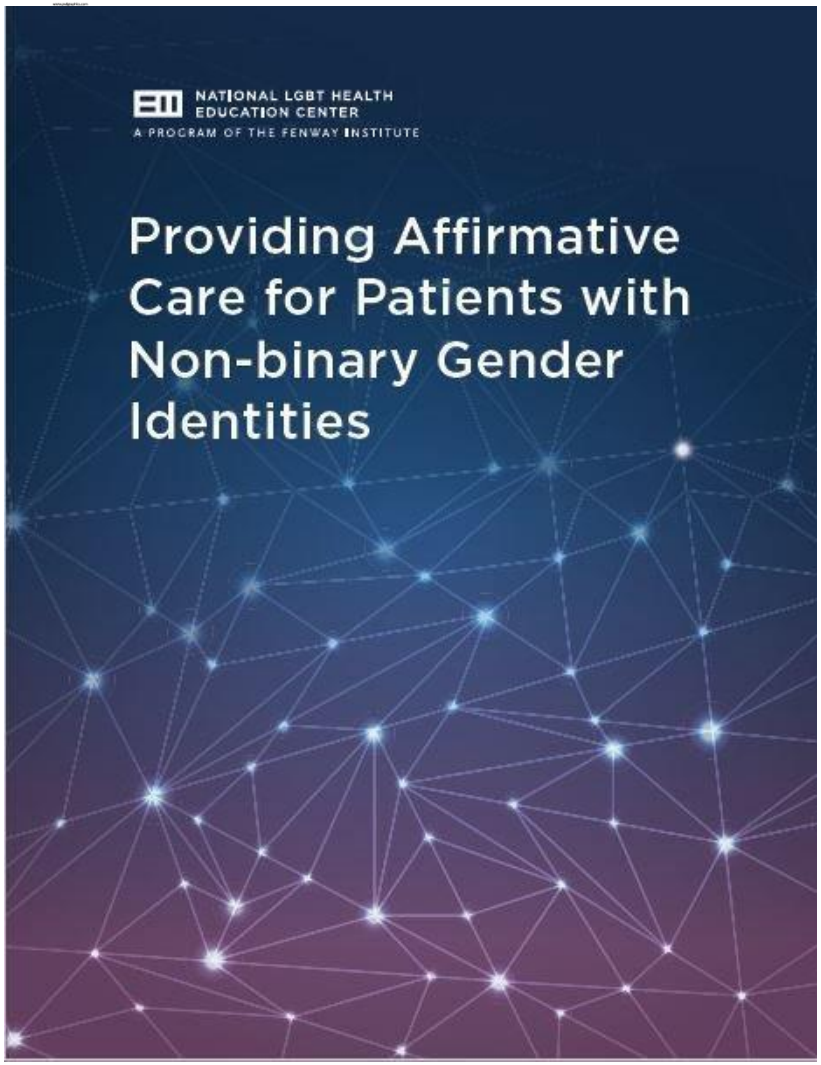
- All people have a sexual orientation and gender identity
  - How people identify can change
  - Terminology varies
- Gender Identity ≠ Sexual Orientation

Gender Identity and Gender Expression

- Gender identity
  - A person's inner sense of being a boy/man, girl/woman, another gender, or no gender
  - All people have a gender identity
- Gender expression
  - How one presents themselves through their behavior, mannerisms, speech patterns, dress, and hairstyles
  - May be on a spectrum

A complete glossary of terms is available at www.lgbthealtheducation.org/publication/lgbt-glossary/

In a 2013 community-based survey of 452 transgender adults, 40.9% of respondents described themselves as having a “non-binary gender identity.”[1]



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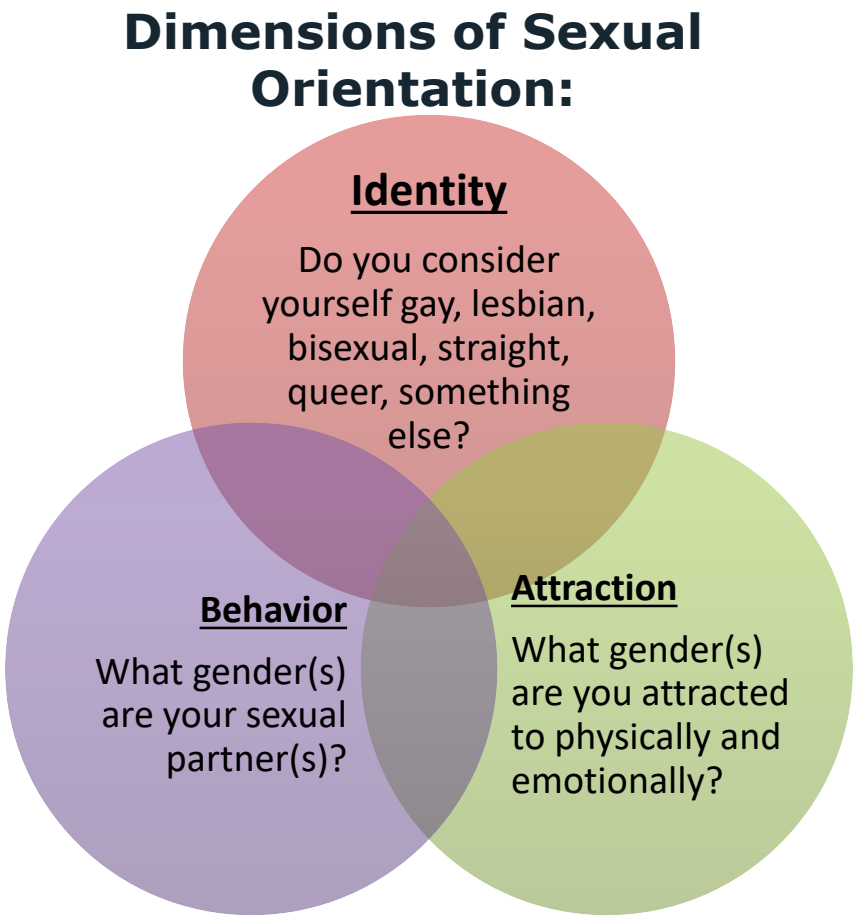
The T in LGBTQ: Transgender

- Gender identity not congruent with the assigned sex at birth
- Alternate terminology
  - Transgender woman, trans woman, male to female (MTF)
  - Transgender man, trans man, female to male (FTM)
- Non-binary, genderqueer
  - Genderqueer person
- Trans masculine, Trans feminine
- Gender identity is increasingly described as being on a spectrum

Sexual Orientation

- Sexual orientation: how a person identifies their physical and emotional attraction to others
- Desire
- Behavior
  - Men who have sex with men- MSM (MSMW)
  - Women who have sex with women-WSW (WSWM)
- Identity
  - Straight, gay, lesbian, bisexual, queer, other



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What Does 'Q' Stand For?

- 'Q' may reflect someone who is 'questioning' their sexual orientation, attraction to men, women, both, or neither.
- 'Q' may stand for 'queer,' a way some people identify to state they are not straight but also don't identify with gay, lesbian or bisexual identities. The term queer is particularly commonly used among younger people, and also used by people of all ages.

Minority Stress Framework

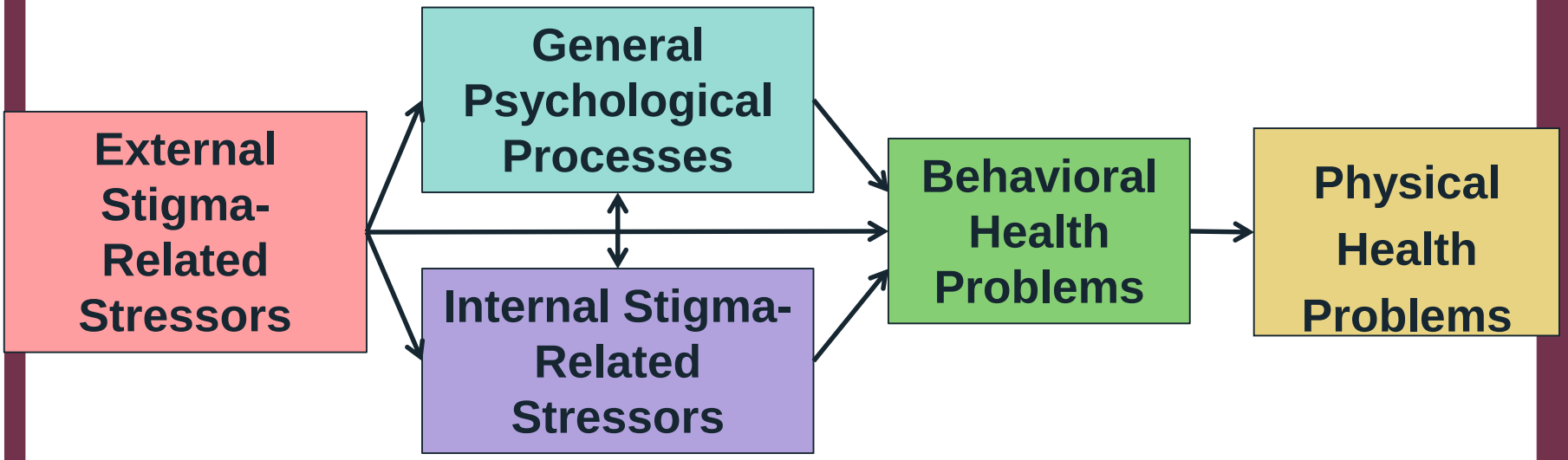

Fig. 1: Adapted from *Introduction to the special issue on structural stigma and health*[3]

Interpersonal Stigma

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Structural Stigma

- Structural, or institutional discrimination includes the policies of private and governmental institutions that intentionally restrict the opportunities of certain people, as well as policies that unintentionally restrict these opportunities.

Intrapersonal Stigma:

"…And to the degree that the individual maintains a show before others that they themselves does not believe, they can come to experience a special kind of alienation from self and a special kind of wariness of others."[4]

Anti-Transgender Discrimination and Victimization

- The 2015 U.S. Transgender Survey found that:[5]
  - 10% reported that a family member was violent towards them because they were transgender
  - 8% were kicked out of the house because they were transgender
  - Many experienced serious mistreatment in school, including being verbally harassed (54%), physically attacked (24%), and sexually assaulted (13%) because they were transgender
  - 17% experienced such severe mistreatment that they left a school

Vulnerability to Poverty

- The 2015 U.S. Transgender Survey found that:[7]
  - 29% of transgender people live in poverty, compared to 14% in the U.S. population
  - Transgender people have a 15% unemployment rate (compared with 5% in the U.S. population)
  - 16% of transgender people report homeownership, compared to 63% of the U.S. population
  - Nearly 30% of transgender people experienced homelessness in their lifetime
  - 12% report past-year homelessness due to being transgender

Health Disparities

- The 2015 U.S. Transgender Survey found that:[12]
  - 39% of respondents experienced serious psychological distress in the month prior, compared with only 5% of the U.S. population
  - 40% had lifetime suicide attempt (compared to 4.6% of US population)
  - 55% of those who sought coverage for gender-affirming surgery in the past year were denied, and 25% of those who sought coverage for hormones in the past year were denied

Health Disparities

- The 2015 U.S. Transgender Survey found that:
  - 33% had at least one negative experience with a health care provider such as being verbally harassed or refused treatment because of gender identity
  - 23% of transgender people report not seeking needed health care in the past year due to fear of gender-related mistreatment
  - 33% did not go to a health care provider when needed because they could not afford it

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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

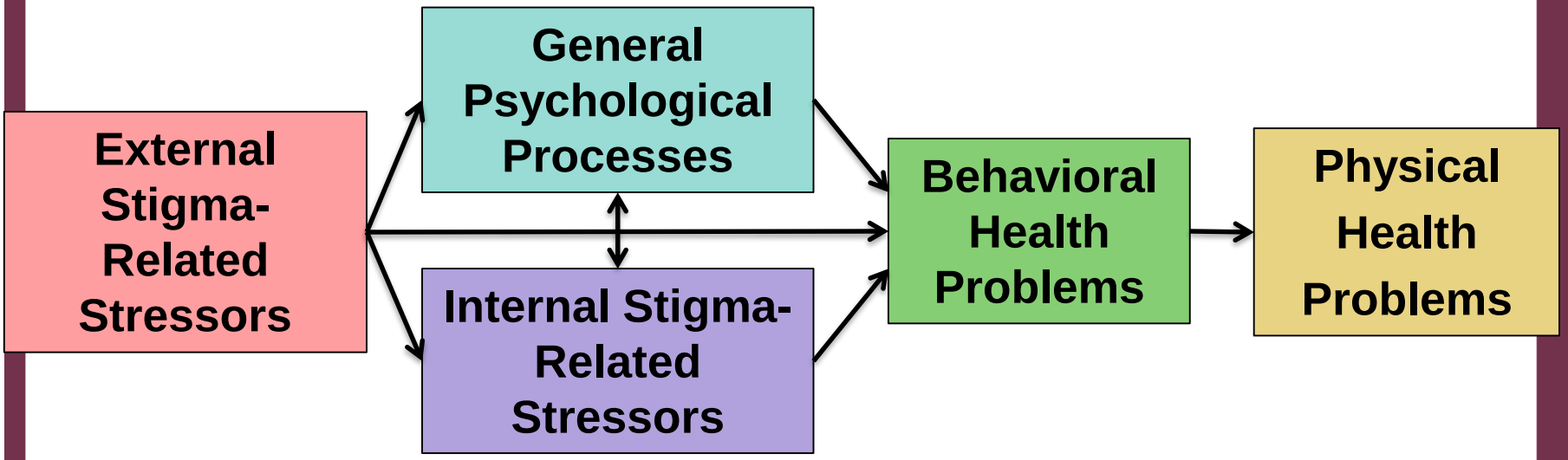
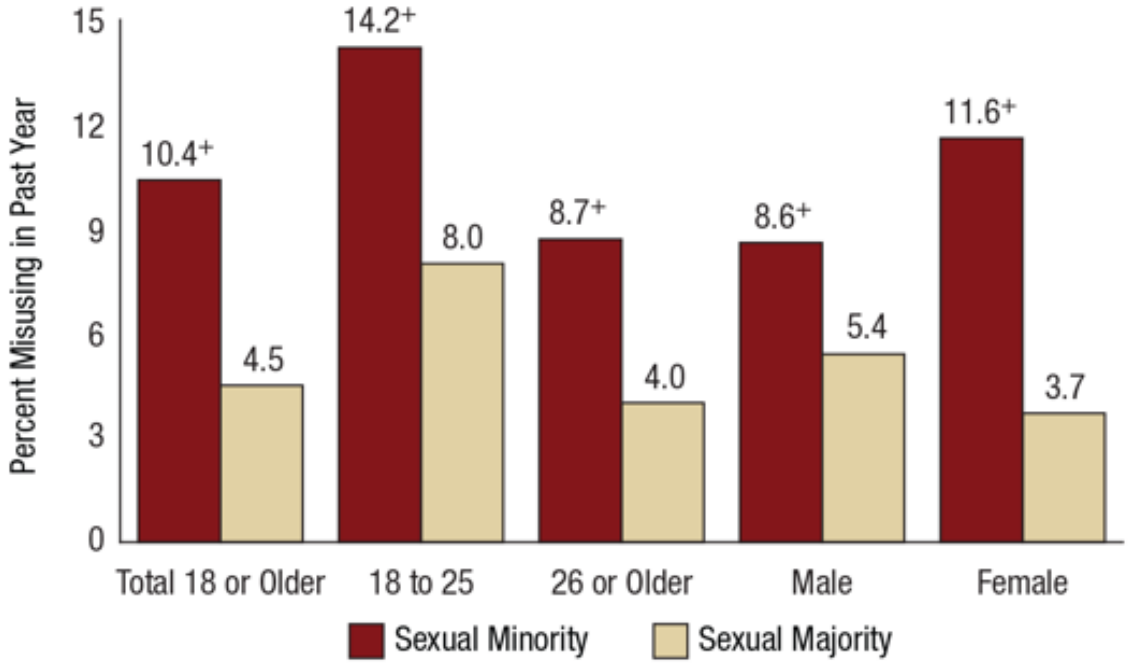


Fig. 1: Adapted from *Hatzenbuehler, 2009*

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

- <u>Tailoring for LGBT patients:</u>
  - 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)

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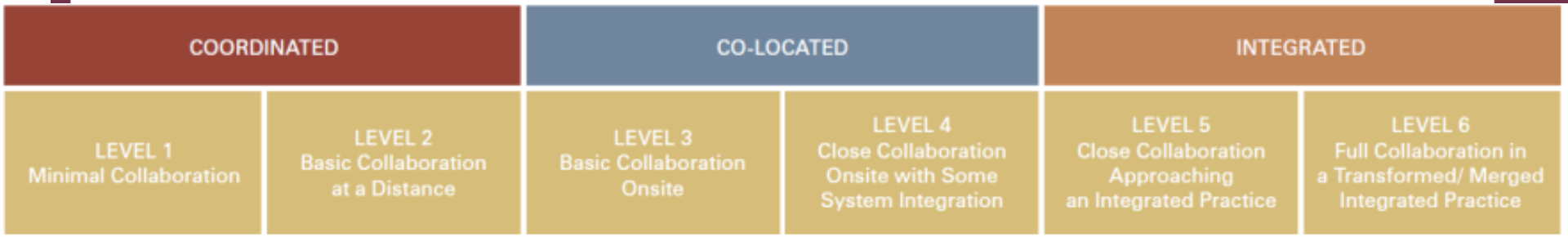
What are the Types of BHI?

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

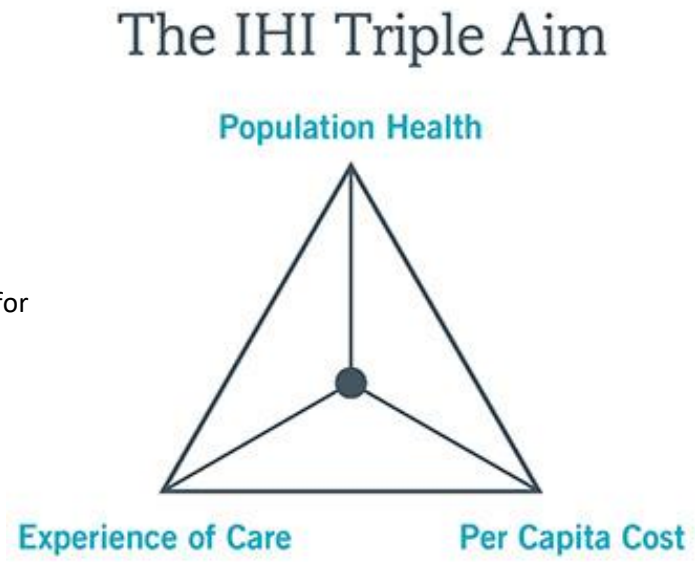


Fig. 3: Diagram from Institute for Healthcare Improvement[56]

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

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

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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TRANSTALKS
TRANSGENDER TRAINING FOR HEALTHCARE PROVIDERS

Thank You

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Q & A

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