Widening the Net: Engaging Sexual and Gender Minority Youth in Addiction Treatment

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Disclosure Information

- Presenter 1: Paula Goldman, MD
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  - No Disclosures
- Presenter 3: Stephanie Klipp, RN, CARN, CAAP. CRS
  - No Disclosures
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  - No Disclosures

Learning Objectives

1. Describe the disproportionate effects of substance use on sexual and gender minority youth and factors that may contribute to this disparity, including minority stress and effects of the COVID-19 pandemic.

2. Discuss the relationship between substance use and high-risk sexual behaviors and apply harm reduction strategies for youth engaging in high risk sexual behavior, including evidence-based STI screening, initiation and monitoring of PrEP, and office-based counseling to reduce risk.

3. Implement innovative and affirming approaches to addressing substance use for sexual and gender minority youth.

Sexual and gender minority (SGM) youth & substance use

- Disparities in substance use
- Disparities in treatment
- Difficult to connect to affirming treatment

Minority Stress Model

Minority stress

Environmental Circumstances
General Stressors
Minority Status
- Sexual orientation
- race/ethnicity
- gender identity
Distal Minority Stress Processes
- Prejudice
- Discrimination
- Violence
Allostasis
Stress
Physiologic Response
Reactivity
Recovery
Time
Minority Identity
- Gay
- Lesbian
- Bisexual
- Transgender
- Genderqueer
Proximal Minority Stress Processes
- Expectations of Rejection
- Concealment
- Internalize homophobia
Allosteric States
Repeated Hits
Lack of Adaptation
Prolonged Response
Inadequate Response
Allosteric Load
Resilience
-Coping Strategies
- Social Support
-Community Resources
Physical Health
Mental Health

Credit: K. Tetzlaff

- Tetzlaff et al., 2009

Minority Stress as a Precipitant for SUD

- Anti-SGM bullying elevate risk of SUD
- Homelessness among youth with SGM also risk factor for SUD

Russell et al., 2011, Cochran et al., 2003

Exacerbation by COVID-19

- Substance use heightened among SGM during the pandemic in survey of 1404 Canadian youths.
  - 31.2% of participants reported illicit substance use in survey of 1404 Canadian youths
  - Barriers to accessing mental health and addiction services associated with increased use of tranquilizers/benzodiazepines and psychedelic drugs.

- Additional barriers to Telehealth platforms (cell phone, reliable Internet) among SGM youth
- Remote learning

Chaiton et al., 2021

Case 1

- A 19 year old non-binary youth with chosen name Raj of South Asian American descent (they/them) pronouns establishes as a patient at your clinic. When you review their chart, you notice that they have been scheduled multiple times in the past for an initial visit for alcohol use disorder, but no-showed their visit. The scheduler has a number of telephone notes in the patient's chart which cites that the phone number was either invalid or not connected to voicemail. During their intake, they are repeatedly called by their dead name and incorrect pronouns by clinical staff including by the administrative assistant at the front desk and the MA who is filling in at the clinic due to a staffing shortage. Prior to rooming them, the MA hands the patient an empty cup, saying "All girls need to pee in a cup to make sure they are not pregnant."

Let’s discuss

- What are the explicit and implicit messages this patient is receiving?

Creating an Affirming Space: Explicit and Implicit Messages

- Explicit
  - misgendering patient
  - calling patient by a dead name
- Implicit
  - protocols that may be triggering (pregnancy tests, pap smears without sufficient preparation
  - not recognizing patterns of care barriers (telephone access)

Strategies for Inclusivity: Using Inclusive Language

- Cisgender vs. transgender
- Transgender woman (AMAB, MTF)
- Transgender man (AFAB, FTM)
- Non-binary
- Gender fluid
- Gender non-conforming or gender diverse
- Gender identity vs. gender expression
- Chosen pronouns (he/him, she/her, they/them, etc.)
- And many more…

Strategies to Make Spaces More Inclusive: Avoiding Assumptions

- Use non-gendered language
  - *Instead* of, “Are you sexually active with men?”
  - *Rephrase* to “Are you sexually active with a sperm-producing partner?”
  - *Instead* of “do you have a boyfriend?”
  - *Rephrase* to “are you in a relationship?”
  - *Instead* of “Do you want to have a baby?”
  - *Rephrase* to “What are your reproductive goals?”

Strategies for Making Spaces Inclusive: Staff Training

- Standardization of pronouns at the beginning of all patient encounters
  - Example: “Hi my name is ______ and I use (she/her or he/him or they/them) pronouns. What name and pronouns would you like me to use?
- Ensuring patient safety in encounters
  - Example: “Is it ok for me to use that name and pronouns in front of your parents?” And “Is it ok for me to use that name/pronouns in your medical chart?”
    - If patients ask why: “I want to ensure your safety, and I know some patients aren’t out to their parents yet, and I want to make sure you are safe and I am protecting your information.”

CAYAH Tip Sheet by Caitlin Thornburgh, LCSW

Strategies for Making Spaces More Inclusive: Responding to Disclosure

- Clinical spaces may present themselves as the first/only opportunities for patients to disclose their gender identities
  - Example language: “Thank you for trusting me enough to tell me about who you are. I want to make sure that you feel safe and affirmed while you’re here. What some ways can I make sure that happens?”

CAYAH Tip Sheet by Caitlin Thornburgh, LCSW

Strategies for Making Spaces More Inclusive: Acknowledging Mistakes

- If you use the wrong pronouns
  - *Take* a breath
  - *Notice* discomfort (or a patient may tell you explicitly)
  - *Apologize: **I'm sorry, it's important to me that you feel supported and affirmed in this space. Could you help me understand what I can do better?***

- CAYAH Tip Sheet by Caitlin Thornburgh, LCSW

Other Considerations for Maximizing Inclusivity

- *Chosen* versus *Preferred* (moving away from language of preference)
- Smart text incorporation into EMRs to have pronouns and chosen name in medical chart
- Being mindful about pharmacy scripts, AVS, lab scripts not having the chosen name

Case 2: Laura, a 17 yo

- 17 y/o transgender female patient had presented to ED for a non-fatal overdose
- Referred to your clinic to engage in care for her OUD
- Patient was displaced from her home due to family conflict and rejection.
- Reports emotional and physical abuse from her father because of her gender identity
- She feels her home is unsafe for her to return to

Case 2: Laura, a 17 yo

- She states she has been homeless for about three months
  - Reports she has been using about 4-6 bags of heroin a day
  - Using IV for the last 4-6 weeks
  - States she has also been sharing needles, but only with friends
- She reports engaging in sex work and has not been using condoms
- She also discloses that her recent overdose was frightening, and that it really scared her.
- She is interested in possibly starting medication for her opioid use disorder, and to discuss how she can keep herself more safe during this time

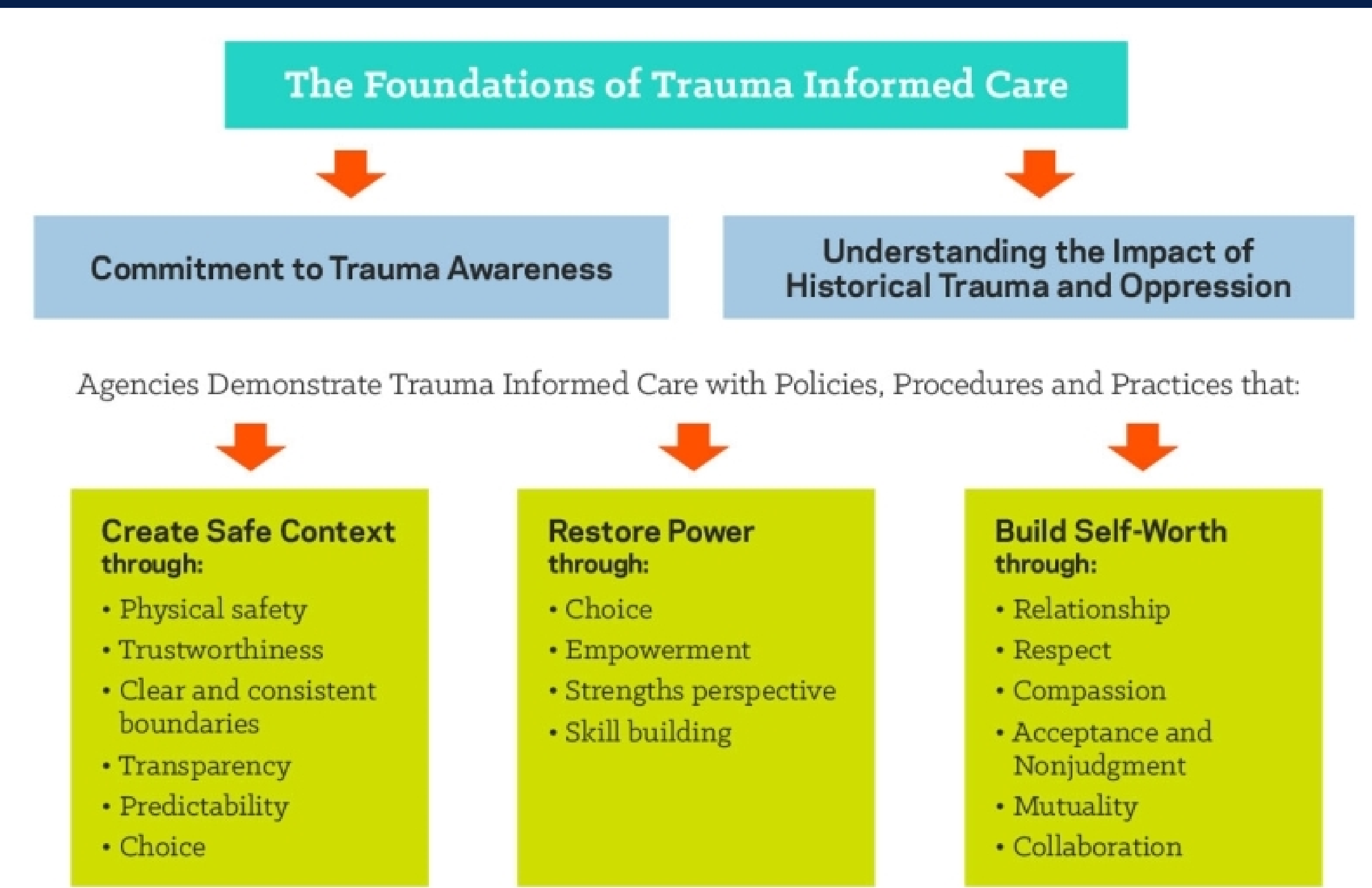
Trauma and SUD in Young People

- Trauma: Increases risk for SUD, Mental health, Housing Instability, & Suicide
  - Risk Factors:
    - Discrimination, bullying, verbal, mental, and physical abuse, sexual assault
    - Rejection - Family, friends, school settings, or faith communities
- Statistics on LGBTQI Youth
    - 86% reported being harassed or assaulted at school
    - 4x more likely to form a SUD, than their heterosexual peers
    - 4x more likely to attempt suicide (8x higher if family is not accepting)
    - 120% higher risk for experiencing homelessness

(NAMI: National Alliance on Mental Illness, 2022)

Trauma-Informed Approaches to Care

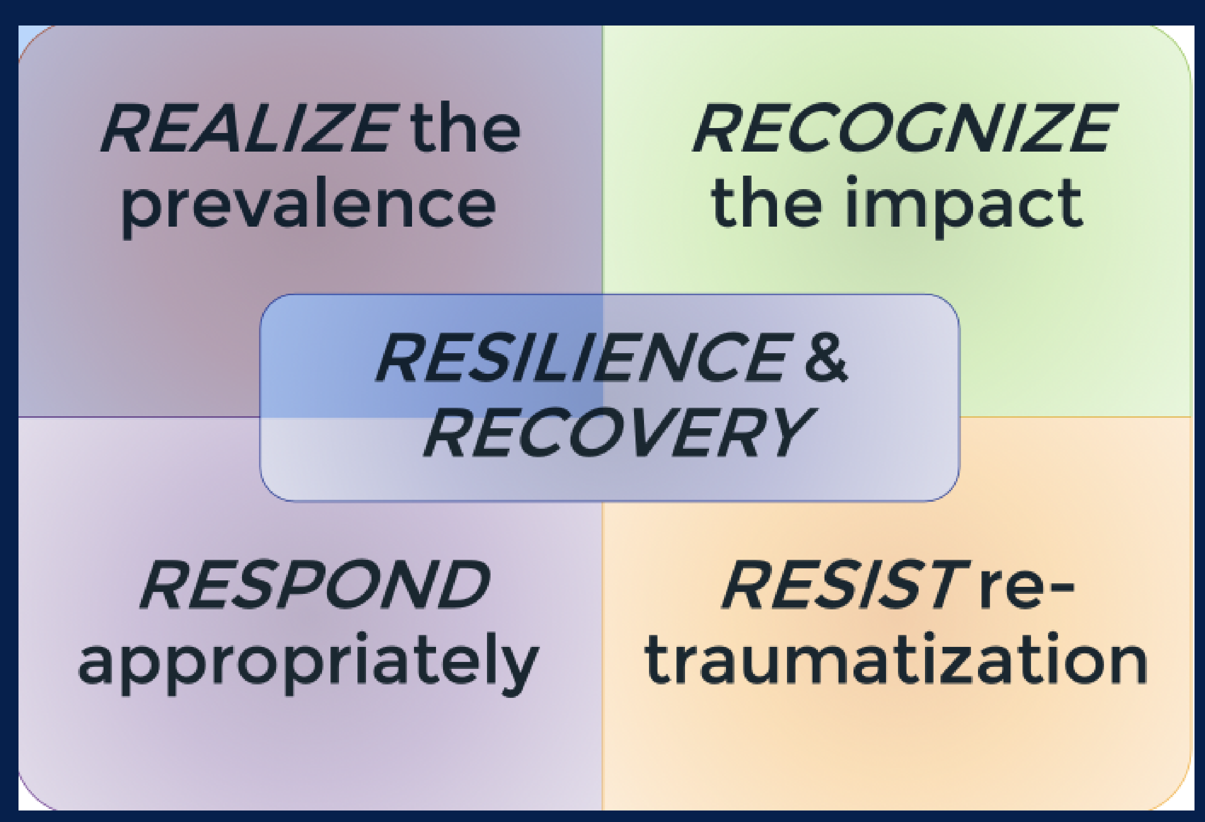
- Safety
- Trustworthiness and Transparency
- Acknowledge fears/concerns
- Peer Support/community
- Collaboration & Mutuality
- Empowerment, Voice & Choice
- Cultural, Historic & Gender Issues



(LGBTQIA+ Health Education Center, 2022)

Trauma-Informed Approaches to Care

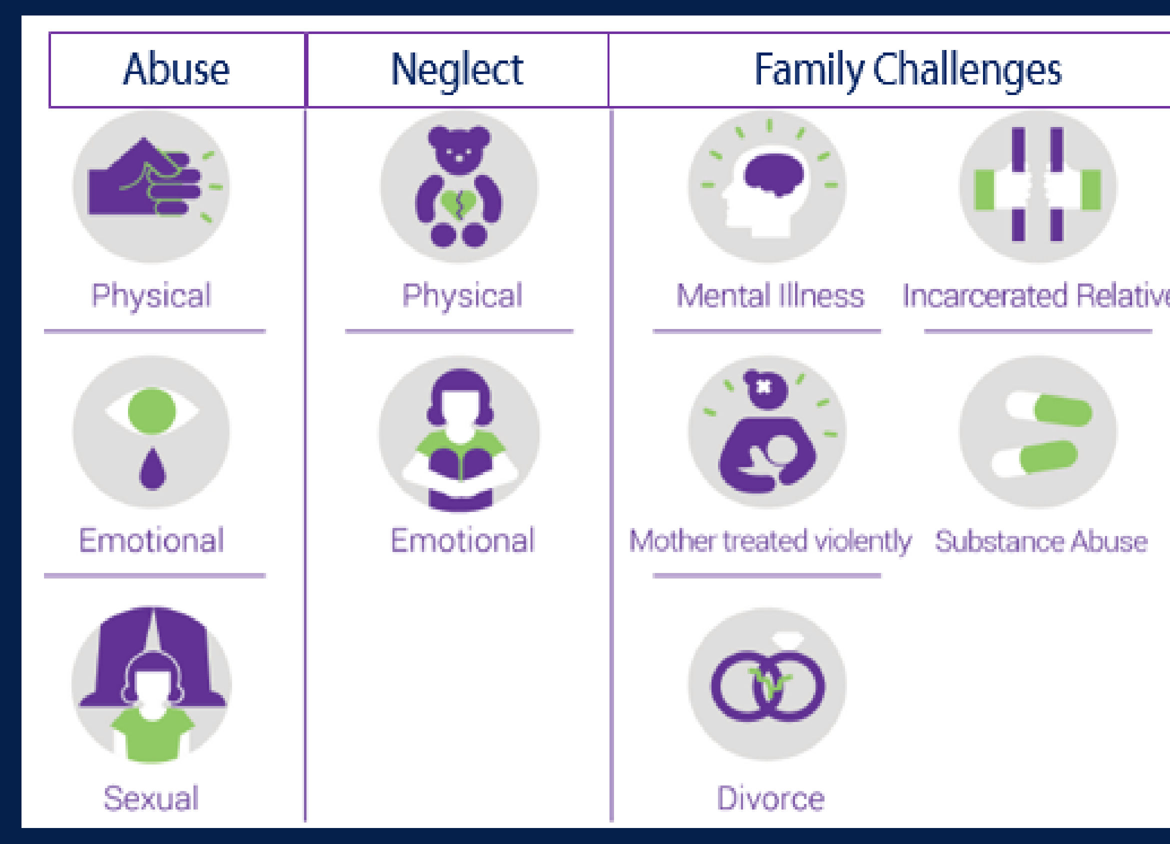
- Realize the widespread impact of trauma and understand the potential paths to recovery
- Recognize the signs and symptoms of trauma in clients, families, staff and others involved with the system of care
- Respond by fully integrating knowledge about trauma into policies, procedures, and practices
- Resist re-traumatization



(Charles, 2014)

Integrate understanding about trauma into clinical approach

- Adverse Childhood Experiences (e.g. childhood abuse, neglect, or significant household stressors) are strongly associated with SUD
    - Those with 4+ ACEs have a 4- to 12-fold increased risk of SUD
    - Those with SUD have an increased risk of experiencing trauma and violence
- Trauma and PTSD associated with worse SUD treatment outcomes



Felitti et al. 1998; Taylor et al. 2017

Using a Harm Reduction Approach

- Create personalized health promotion strategies in collaboration with youth
- **Understands** substance use as a complex, multi-faceted issue, that is on a spectrum from severe use to abstinence
- Reduces negative consequences associated with stigmatized behaviors
- Recognizes inherent strengths and motivation to be well
- It does not attempt to minimize the real dangers associated with licit and illicit drug use, and how those issues impact lives
- **Understands that a return to use is not a sign of failure**

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Using a Harm Reduction Approach

- Able to be contextually relevant and responsive to the lived experiences of youth
- Offers options so the youth themselves can determine what is right for them at that time
  - Places focus on reducing morbidity and mortality, reducing risk
- Applies **evidence-based interventions** to reduce negative consequences of behaviors

Responsive to Adolescent Development

- Recognize adolescent development and decision-making skills
  - Executive function matures at 25
  - Normative increase in desire for autonomy and resistance to control
- Create a personalized health promotion strategy
  - Building off their goals and desires
  - Offers choices
  - What works for one youth may be very different from what another youth needs

What can we discuss with this patient?

- Educate on safe injection practices – clean needles/supplies, skin cleaning, where to inject on the body

So what do you say?

- Be concrete
  - Remember developmental stage
  - Use simple language

- Recognize the goal is to help move people from more to less harmful behaviors

Injecting with someone else's uncleaned needle

Injecting with someone else's uncleaned cooker

Rinsing a used needle one time with cold water before injecting

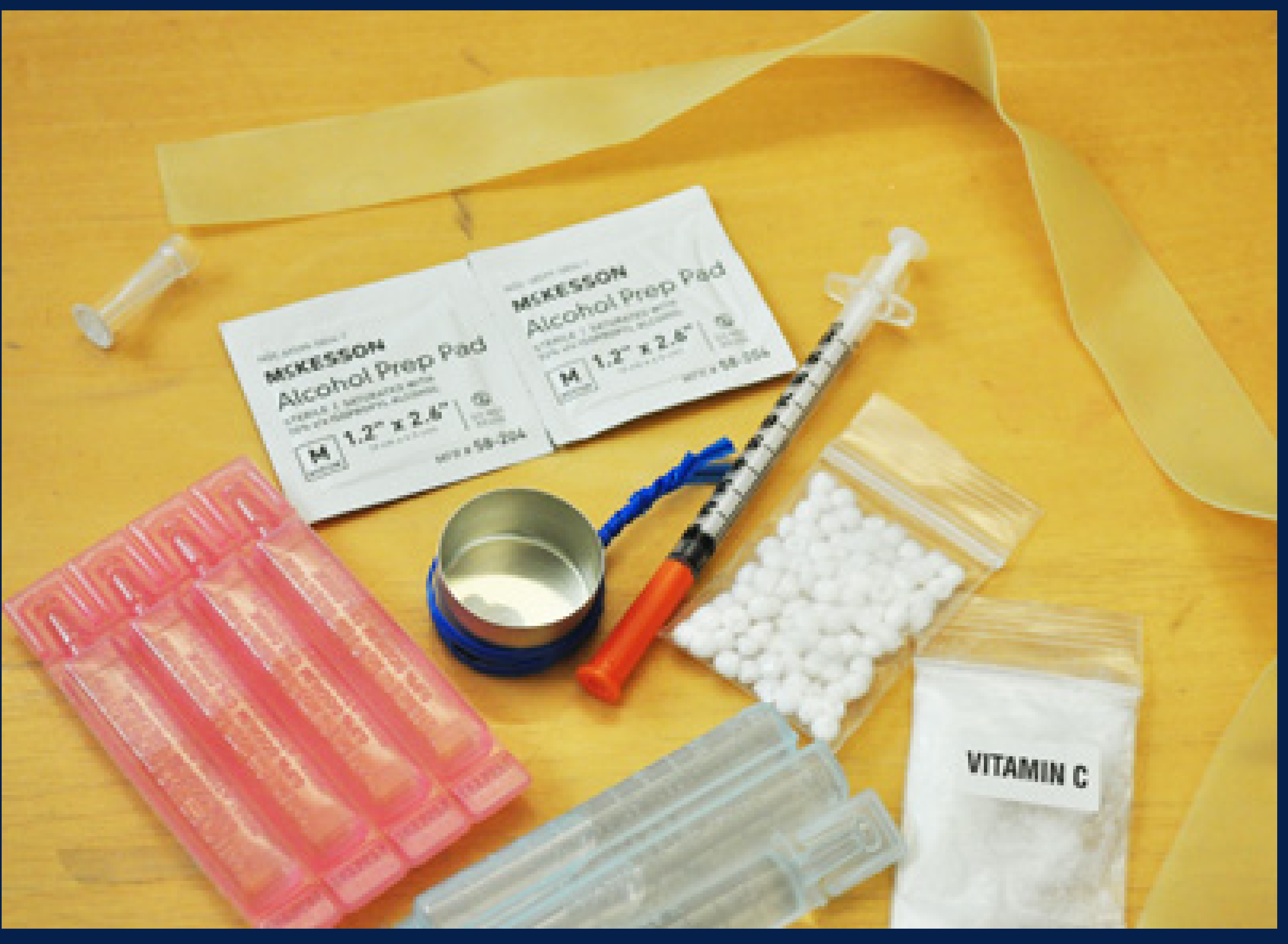
Rinsing a used needle 5 times with cold water

Use a brand new needle every time you inject

NOT INJECTING DRUGS

Tools

- Tourniquets
  - Help reduce failed IV attempts
- Sterile water
- Cookers
  - Holds drugs/water while being “cooked”
  - Use twist-ties
    - Different colors to label cookers for different people
- Alcohol wipes
- Cotton
  - Filters particulates as drug drawn into syringe



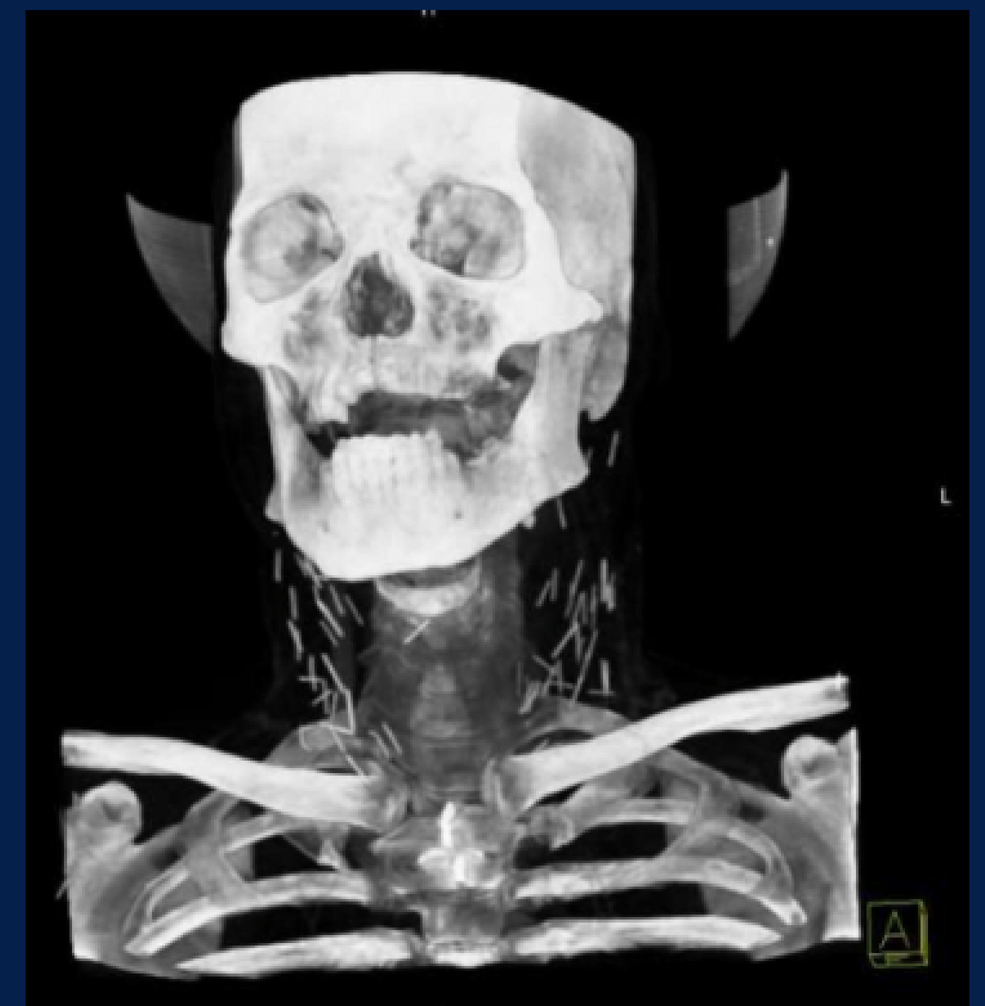
San Francisco AIDS Foundation

Safe injection education

- Choose safe place to inject
  - Access to clean water
  - Safe from crime/risk of arrest
- Have a partner and alternate use (in case of overdose)
  - Have naloxone available and someone sober to give it
- Carefully choose materials
  - Most use 25 to 28 G needles
    - Smaller the size puncture wound, less risk for infection
    - If many impurities (e.g. tar heroin), will need larger needle

“Getting off right.” Harm Reduction Coalition.

Choose safer injecting sites



This diagram shows the risk levels of injecting into different areas of the body.

- Dangerous! Never inject here!
- Better NOT to inject here, but safer than red. Inject with caution, slowly.
- These are the safest and best veins to use (remember to rotate sites!).

Safe injection education

- One shot= one new needle and syringe
  - If using needle again for even a few uses, it will become more dull
    - Results in larger puncture wound
    - Sharpening needle can lead to burr→ cause damage to veins or break off in vein

“Getting off right.” Harm Reduction Coalition.

Safe injection education

- No sharing needles, syringes, cookers, spoons, cottons
  - Even sharing non-needles can lead to HIV and HCV transmission

- If you HAVE to reuse needle or syringe
  - Flush with cold water immediately after using
  - Then flush with undiluted bleach (2 min)
    - Necessary for 2 minutes to kill HBV (Unclear if kills HCV)
  - Rinse with cold water to remove bleach

“Getting off right.” Harm Reduction Coalition.

Safe injection practices

- Use sterile water to dissolve drug
  - If no sterile water, then can boil water for 10 minutes and seal in a jar
  - If no boiled water, then fresh, cold tap water or bottled water
  - If no sink, then water from toilet tank (NEVER BOWL)
- Wash hands prior to injecting with soap and water
- Clean skin prior to injecting with alcohol wipe

"Getting off right." Harm Reduction Coalition.

What else can we discuss with this patient?

- Overdose prevention
  - Test supply
    - Fentanyl test strips
  - Go-slow
  - Test shot
  - Don’t use alone
    - Have naloxone when you use
  - Use in safe settings (away from elements, away from police)

What else can we discuss with this patient?

- Reduce sexual risks
  - Condoms
  - Lube
  - Other protective barriers to use during engaging in sex work
  - Minimize substance use while having sex
  - PrEP—stay tuned
- Offer screening for HCV/HIV and STI
- Initiate buprenorphine – low threshold, minimize barriers

Collaborating with a Multidisciplinary Team

- Medical Services:
  - Pharmacotherapy for OUD/AUD
  - Psychiatric interventions (medication management and/or Psychiatry consult)
  - Evaluation for complications of use
  - Health education
  - Referrals

Working with a Multidisciplinary Team

- Behavioral Health Services:
  - Mood/risk/safety assessment
  - Psychoeducation
  - Drug and alcohol counseling
  - Evidence-based counseling methods: MI, MET, CBT, mindfulness, and DBT skills
  - Level of Care Assessments
  - Connect patient to higher level of care if needed

Working with a Multidisciplinary Team

- Case Management:
  - Screen for social determinants of health
  - Referrals to community resources

- For Housing first programs, referral to sex workers union, referral transgender youth support groups, peer support
  - Help patients connect with support groups that are of interest to them in the community, from our referral map of groups.
  - Many are in online format. Some psychoeducation on different group modalities is often needed.

Case 3: Theo, 19 yo w/ opioid and meth use

- Theo is a 19 yo young man referred to your OBOT program after being seen in the ED.
- Presented with complaints of rectal pain and discharge and was treated for rectal gonorrhea. He reported a history of opioid use with mild withdrawal at that time.
- He reports a history of pressed fentanyl use. Snorting 10-15 tabs per day with escalating use over the past 9 months. Last use was 8 days ago. He had significant withdrawal symptoms, but these have since resolved. Wants to quit using opioids. Interested in extended-release naltrexone.
- When you ask about other substance use, he reports also smoking methamphetamine on “weekends” and “when he parties.” Reports escalating quantity and frequency. Is ambivalent about quitting because he likes how methamphetamine makes him feel, but wants to learn more about treatment options.

Treating methamphetamine use

- **Trivedi, NEJM, 2021 Trial**
  - ER-inj naltrexone (380 mg q3 weeks)
  - Oral ER bupropion (450 mg per day)
  - # number needed to treat is 9

- **Coffiin, JAMA Psychiatry, 2020 Trial**
  - Mirtazapine, 30 mg, or matched placebo orally once daily for 24 weeks, with background counseling
    - Increased monoamine levels may reduce craving and withdrawal symptoms, which is in turn thought to help facilitate reductions in methamphetamine use and methamphetamine-associated risk behaviors
  - Study pop: transgender women who have sex with men and cis-men who have sex with men
  - Those assigned to receive mirtazapine had fewer sexual partners, fewer episodes of condomless anal sex with partners who were serodiscordant
  - # needed to treat for end of study abstinence was 15

Trivedi, NEJM, 2021 Trial; Coffin, Jama Psych, 2020

How do we talk to Theo about his sexual behavior?

Relationship between Substance Use and High Risk Sexual behavior

- Methamphetamine use has been drive of HIV transmission among MSM
- Commonly used to enhance sex among subpops of MSM
  - As high as 19% in some communities
    - Use of Meth is associated with increase in sexual risk behaviors
  - Loss of inhibitions and enhancement of libido
  - Chemsex, Party and play
- Booty-bumping as risk factor for infection

Rivera, AIDS Behav, 2021; Hoenigl, J AIDS, 2015; Blanchard, Filtermag, 2019

General tips for talking about sex

- Check your own biases and discomfort
- Make your patient feel comfortable first--establish rapport
- Normalize asking these questions
- Be neutral and inclusive
- Avoid assumptions
- No overt reactions—check your body language/posture
- Be prepared to rephrase questions—remember developmental level
- Do not be afraid to ask clarifying questions
- Have these discussions alone

NCSH: Sexual Health and Your Patients: A Provider's Guide

An example:

"I'm going to ask you a few questions about your sexual health. Since sexual health is very important to overall health, I ask all my patients these questions.

Before I begin, do you have any questions or sexual concerns you'd like to discuss?"

NCSH : Sexual Health and Your Patients: A Provider's Guide

Other strategies:

- May I ask you a few questions about your sexual health and sexual practices? I understand that these questions are personal, but they are important for your overall health.
- At this point, I generally ask some questions regarding your sexual life. Will that be ok?
- I ask these questions to all my patients, regardless of age, gender, or marital status. These questions are as important as the questions about other areas of your physical and mental health.
- Do you have any questions or concerns about your sexual health?

CDC: A guide to taking a sexual history

Questions to ask: 5 Ps

- **Partners**
  - Do you know whether your partner has other sexual partners?
  - In the past 3 months have you had sex with someone you didn't know or just met?
  - Have you ever been coerced or pressured to have sex?
- **Practices**
  - In the past 3 months, what kinds of sex have you had?
    - Anal? Vaginal? Oral?
    - For MSM, receptive, insertive, or both?
    - Use drugs before or during sex? In what ways?
- **Past history of STI**
  - Have you ever had a sexually transmitted infection?
    - If yes, which? Were your partners treated?
  - Have you ever been tested for HIV?
    - How long ago? What was the result?

Remember developmental stage of your patient—may need to use simple language and define what exactly you mean.

CDC: Sexual Health and Your Patients: A Provider's Guide

Questions to ask: 5 Ps

- **Protection**
  - What do you do to protect yourself from STIs including HIV?
  - When do you use this protection?
  - Have you been vaccinated against…HPV? Hepatitis A? Hepatitis B?
- **Pregnancy prevention/reproductive life plan**
  - Do you have any desire to have (more) children?
    - If yes, how many? When?
      - What are you and your partner doing to prevent pregnancy until then?
    - If no, are you doing anything to prevent pregnancy?
      - Remember to ask transgender patients with female reproductive organs

CDC: Sexual Health and Your Patients: A Provider's Guide

Additional questions to ask:

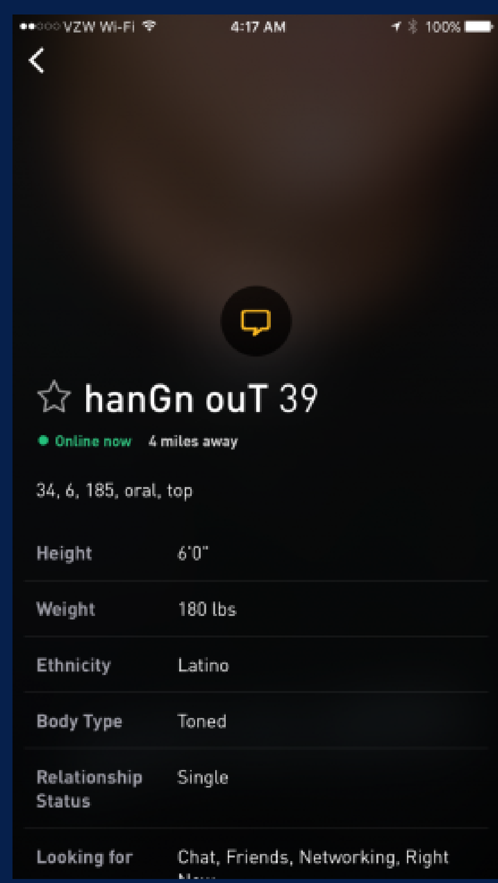


Image: https://wehoville.com/2016/09/19/looking-buy-meth-weho-business-makes-easy/

- **Are you meeting partners using:**
  - Mobile apps
  - Social networking sites
  - Social media
- **Having sex under the influence:**
  - Chemsex, party and play, PnP, GnT
  - Lowered inhibitions decrease protective measures
  - Sex itself can be riskier
    - Higher risk for exposure to infections
    - Unknown partners

https://www.avert.org/sex-stis/safer-sex-hiv/chemsex-and-hiv

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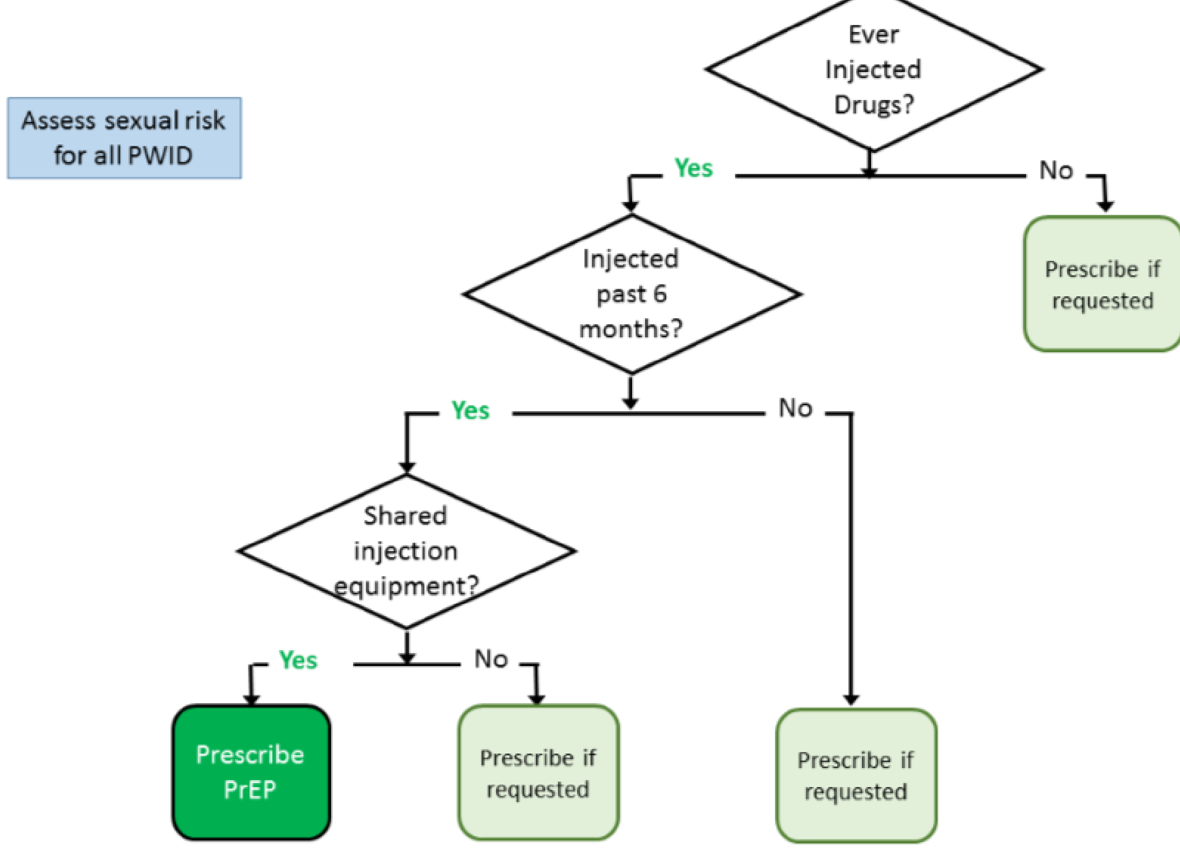
Are there other things we can offer him to keep him healthy?

Eligiblity for PrEP

- A note on language—words matter

- If you have had anal or vaginal sex in the past 6 months AND:
  - Sexual partner with HIV
  - Not consistently used a condom
  - Been diagnosed with STI in the past 6 months



2021 CDC PrEP update

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Dosing regimens

- F/TDF: Truvada-200mg/300 mg
  - Dosed daily or 2-1-1
  - Approved for adults and adolescents at risk for acquiring HIV
  - Most commonly prescribed (including PWID)
  - Available as generic
- F/TAF: Descovy
  - Dosed daily or 2-1-1
  - Available for MSM and transgender women at sexual risk
  - No generic
  - Indicated for patients with reduced renal clearance

2021 CDC PrEP update

2-1-1 Dosing

Sex

2 to 24 hours
before sex

24 hours after
first 2 pills

48 hours after
first 2 pills

2021 CDC PrEP update

Adherence

- Maximum protection for:
  - Receptive anal sex after 7 days of daily use
  - For receptive vaginal sex and IDU, after 21 days
- Significant protection against HIV for vagina is 6-7 doses per week
- For colorectal: 2 doses per week

2021 CDC PrEP update

Side-effects

- <10% of patients prescribed F/TDF or F/TAF experience a “start-up syndrome
  - Resolves in first month
  - Headache, nausea, or abdominal discomfort
  - Weight gain is a reported side effect of F/TAF

FTC/TDF

- Weight loss
  - Fanconi Syndrome
    - Loss of kidney function and protein in urine
- Bone mineral density
  - Loss of bone mineral density • ~1-2%
  - No increased fracture risk

FTC/TAF

- Weight gain
  - Mean weight gain 1.7 kg
- Possible lipid abnormalities

2021 CDC PrEP update

Table 5 Timing of Oral PrEP-associated Laboratory Tests

Test	Screening/Baseline Visit	Q 3 months	Q 6 months	Q 12 months	When stopping PrEP
HIV Test	X*	X			X*
eCrCl	X		If age ≥50 or eCrCL <90 ml/min at PrEP initiation	If age <50 and eCrCl ≥90 ml/min at PrEP initiation	X
Syphilis	X	MSM /TGW	X		MSM/TGW
Gonorrhea	X	MSM /TGW	X		MSM /TGW
Chlamydia	X	MSM /TGW	X		MSM /TGW
Lipid panel (F/TAF)	X			X	
Hep B serology	X				
Hep C serology	MSM, TGW, and PWID only			MSM,TGW, and PWID only	

* Assess for acute HIV infection (see Figure 4)

Clinicians can call the National Clinicians Consultation Center PrEPline at 855-448-7737 for advice about interpretation of HIV test results and management of patients who acquire HIV infection while taking PrEP medication.

Counseling to reduce risks

SAFER WAYS TO PARTY AND PLAY...

PACK SOME PROTECTION

Always carry condoms and plenty of lube!

KNOW YOUR HIV STATUS

Keep yourself and others healthy

+ / –

PARTY WITH PEOPLE YOU TRUST

Remember to look out for each other!

SET YOUR LIMITS

Be clear about what kinds of sex you're into

STAY AWARE

...of what drugs you've taken

SET REMINDERS

...so you don't forget to take your PrEP or ARVs

AVERT.org

https://www.avert.org/sex-stis/safer-sex-hiv/chemsex-and-hiv

New

- 600 mg of cabotegravir injected into gluteal muscle every 2 months
- 30 mg daily oral cabotegravir is optional for a 4-week lead-in prior to injections
- Approved Dec 2021
- The “tail” and risks with declining levels post-injection

Side-effects of CAB

- Injection site reactions (pain, tenderness, induration) were frequent
  - Lasted only a few days
  - Occurred most frequently after the first 2-3 injections.
- Offer anticipatory guidance
  - NSAIDS
  - After the injection apply a warm compress or heating pad to the injection site for 15-20 minutes

Table 7 Timing of CAB PrEP-associated Laboratory Tests

Test	Initiation Visit	1 month visit	Q2 months	Q4 months	Q6 months	Q12 months	When Stopping CAB
HIV*	X	X	X	X	X	X	X
Syphilis	X			MSM^/TGW~ only	Heterosexually active women and men only	X	MSM/TGW only
Gonorrhea	X			MSM/TGW only	Heterosexually active women and men only	X	MSM/TGW only
Chlamydia	X			MSM/TGW only	MSM/TGW only	Heterosexually active women and men only	MSM/TGW only

* HIV-1 RNA assay

X all PrEP patients

^ men who have sex with men

~ persons assigned male sex at birth whose gender identification is female

Counseling to reduce risks

SAFER WAYS TO PARTY AND PLAY...

PACK SOME PROTECTION	KNOW YOUR HIV STATUS	PARTY WITH PEOPLE YOU TRUST
Always carry condoms and plenty of lube!	Keep yourself and others healthy	Remember to look out for each other!
SET YOUR LIMITS	**STAY AWARE**	**SET REMINDERS**
Be clear about what kinds of sex you're into	...of what drugs you've taken	...so you don't forget to take your PrEP or ARVs

+/−

AVERT.org

https://www.avert.org/sex-stis/safer-sex-hiv/chemsex-and-hiv

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Case 4: Gender Minority Youth

A 15-year-old patient assigned female at birth establishes with your clinic due to parental concerns about escalating marijuana use. In confidential interview, the patient reports identifying as male and requests that you use the preferred pronouns of he/him/his. He tells you that he has been experiencing bullying at school. He tried to talk to his parents about his gender identity but his parents reassured him that this is a “phase” and he will “grow out of it.” He has been using marijuana to cope with feelings of isolation, rejection, and gender dysphoria. He has been feeling very depressed and admits that there have been times in the past that he has thought about suicide.

Let's Discuss

What would you do next?

What are the potential benefits of referring this young person to gender-affirming care?

How is Gender Dysphoria Defined?

Marked incongruence in assigned gender and experienced/expressed gender (2+ of the following):

1. Incongruence in experienced gender and sex characteristics
2. Strong desire to rid assigned sex characteristics
3. Strong desire for other gender's secondary sex characteristics
4. Strong desire to be of another gender
5. Strong desire to be treated as another gender
6. Strong conviction of feelings of another gender

Lasting for >6 months

Causing distress and/or impaired function

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www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria

Why Connect Patients to Gender-Affirming Care?

Disproportionate morbidity and mortality for gender diverse youth

- 60% engaged in self-harm in 12mo
- 52% contemplated suicide in 12mo
- 20% attempted suicide in 12mo
- Increased risk of anxiety, depression, and eating disorders
- Increased risk of substance use
- Increased risk of trauma victimization

Austin et al. 2020; Connolly et al. 2016; www.thetrevorproject.org

Why Connect Patients to Gender-Affirming Care?

Gender affirmation improves health outcomes

- 15 studies to date have examined the impact of gender-affirming medical care for transgender youth
- Improved depression – similar levels to cisgender peers
- Improved anxiety
- Reduced suicidal ideation and suicide attempts
- Improvement in body image and reduced disordered eating
- Improved psychosocial functioning and feelings of social acceptance

Olson et al. 2018; Turban, 2022

Gender Affirming Care 101

- Social Transition
- Non-pharmacologic affirmation (e.g. binders, tucking)
- Pubertal blockers
- Cross-sex hormones
- Surgery
- Therapy support
- Support groups/networks
- Treatment for co-occurring mental health diagnoses and trauma related to gender identity

Medication Interactions

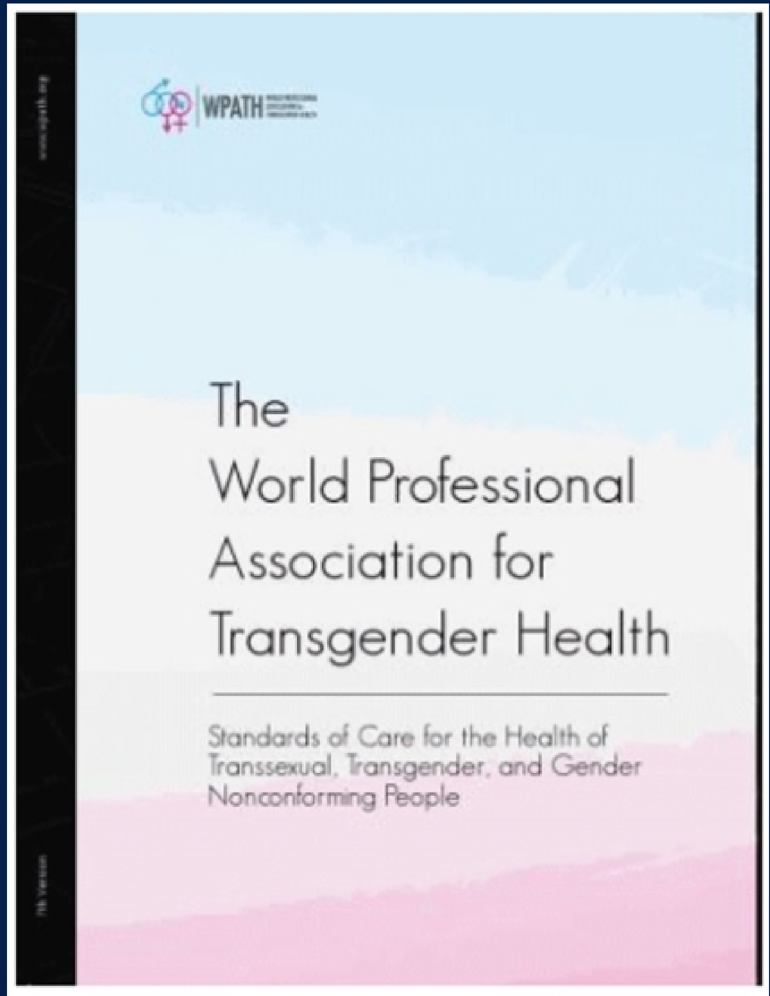
- **Combinations without any Interactions:**
  - Buprenorphine with Testosterone or Estradiol
  - Methadone with Testosterone or Estradiol
  - Naltrexone with Estradiol or Leuprolide
- **Possible Interactions to Consider:**
  - Naltrexone and Testosterone: MODERATE

  monitor liver function
  - Buprenorphine and Leuprolide: MODERATE
  - Methadone and Leuprolide: MAJOR

  due to compounded risk of QTc prolongation

Abbasi et al. 2020; Gagliano-Juca et al. 2018; www.drugs.com/drug_interactions.html

How To Learn About Gender Affirming Care



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PREVIOUS ARTICLE NEXT ARTICLE

Endocrine Treatment of Transsexual Persons:An Endocrine Society Clinical Practice Guideline

Wylie C. Hembree, Peggy Cohen-Kettenis, Henriette A. Delemarre-van de Waal, Louis J. Gooren, Walter J. Meyer, III, Norman P. Spack, Vin Tangpricha, and Victor M. Montori [1]

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For Providers » Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People

Welcome

Place a Referral

e-Consults (Internal to

Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People

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Final Takeaways

- SGM youth are at higher risk of substance use and mental health comorbidities
- SGM youth often experience barriers in connecting to both substance use treatment and gender affirming medical care
- All addiction team members can take steps to create a more welcoming, affirming environment for SGM youth
  - It is our job to ask hard questions and assess sexual risk factors
  - It is our job to learn and incorporate affirming language
- Trauma informed approaches are critical to engaging SGM youth
- Harm reduction strategies can protect and empower youth
- Connecting youth to gender-affirming care improves health outcomes
  - Care may include non-pharmacologic affirmation, puberty blockers, cross-sex hormones, surgery, therapy and/or community engagement
  - Possible medication interactions:
    - Naltrexone + Testosterone → monitor LFTs
    - Buprenorphine/Methadone + Leuprolide → risk of QT prolongation

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