Understanding Substance Reuse Among Sexual and Gender Minority Individuals With HIV

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Introduction

- Sexual and gender minority (SGM) individuals experience higher rates of substance use disorders (SUDs) compared to heterosexual, cisgender individuals[1]
- SGM individuals with multiple minority statuses--such as racial minorities, people living with HIV (PLWH) or individuals with low socioeconomic status (SES)--may be at an even higher risk for SUDs[2,3]
- Syndemics Theory[4] and Minority Stress Theory[5] can contextualize these higher SUD rates

Objectives

- Focus on a complex, multiple minority PLWH population
- Focus on a complex intervention in an inpatient/outpatient clinical setting
- Examine how SGM status impacts:
  - Time to substance reuse (via a discrete time survival analysis)
  - Frequency of use (via a trajectory analysis*)
  - Substance use related problems (via a trajectory analysis*)

*Analyzed an SGM-only model and a final multivariate model that controlled for age and number of prior treatment episodes

Methods

- **Participants:** 60 adult PLWH (SGM and non-SGM) recruited from an abstinence-focused, residential treatment center in Washington, D.C.
- **Procedures and Measures:** Data for this study were taken from a larger, randomized clinical trial which assessed a behavioral activation intervention administered by PhD level trainees with multicultural training
  - **SGM Status.** Participants who self identified as gay, lesbian, bisexual, and/or transgender were considered SGM
  - Participants completed 16 sessions and were followed over 12 months post treatment to assess:
    - **Substance Use.** Assessed via:
      - **Dichotomous Assessment.** Yes/no according to Timeline Follow Back (TLFB) and urinalysis results
      - **Frequency of Use.** Number of days used divided by total days in assessment period using TLFB data
    - **Substance Use Related Problems.** Measured using the Short Inventory of Problems-Alcohol and Drugs (SIP-AD)

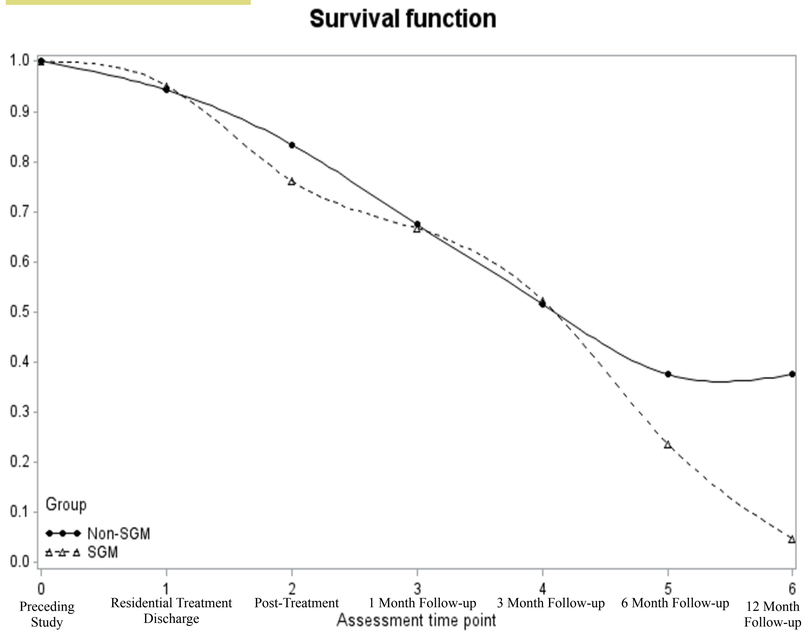
Demographics

- Participants (*n*=61 in study; *n*=60 with defined SGM status; *n*=56 included in survival analysis)
  - >95% African American
  - >90% unemployed
  - *n*=21 self-identified as SGM; *n*=35 identified as non-SGM
  - SGM participants significantly younger (42.38 vs. 47.0 years) with more prior treatment episodes (4.70 vs. 2.68 episodes)

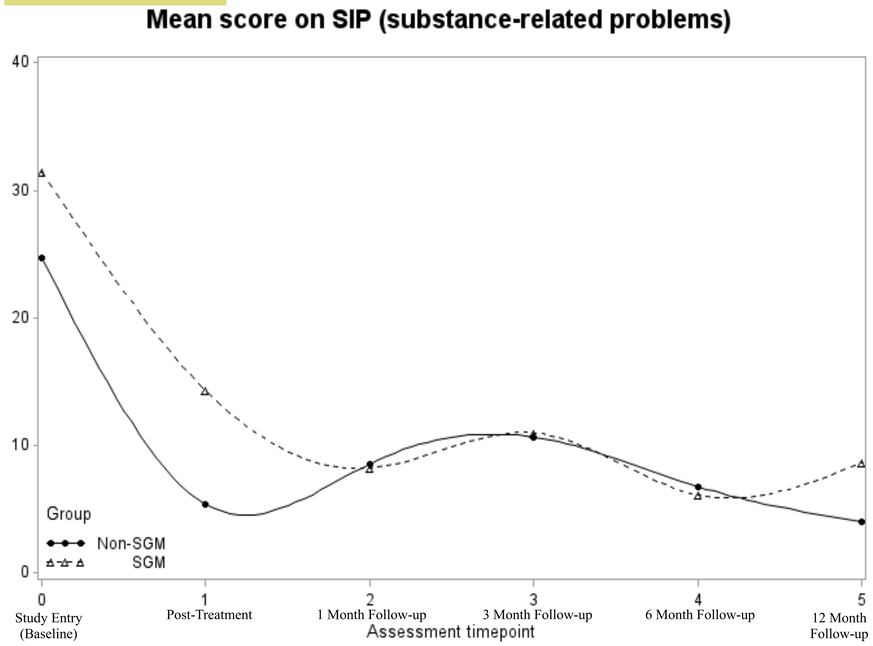
Results

- **Overall sample**
  - At the end of the 12-month follow-up, 20.5% of participants who were at risk had not returned to substance use (survival rate)
  - Problems associated with use decreased over time (Estimate = -.76, p<.001)
- **Time to substance reuse**
  - Overall time to event model was significant (λ^2= 25.46, p<.001)
  - Non-SGM survival rate= 37.5%; SGM survival rate= 4.8%
  - SGM individuals have 1.88 [95% CI: .84, 4.19] times the odds of reuse compared to non-SGM individuals
- **Frequency of use**
  - In SGM-only model, SGM status was a significant predictor of the model intercept (*log odds* = 3.62, *p*=.02)
    - Frequency of use was greater on average for the SGM group at baseline (residential discharge) (non-SGM intercept= -7.94 → 0.04% days used; SGM intercept= -4.33 → 1.3% days used)
  - In final multivariate model, SGM status was not a significant predictor (*log odds*= 2.46, *p*= .14)
- **Substance use related problems**
  - No effect of SGM status on substance use related problems in any model

Survival Function



SIP-AD Means



Discussion

- Findings suggest an almost two times increase in the odds of reuse for those who identify as SGM (though not significant)
  - Not a statistically significant finding, perhaps due to:
    - Small sample size
    - Too short of a follow-up period
  - Yet, these results are notable, supporting the need for SGM and multiple minority specialized care
- Despite the strengths of the longitudinal design, future work must:
  - Replicate these findings in a larger sample
  - Measure stigma and other SGM-relevant variables
  - Examine providers with normative training
    - PhD level trainees may have more multicultural training than the average substance use treatment provider
  - Consider harm reduction instead of abstinence-only-focused care

References