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Running Head: COMING OUT TO TREATMENT

Coming Out to Treatment: Identifying facilitators & characterizing experiences of Sexual and  
Gender Minoritized Individuals in Opioid Use Disorder Treatment before and during the  
COVID-19 pandemic

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of  
Philosophy in Clinical Psychology at Virginia Commonwealth University.

By

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### **Acknowledgments**

I would like to thank my advisor and committee chair, Dr. Dace Svikis, for her support, guidance, and friendship. I feel very lucky to be her mentee. I would also like to thank Dr. Laurie Cathers for her mentorship throughout the qualitative portion of this study. I would also like to recognize my dissertation committee members, Drs. Hood, Martin, and Allison, and thank them for their feedback and support of this project. I would like to thank my program mates for their care, support, and solidarity in the home stretch. Additionally, I would like to thank my family and chosen family for their encouragement and support— especially my loving and patient partner who kept our family fed and cared for during this process. This dissertation is dedicated to the memory of my mother, as she instilled in me the importance of making every effort to listen well to others, demonstrate compassion and empathy, and offer support where I am able.

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**Abstract****COMING OUT TO TREATMENT: IDENTIFYING FACILITATORS & CHARACTERIZING EXPERIENCES OF SEXUAL AND GENDER MINORITIZED INDIVIDUALS IN OPIOID USE DISORDER TREATMENT BEFORE AND DURING THE COVID-19 PANDEMIC**

by Jaclyn S. Sadicario, M.S.

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy at Virginia Commonwealth University

Virginia Commonwealth University, 2023

Director: Dace S. Svikis, Ph.D., Professor, Department of Psychology

Sexual and Gender Minority (SGM) individuals are disproportionately impacted by substance use disorders vs. their non-SGM counterparts. Additionally, SGM folks face more barriers to access for treatment than others due to minority stressors including discrimination, internalized stigma, and marginalization related to their sex and gender minority statuses. It is important for researchers and treating providers alike to understand how these different factors are impacting the treatment of substance use disorders in SGM populations. With this in mind, this two phase study employed a mixed-methods approach to (1) describe the population of SGM folks enrolled in a MOUD treatment program with a focus on engagement and retention called BRITER (“Bringing Resources Individually To Engage Recovery”) at a clinic in Baltimore, MD, (2) identify factors impacting treatment engagement and retention using subjective experiences and quantitative measures, and (3) better understand the impact of COVID-19 on treatment in a sample of SGM individuals with OUD. The majority of Phase 1 participants in the eligible participant pool (n=52) were bisexual women, screened positive for PTSD at enrollment, and were receiving Methadone treatment. Of that participant pool, N=4 completed surveys and interviews in Phase 2. From the interviews, five themes were identified as influencing treatment engagement among SGM including: how they think about themselves, their experience of



support vs. discrimination during treatment by staff and fellow patients, the support they have from family and friends to engage in care, as well as policy associated with the context in which they are receiving treatment. SGM in treatment for OUD encounter unique challenges when engaging in treatment, and further research is needed to ascertain how best to support them.

## Review of the Literature

### Overview: Substance Use Disorders & Treatment Perspectives

Substance misuse and substance use disorders (SUDs) constitute a major public health problem. In the USA among individuals 12 years or older, estimations of recent use (past 30 day) are as follows: 164.8 million report alcohol use, 47 million report tobacco use, and 31.9 million report use of illicit drugs (SAMHSA, 2019). Approximately 20.3 million persons aged 12 or older (7.4 percent) met DSM 5 criteria for SUDs in the past year, in 2018 (per DSM 5). The annual costs to the U.S. economy associated with alcohol and other SUDs exceeds \$600 billion (Bouchery et. al, 2011). Given these considerations, the utilization of evidence-based treatment for SUDs is important.

Historically, alcohol use disorder (AUD) and other SUDs were treated with an acute care model and success in treatment was equated with abstinence, making the outcome of treatment binary (abstinent or not) (see: Marlatt et. al, 1993). Treatment for alcohol and treatment for other drugs were separate programs, with alcohol treatment programs with a more behavioral focus and opioid treatment on the medical side. Treatment duration typically ranged from less than 7-day medical detox to 30–60-day residential treatment to 6 to 12 months of outpatient treatment (Henninger and Sung, 2013). Aftercare often consisted of a referral to community support groups (i.e.: AA, NA, Smart Recovery) and varied widely.

For decades, SUD treatment was often confrontational, as counselors sought to “break through denial and resistance.” This approach overtly contained moralizing messages regarding an individual’s struggle with substance use issues (O’Brien & McClellan, 1996). More recently, with recognition of SUD as a chronic, relapsing disorder, the definition of success has broadened, with a harm reduction approach gaining popularity. The goal is instead to reduce or eliminate substance use, prevent or reduce the frequency and severity of relapse, and improve

adaptive functioning (McLellan et. al, 2000). Methods for addressing substance use disorders have evolved, driven by data collected in studies demonstrating greater efficacy from more client centered approaches (See review: Rubak, et. al, 2005). For example, Motivational interviewing (MI) is an evidence-based approach originally developed for individuals with SUDs which was designed to cultivate and strengthen motivation to change and commitment to goals using a non-judgmental approach (Miller & Rollnick, 2013). With greater appreciation for tailored and multimodal methods of treatment, motivational interviewing is often integrated with a variety of psychological, pharmacological, and social approaches of varying duration, with a greater focus on continuing care. While federal organizations recognize a variety of evidenced based, effective treatments for SUD (Polak et. al, 2021), translation from research to practice has been slow, with many substance use treatment programs not providing evidence-based care (Miller et. al, 2006). For example, a study examining adoption of MI as clinical practice in clinics that participated in clinical trials of MI found mixed results, with full adoption of MI into one clinic and partial and/or no adoption in four clinics (Guydish et. al, 2010). This lack of translation is also true of other behavioral interventions, like Cognitive Behavioral Therapy (CBT) and Contingency Management (CM), where issues of ideology, training, funding, and structure in substance use disorder treatment provide a barrier to implementation (Carroll, 2014). Additionally, the overarching problem of treatment provision regardless of type remains a substantial issue. According to a report that used 2018 NSDUH data, of the 21.2 million people in the United States who needed substance use treatment, the majority (89%, 20.6 million) did not receive SUD treatment (SAMHSA, 2019). Thus, engagement in treatment is an essential first step to addressing substance use disorder outcomes.

**Engagement and retention in the treatment of substance use disorders**

There is variability in how engagement with how substance use treatment is defined in the literature. The group, Washington Circles, an organization supported by the Center for Substance Abuse Treatment, defines treatment engagement as having engaged in initial service and a following service within a month at a SUD treatment program (Garnick et. al, 2006). Engagement is an essential first step in SUD treatment. However, engagement may also be used to refer to the *intensity* and *duration* of treatment participation, with high engagers being those who frequently engage with treatment (counseling, groups, medication visits, etc.), or at least stay in treatment for a longer period of time, also referred to as *retention* (Fiorentine et. al, 1999). Engagement in SUD treatment is associated with more favorable outcomes including reduced substance use severity, (Mattick et. al, 2014; Nielsen et. al, 2016; Saxon et. al, 2013; Harris et. al, 2010), better employment outcomes (TOPPS-II, 2003), more favorable legal outcomes (Harris et. al, 2010), reduced overdose rates (Sordo et. al, 2017), and reduced mortality among individuals with SUD (Sordo et. al, 2017; LaRochelle et. al, 2016). Thus, the wide-ranging benefits of engaging with treatment are apparent in the literature.

Factors associated with treatment engagement can be divided into treatment level factors and patient level factors. However, studies have found mixed results on what factors are most salient. Fiorentine and colleagues (1999) found treatment level factors such as perceived usefulness of treatment or ancillary clinic services and the empathy or helpfulness of the counselor were more impactful than demographic factors. However other studies have found patient level factors, such as demographic characteristics and drug use status, to be stronger predictors of treatment engagement and retention (McCaul et. al, 2001; Simpson et. al, 1997). One systematic review of SUD treatment studies looking at gender specific predictors of

engagement and retention in treatment found that women were less likely than men to enter SUD treatment (Greenfield et. al, 2006). Similarly, a recent meta-analysis found higher attrition among Black and Lower-income participants (Lappan et. al, 2020). Guerrero and colleagues (2015) found that simultaneous attention to patient and treatment level factors contributed to engagement; specifically, tailored services for racial and ethnic minorities combined with coordinated care services and large treatment program capacity increased the time in treatment for these groups. These findings suggest that addressing structural barriers to engagement associated with social determinants of health at the patient and treatment level may be supportive of treatment engagement (See: Disparities in OUD section).

Despite the benefits of treatment engagement and retention (Hser et. al, 2004; Simpson et. al, 1997), attrition from treatment is common. One recent metanalysis of in-person substance use treatment studies, along the continuum of care (outpatient to residential) found a 30% attrition rate across all SUD treatment studies (Lappan et al. 2020). Leaving treatment prematurely is associated with poorer outcomes. Though, it is worth noting that historical definitions of treatment outcomes centered abstinence as the goal of treatment, more recent research emphasizes *recovery capital*, or resources individuals can draw upon to support recovery, as a more strengths-based means of measuring treatment outcomes (Parliar-Ahmad et.al, 2021). The impact of discrimination was associated with lower recovery capital in one such study (Parliar-Ahmad et. al, 2021). Thus, attending to treatment engagement is especially important among communities experiencing marginalization who are disproportionately impacted by SUDs and associated outcomes. Thus, it is important to understand what experiences in treatment or personal factors might be associated with engagement and retention in treatment, especially for those more vulnerable.

## **Overview of Opioid Use Disorders and Misuse of Opioids**

Opioid Use Disorders (OUDs) and misuse of opioids, including heroin, prescription pain relievers, and synthetic opioids (fentanyl) is a critical public health and social welfare concern. The Centers for Disease Control and Prevention has estimated the misuse of prescription opioids alone has created an "economic burden" of \$78.5 billion a year in the United States, which encompasses both costs of healthcare and treatment, as well as lost productivity and related legal involvement (Rhyan, 2017). The mortality associated with such problems is staggering, with at least 50,000 people dying from opioid overdoses in the US alone in 2019 (CDC, 2020). This is twice the number of deaths (approximately 25,000) reported by the World Health Organization for the United States in 2014 (Rudd et. al, 2016). A national survey found that in 2018, 10.3 million Americans aged twelve or older reported misuse of opioids (i.e., non-medical use of pharmaceutical opioids or use of heroin) within the past year (SAMHSA, 2019). In terms of specific opioids discussed in this population survey, an overwhelming majority (97%) misused pharmaceutical opioids only, with only a small percentage misusing pharmaceutical opioids and heroin (4.9%) or heroin only (2.9%) (SAMHSA, 2019). In 2018, it was estimated that 1.7 million people in the United States suffered from opioid use disorder related to opioid pain relievers and approximately 526,000 suffered from opioid use disorder related to heroin, these figures are not mutually exclusive (SAMHSA, 2019). It is important to understand the origins of this widespread issue, aptly referred to as the opioid epidemic.

## **History of The Opioid Epidemic and Treatment Approaches**

Heroin was first derived from opium in 1898 and by 1912 heroin addiction in the US was already resulting in tragedy. As a result, the Harrison Narcotic Act was passed in 1914 in an

attempt to control distribution of drugs (Terry, 1915). By 1919, the US had the highest rate of drug misuse globally. Treatment for individuals with OUD at that time meant being consigned to remote farms to be imbued with “wholesome, cultural” values. This model rested in the belief that OUD was the result of poor character, personality issues, or social environment factors (Joseph and Woods, 2018). The first medical treatment for opiate addiction was by Dr.’s Vincent P. Dole, Marie Nyswander, and Mary Jeanne Kreek, in collaboration with psychologist Norman Gordon and sociologist, Herman Joseph (Joseph and Woods, 2018). Dole, Nyswander and Kreek demonstrated preliminary effectiveness of methadone as a treatment for heroin addiction. Their research was groundbreaking, changing addiction from “a moral issue to a metabolic disease,” with stabilization coming from a proper dose of medication improving the ability of individuals to participate in work (Dole, Nyswander 1965; Dole, Nyswander, Kreek 1966; Dole, Nyswander, 1967). Soon after, methadone, a long-acting opioid drug, was found to be an efficacious treatment that helped patients improve their social functioning (employment, education, housework), relieve cravings and withdrawal, and reduce illicit-opioid use (Gearing & Schweitzer, 1974; Dole, 1978).

The current epidemic warrants additional efforts to promote engagement in existing evidence-based services for OUD, including medication for OUD (MOUD). In an effort to make medication more accessible, buprenorphine, a high affinity partial opioid agonist was approved by the FDA in 2002 (Ling et. al, 2010). Buprenorphine offers flexibility methadone does not, as it can be prescribed in a physician’s office (for those who have training and a waiver to prescribe it as of 2022) and patients can receive medication to self-administer at home for days, to months at a time without needing to attend a methadone treatment program daily (Ling et. al 2000). Additionally, the combination of buprenorphine and naloxone (Suboxone) was created to

improve safety of the medication and increase acceptance among treating providers (Ling et al., 2010). While buprenorphine enabled more treatment programs to offer MOUD began to do so, the transition has been slow, illustrating how as “good science alone is no guarantee for successful adoption of a new treatment in the [addiction] field” (Ling et al., 2004; p 117).

When receiving MOUD (methadone or buprenorphine) individuals with OUD have an estimated mortality reduction of 50 percent compared to those who do not take medication for OUD. (Degenhardt et al., 2014; LaRochelle et al., 2017; Ma et al., 2018; Pierce et al., 2016; Sordo et al., 2017). The use of MOUD is associated with a variety of positive treatment outcomes, including better treatment retention. Jancaitis et. al (2020) found pregnant women with OUD who elected to receive non-pharmacological treatment for their disorder were 2.77 times more likely to leave residential treatment prematurely than those who elected to receive MOUD. Other positive outcomes include: lower rates of opioid use (Kakko et al., 2003; Mattick et al., 2009, 2014; Thomas et al., 2014), decreased injection drug use (Woody et al., 2014), reduced HIV transmission risk, diagnosis, and behaviors (MacArthur et al., 2012; Gowing et al., 2011), reduced risk of hepatitis C virus (HCV) infection (Peles et al., 2011), reduced involvement in criminal behavior (Bukten et al., 2012; Gearing, 1974; Schwartz et al., 2009, 2011; Sun et al., 2015), better social functioning (Bart, 2012), and improved quality of life (Ponizovsky and Grinshpoon, 2007). Benefits of treatment for OUD can be identified in those who engage and are retained in treatment.

### **Engagement and retention in the treatment of opioid use disorder**

Medication for opioid use disorder, specifically opioid agonist therapies like methadone and buprenorphine, are FDA approved, highly effective treatments for OUD and are associated with better treatment engagement and retention (e.g., Jancaitis et.al, 2020). MOUD relieves



withdrawal and prevents cravings, so individuals in recovery can participate in their normal, daily activities. Opioid agonist therapies promote and encourage treatment attendance.

Remaining in treatment mitigates risk of death and a sizeable proportion of people would benefit from long term treatment (Kleber, 2007). One review of 11 randomized controlled trials found that, individuals who received methadone had significantly lower rates of heroin use and were also four times more likely to stay in treatment than those who did not (Mattick et al., 2009).

Despite this, in 2019, it was estimated that less than 35% of adults (18+) with OUD received any treatment for their opioid use in the previous year (Jones and McCance-Katz, 2019),

Return of illicit drug use is common after buprenorphine discontinuation (Bentzley et. al, 2015), with high rates of overdose among those who leave treatment (Cornish et. al, 2010). The period immediately following leaving treatment is a time of higher risk for overdose, which speaks to the importance of enhancing retention (Manhapra et al., 2017; Sordo et al., 2017). In a systematic review, Timko and colleagues (2016) found great variability in retention rates across treatment settings, with retention rates for individuals with OUD ranging from 19-94.1% at 3 months, 45.9-91.9% at 4 months, 3-88% at 6 months, and 37-90.7% at 12-month follow-up. It is notable that this review included treatment with naltrexone, which has been identified to have lower retention rates than methadone. Their review found rates treatment drop-out to be high across all medications, with most discontinuations happening early in treatment. Given the rate of treatment dropout, and the implications of drop out, it is important to understand what factors promote retention in treatment.

Factors associated with retention in treatment of OUD include the provision of combining psychosocial services and MOUD (Timko et. al, 2016; Presnall et. al, 2019; Vogel et. al, 2020), coordinated/integrated care (Bailey et. al, 2021; Vogel et. al, 2020), peer recovery supports

(Vogel et. al, 2020), patient satisfaction (Kelly et al., 2010; Kelly et al., 2011; Trujols et. al, 2012; Villafranca et al., 2006; Ali et al., 2017), shared decision making / incorporating patient perspectives (Trujols et. al, 2012; Uebelacker et. al, 2016), setting of treatment initiation and dose of medication (Kennedy et. al, 2021; Uebelacker et. al, 2016). Patient level factors and the potential associated structural barriers associated with those factors, including demographic characteristics, resources, and drug use status, have also been shown to impact retention as well. One consistent individual factor associated with retention across studies is older age (Mertens and Weisner, 2000; Saxon et al., 1996; Stark, 1992), drug use status, history of substance use treatment (Simon et. al, 2017). Overall results for gender are mixed, some with intersectional implications (Ling et al., 2019; Hser et. al, 2014; Marsh et. al, 2021, Parlier-Ahmad et. al, 2022), For instance, a recent study found that intersection of gender, race, and ethnicity may also have a relationship to retention, wherein Black and Latina women are at a greater risk for shorter treatment duration than those not Latino, white men (Marsh et. al, 2021). Patient and societal beliefs (including stigma) may make individuals seeking treatment for OUD reticent to engage in treatment due to the fear of holding a stigmatized identity (Lemke & Zhang, 2015). Given the potential discrepancies in retention based on aforementioned factors, it is important to recognize the systemic forces that may be contributing to increased barriers and the development of SUD in marginalized populations and how to best support individuals in treatment. It should be noted that the WHO defines social determinants of health (SDH) as “conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life,” may provide explanation for additional barriers to OUD treatment some individuals experience differentially (Park, et.al, 2020).

### **Disparities in OUD treatment**

While there are effective, evidence-based treatments for OUD, some rates of treatment engagement vary. The minority stress model offers a framework to understand in part the health disparities that exist between groups that are marginalized and those that are not (Meyer, 2003). Accordingly, the crux of social stress theory is that systemic oppression and discrimination that causes social disadvantage can translate into differences in health status (Schwartz and Meyer, 2010). The processes illustrated within this model are both distal and proximal stress processes. Distal stress processes can be best understood as originating from institutions or people including discriminatory policies, major life events, chronic stressors, overt interpersonal discrimination, and microaggressions. Proximal stress processes are those that originate from internalization of societal stigma like internalized heterosexism, expecting rejection from others based on identity, and concealment of identity to maintain safety (Frost & Meyer, 2023). Marginalization leads to exposure to increased stress and fewer resources to cope facilitated through acts of discrimination and social exclusion, which are added stress burdens to which socially advantaged groups are not equally exposed. These outsized burdens, paired with a lack of available culturally competent care, may impact an individual's ability to engage with treatment for OUD. Disparities exist along a spectrum of identity and experience including, pregnancy or postpartum status (Klaman et. al, 2017; Short et. al, 2013), psychiatric co-morbidities (Brown et. al, 2010), and housing security (Chaterjee et. al, 2018; Midboe et. al, 2019), as well as Black women and SGM individuals. The latter two groups were the focus of the program that provided the opportunity for the current study.

### **The BRITER Program at REACH**

REACH (Recovery Enhanced by Access to Comprehensive Healthcare) Health Services program. It is a comprehensive, outpatient, substance use recovery program designed to deliver

medication-assisted treatment services (now referred to as medication for OUD or MOUD), to individuals in the community. REACH prioritizes a patient centered and trauma informed approach to treating substance use disorders and is committed to offering culturally competent services to all individuals regardless of race, ethnicity, gender, sexual orientation, or religion. REACH is unique in its attention to implementation of evidence-based practices for SUD treatment in a culturally humble manner.

In addition to MOUD, REACH offers standard and intensive outpatient treatment. REACH has a Health Home program designed to assist individuals in treatment for OUD in coordinating/navigating healthcare services and managing chronic conditions through referrals, education, and other supportive activities. The Health HOME provides integrated healthcare for primary specialty and behavioral health, as well as limited primary care services. Although REACH has ample service provision, and provides evidenced based SUD treatment, program evaluation found lower rates of treatment engagement and retention of SGM individuals and Black women.

BRITER, “Bringing Resources Individually To Engage Recovery,” a SAMHSA funded program, was established to address gaps faced in care by these two minoritized groups, namely Black women and SGM individuals in the community. Launched in 2019, BRITER builds on IBR/REACH’s behavioral health home, trauma-informed services, and cultural competency improvement efforts to enhance engagement and retention of Black women and SGM individuals through expanded and tailored services for those groups. Goals are to: (1) increase engagement and retention in substance use treatment, (2) increase awareness of HIV and HCV status and access to corresponding treatment, (3) address trauma related symptoms, and (4) provide risk-reduction education to the participant groups who serve as a focus for the program. All

participants with an OUD diagnosis are eligible for MOUD with their choice of Methadone or Suboxone. In addition, they are eligible for: individual substance use counseling and case management, as well as peer recovery assistance.

As a SAMHSA funded program, all BRITER participants were asked to complete the GPRA (see Measures section) psychosocial assessment at intake (baseline) and 6 as well as 12 months post enrollment (time of discharge). All assessments were completed during a 30-minute structured interview with the BRITER data assistant either on site or over the phone. The current study utilized GPRA baseline data from these assessments and other measures routinely collected for BRITER participants.

### **Black Women in OUD Treatment Settings**

The opioid epidemic has had devastating impacts across communities and demographics. However, attention to those impacted by the current epidemic has prioritized white rural and suburban communities. Black communities are also experiencing increases in opioid misuse and overdose deaths. The disparity is evident in the data, between 2015-2016 there was a 40% increase in drug overdose deaths among Black individuals as compared with an increase of 21% in the overall population (Rossen et. al, 2017). This increase exceeds that of any other racial or ethnic group during the same time period. Additionally, between 2011 and 2016, the highest increase in synthetic opioid-related deaths were among Black individuals (Spencer et. al, 2019). Baltimore City, setting of the current study, has seen a significant increase in opioid related overdose deaths, with a 455% increase in fentanyl-related deaths from 2015 to 2018 (MDH, 2019). The previous responses for drug use issues among the Black community was the instigation of “The War on Drugs,” a racist endeavor which criminalized drug use offenses, and

disproportionately impacted Black Americans at drastically higher rates than white Americans, the consequences of which we are still attempting to coping with today.

Supporting Black women in accessing, engaging, and staying in SUD treatment is of particular concern. Black women who use drugs cope with two layers of relative marginalization in SUD treatment: marginalization for “Black “and “woman” identities. Compared to men, women who have SUDs are subject to interpersonal factors and systemic forces that may contribute to gender disparities in treatment (Greenfield et al., 2007). Substance use in women is often impacted by social connections and sexual partners (El-Bassel et al., 2012). Additionally, women who are in a mothering or caregiving role who use drugs and could face legal consequences or become subject to the oversight in their role as a mother or caregiver (Angelotta et al., 2016; Toscano, 2005; Wyatt et al., 2004). Black communities are disproportionately affected by criminalization approaches to SUD (Glaze & Kaeble, 2014), exacerbating health disparities and disparities in treatment. In addition to high attrition from OUD treatment, Black women are less likely to progress in treatment than Black men (Marsh et. al, 2021). One study found that women clients receiving MOUD had lower odds of completing their treatment plan or making progress in treatment (Guerreo et. al, 2021). Given this attrition, BRITER aims to support Black women in remaining in treatment.

### **Substance Use Disorders among Sexual & Gender minorities**

A recent scoping review of articles published between 2011 and 2021 found that among 113 published studies that examined that included opioid use disorder outcomes among LGBTQ+ populations, only 10% ( $n = 11$ ) of those studies focused on specifically on LGBTQ+ individuals (Paschen-Wolff et.al, 2023). However, there is a growing literature documenting that sexual and gender minority identity individuals experience mental and physical health issues at a

higher rate than their non-SGM peers (Caceres et al., 2019; Muller & Hughes, 2016; Patterson, 2020). Such robust findings speak to the need for addressing health disparities experienced by SGM populations. Those disparities associated with alcohol and other drug use among SGM are some of the most prevalent. Although federal survey data asking participants about sexual orientation and gender identification are relatively new, National Survey on Drug Use and Health (2015) data showed that sexual and gender minorities (SGM) had higher rates of substance use and SUDs than their heterosexual and cisgender peers (Medley et. al, 2016; See Table 1. in Appendix A for definitions of key terms). Specifically, SGM adults were more likely than sexual and gender majority adults to have used an illicit drug in the past year (Medley et. al, 2016). To illustrate, over one third (37.6%) of sexual minority adults reported marijuana use as compared to less than one fifth of the population overall (16.2%) (Medley et. al, 2016).

Results of smaller studies demonstrate how types of substances used differ across various SGM groups. For instance, SMW women, especially bisexual women, are more likely than their sexual majority counterparts to experience alcohol related problems and alcohol use disorder. Lesbian and bisexual women are 3 to 7 times more likely to have an AUD (past year (Hughes et. al, 2020). Compared with same-aged heterosexual women, rates of lifetime cannabis use were significantly higher among Lesbian/Gay women and bisexual women than sexual majority women (Hughes et. al, 2020). In a recent systematic review of the literature pertaining to substance use among transgender individuals, there was a higher relative prevalence of substance use among transgender adults than cisgender, but the studies, unfortunately, are not well powered enough to quantify risk or overall prevalence (Connolly & Gilchrist, 2020).

There is little known about the prevalence of opioid use disorders or opioid misuse in all subpopulations of SGM. Recent national data show bisexual individuals over all had a greater

than 1.5 higher odds of reporting past year and past month of opioid misuse (Duncan et. al, 2019). Overall, past year opioid use (including both heroin and misuse of prescription opioids) was higher in sexual minority adults (9%) than the population (3.8%) (SAMHSA, 2018).

Although the general population of individuals who have a SUD is heterogeneous, minority stress associated with the stigmatization of SGM identity and systematic oppression of SGM, plays a role in the development and maintenance of SUDs.

### **Minority Stress Model: SUD in SGM**

The minority stress model of health suggests higher prevalence of use and use disorders among SGM individuals is likely associated with stress placed on SGM individuals by the dominant oppressive forces of heterosexism and cissexism both external and internal (Meyer, 2003). SGM individuals are discriminated against, presenting a barrier to engagement, which can then be coupled with the need to conceal their identity in order to preserve their safety. They also may experience feelings of internalized homophobia and experience additional burdens of stress not experienced by their heterosexual and cisgender peers. The combination of discrimination and internalized stigma creating minority stress and impacting health outcomes in SGM individuals has been supported in previous studies (Lehavot & Simoni, 2011). One systematic review on prevalence and correlates of substance use among trans adults found that transphobic discrimination or violence, unemployment and sex work, gender dysphoria, high visual gender non-conformity and intersectional sexual minority status were all correlated with substance use (Connolly & Gilchrist, 2020). In addition to the impact of stress itself on health, individuals may be less likely to access social and spiritual resources that serve as a buffer for the impacts of such stress when it is experienced (Lehavot & Simoni, 2011). As a result, SGM individuals are more likely to engage in substance misuse or develop a SUD (McCabe et. al, 2010).



SGM are also at increased risk for developing substance use related health problems such as co-morbid depression and trauma-related disorders (Gilman et.al, 2001; Robert et. al, 2010; Shipherd et. al, 2011). One study found a stronger relationship between victimization and suicidality in SGM with a substance use problem compared to SGM without a substance use problem (Meir et. al, 2014). An association between risky sexual behavior and substance use in subgroups of SGM individuals has also been reported contributing to increased risk of sexually transmitted infections (STIs) like HIV (Mimiaga et. al, 2015). This has led researchers to coin the phrase “syndemic,” describing the dual issues of substance use and HIV risk. In fact, the increased potential for co-occurring issues with substance use in SGM, have contributed to the development of many interventions that either promote harm reduction or abstinence from substances in SGM populations while concurrently seeking to address substance use related sexual risk behavior, including instances of unprotected sexual encounters (see: Mimiaga et. al, 2015).

Despite an increased risk of substance use and associated comorbidities/risks in SGM populations, little attention has been focused on discrimination and substance use and mental health outcomes in this group (McCabe et. al, 2010). McCabe and colleagues (2010) using a national data set, found that more than 66% of lesbian, gay, and bisexual adults have reported an experience of discrimination based on their sexual orientation, race, or gender in their lifetimes. The odds of past year substance use in this sample were almost 4 times greater (OR=3.85) for those who reported sexual orientation, race, and gender discrimination, all three in the past year, than for those lesbian, gay, and bisexual adults who did not. Another study found that sexual minority men who ever experienced discrimination were more likely to have a drug use disorder than SMM who had not experience discrimination (Lee et. al, 2016). Among sexual minority

women, victimization and internalized homophobia were associated with substance use issues (Lehavot et. al, 2014).

Although less prevalent, there are studies that show the relationship between discrimination based on transgender identity and substance use as well (Schweizer & Mowen, et al, 2020). Hughto et. al (2021b) for example, found that gender diverse individuals who reported experiencing stigma in healthcare had increased odds of past-year opioid pain medication misuse. Given the impact of minority stress on substance use outcomes among SGM, it is important to understand the experiences of SGM in treatment for SUDs.

### **Factors associated with SUD treatment entry in SGM**

Research on factors associated with entry into substance use treatment found many of which are often associated with marginalization. Sexual and gender minority individuals experienced more barriers to care access than their non-SGM counterparts (Cochran et. al, 2007). SGM, as a group, also had relatively lower amounts of healthcare coverage than non SGM individuals (Buchmueller & Carpenter, 2010), and they have to contend with providers with cis- and heterosexist bias or providers with a lack of cultural competence regarding SGM needs (Eliason & Hughes, 2004; Hellman, 1989). One study found that only 20% of SUD treatment providers had formal education about the needs of their gender minority patients, with 90% of those staff receiving five hours of total training (Cochran, 2007). Many providers may conflate sexual and gender identity, like the belief that “all transgender people are gay.” (Cochran, 2007). Additionally, one qualitative study found that transgender individuals did not participate in treatment both because of transphobic threats and violence as well as providers restricting them to treatment clinics that serve their sex assigned at birth (Lyons et al., 2015). Therefore, the

discrimination SGM may face from health care providers can make care less effective and dissuade SGM individuals from seeking care (Keuroghlian et. al, 2017).

SGM individuals present unique concerns upon entry to treatment. Although they have less access than their peers (Keuroghlian et. al, 2017), sexual and gender minority individuals are more likely to seek and obtain substance use treatment compared to heterosexual individuals (McCabe et. al, 2013). At treatment enrollment, SGM present with greater severity SUD symptoms than non SGM (Cochran, 2006). Sexual minority individuals are more likely to present with physical and mental health needs when entering treatment for SUDs (Flentje et. al, 2016). Misconceptions about medications may deter care entry as well, specifically among those who are HIV+ and/or transgender who are considering the use of agonist medications to treat OUD. MOUD has known interactions with both specific antiretroviral HIV medications for those who are HIV+ and also some hormone modulating medications prescribed as a component of affirming care for transgender individuals (Girourd et. al, 2019). Despite these interactions, co-prescription of these medications is both safe and feasible with monitoring and support.

There is a paucity of research on the association between engagement, retention, and outcomes specifically in SGM individuals in (any) SUD treatment. One review study of Contingency Management (CM) found treatment outcomes differed based on sexual orientation. Although sexual minority individuals and non-sexual minority individuals had similar outcomes drug abstinence outcomes (percentage of negative urine screens) to both CM and standard IOP, equivalency testing found differential treatment response between sexual minority individuals and their non-minority counterparts, leading the investigators to the conclusion that we “cannot conclude that treatment response is equivalent for LGB and heterosexual individuals” (Zajac et. al, 2021).

Elucidation of the factors associated with treatment entry highlights the need for both tailoring and culturally specific treatment and developing in cultural competence of SGM needs among practitioners. One study simulated the experience of finding SGM specific treatment for OUD using the SAMHSA treatment directory and found that of the 570 programs offering treatment for OUD nationally, only 107 programs offered both MOUD and SGM-specific treatment with three states having no programs that offer both (Paschen-Wolff et. al, 2022). Fortunately, the literature on SUD treatment interventions (tailored or not) for SGM is growing. However, before engagement efforts can be tailored, it is imperative that SGM are empowered to discuss their subjective experiences in treatment, and factors that contribute to engagement and retention.

### **Care in the time of COVID-19**

The emergence of the novel corona virus (COVID-19) and associated disease quickly and dramatically altered the delivery of healthcare services in the United States. The corona virus disease 2019 (COVID-19) is caused by a severe, acute respiratory syndrome (SARS-CoV-2), with acquisition, hospitalizations, and deaths due to acquisition, escalating rapidly since the beginning of the pandemic (Fu et. al, 2020; Garg et. al, 2020). Because social distancing was recommended due to the nature of the virus and nature of transmission, providers were advised to convert in-person services to telehealth when possible, as well as postpone routine patient visits and elective procedures (Czeisler, 2020). Additionally, providers were encouraged to continue limiting risk by employing a tiered approach to restarting elective procedures and regular clinic visits that encouraged telehealth when possible.

To ease this transition, barriers to telehealth were eliminated; HIPAA Security and Privacy Rule requirements were waived; and reimbursement policies were revised (USDHHS,

2020) to support telehealth for both behavioral health and medical providers. One national study found that pre-pandemic, psychologists reported using telepsychology for only 7% of their clinical work time. During the pandemic, this increased 12-fold, to 85% of their work time (Pierce et. al, 2021). There was also a drastic increase in uptake of telemedicine overall among medical providers. Cantor and colleagues (2021) reported a 20-fold increase in the incidence of telemedicine utilization from March 13, 2020 through the end December 2020. Some studies have demonstrated that patients are highly satisfied with telehealth interventions, when available and accessible (Fleischhacker, 2020). Although telemedicine is generally viewed favorably by patients and can increase access and flexibility to care and reduce barriers, there may be additional barriers presented by the COVID-19 pandemic. There is some speculation that the pandemic and service changes may exacerbate existing health disparities for marginalized groups. For instance, there is evidence to suggest lower income individuals might be accessing telemedicine at a lower rate than their peers, which some speculate is related to scarcity of resources (Cantor et. al, 2021). One specific population that is of particular concern is individuals with SUDs.

### **COVID-19 and Substance Use Disorder Treatment**

Little is known about the impact of COVID-19 on SUD populations, however one study of electronic health record data of 73,099,850 patients, found that 7,510,380 patients had lifetime SUD (10% of study sample) and 722,370 had recent SUD (diagnosed in past year) (1% of study sample). Further, the 12,030 patients diagnosed with COVID-19 in this study, 1880 patients had been diagnosed with SUD (including AUD) in their lifetime (15.63% of Covid Patients) (Wang et. al, 2021). This is of great public health concern, given 1 in 10 adults, has a SUD (including alcohol and tobacco) (SAMHSA, 2018). Early on in the pandemic SUD experts speculated that

individuals with SUD may be at increased risk for more severe COVID-19 disease, as chronic use of alcohol, tobacco, and other drugs is associated with cardiovascular, pulmonary, and metabolic disease (Volkow, 2020). Such individuals are also at increased risk due to psychosocial and environmental factors (Volkow, 2020). Community support is important to those with substance use disorders or in recovery, often as a means of primary support in recovery, and restrictions on the ability to socialize and engage in recovery related activities can negatively impact individuals in recovery (Volkow, 2020).

Consistent with the general healthcare landscape many SUD treatment providers and community support agencies were prompted to move their services online as well. Community groups like Alcoholics Anonymous and Narcotics anonymous and other treatment providers began also offering online services, including intensive outpatient and group therapy providers (see: [recoverttogether.withgoogle.com](https://recoverttogether.withgoogle.com)). There was concern that the overall transition to majority telehealth sessions may present additional challenges for SUD patients. In addition to elevated risk for acquisition of COVID-19, individuals with SUD may also be at risk for instability in their recovery due to service interruptions caused by the pandemic (Lin et. al, 2021).

Telemedicine has not previously been well studied, and has been underused, in SUD populations especially given the more frequent visits, intense monitoring (drug assays), and other restrictive practices that increase barriers to telehealth implementation (Lin et. al 2019; Kouronis et. al, 2016). Prior to the pandemic, a study using a large claims database analyzed the utilization of telemedicine in SUD care (between 2010-2017), found low tele-SUD care rates overall. It also found that telemedicine in SUD care as a complement to face to face care with the median number of telemedicine visits among tele-SUD users as ten in a given year, suggesting that most users of telemedicine are not receiving intensive services (Huskamp et. al 2018). Given the lack

of prior utilization and knowledge regarding telemedicine in COVID-19 it is important to learn more about how individuals with SUD are experiencing related treatment changes. One group for which telemedicine has historically been restricted is individuals with OUD.

### **COVID-19 and Opioid Use Disorder Treatment**

*“The greatest strength of the treatment system has always been compassion and care for the most vulnerable— qualities needed now more than ever.”* (Alexander et. al, 2020)

Although there can be no fortunate timing for a global pandemic, the COVID-19 pandemic coincided in timing with the opioid epidemic (Volkow, 2020). As hypothesized early on in the pandemic, individuals with SUD have suffered disproportionately in contrast to individuals without SUD. Experts in SUD posited that individuals with OUD would be at an increased risk for COVID-19 and experience greater symptom severity, given the respiratory depressant effects of opioids and the respiratory nature of the illness, as the combination could prove potentially lethal (Volkow, 2020). Wang et. al (2021), using EMR data study demonstrated an increased risk of COVID-19 for individuals with SUD ,with the greatest risk being for those with OUD (Wang et. al, 2021). Additionally, concerns regarding the health of those with OUD during the pandemic were not just related to COVID-19 itself, but to stability in their recovery and increased potential for overdoses. Isolation related to the need to physically distance, as well as increased stress, put individuals with OUD at risk for relapse (Volkow, 2020). Unfortunately, in the year leading up to May 2020, drug overdose deaths in the United States rose rapidly, the highest number of overdose deaths ever recorded in a 12-month period (81,000) (CDC, 2020). In the state of Maryland alone, there were 2,499 opioid-related intoxication fatalities in 2020, which was an 18.7% increase in from the previous year (MDH,2021). Emergency room admissions for overdoses also increased by a larger proportion than overall emergency department visits during

the pandemic (Rosenbaum et. al, 2021), with other locales reporting 17% increase in overdose EMS runs brought into the emergency department, and a 50% increase in EMS called to a scene of a suspected overdose death (Slavova et. al, 2020). Given the impact of the pandemic on individuals with OUD, it is important to understand the implications the COVID-19 pandemic has for treatment of OUD.

The treatment of OUD has changed as a result of the pandemic. Early in the pandemic, experts called on leadership to expand access to care outside of face-to-face office visits given pandemic precautions as to not interrupt the flow of care (Sun et.al, 2020), especially for those taking methadone for OUD (Alexander et. al, 2020). In addition to the previously mentioned elimination of barriers (HIPAA requirements relaxed, reimbursement changes) the DEA and DMAS relaxed prescribing regulations for buprenorphine for treatment of Opioid Use Disorder (DHHS, 2020; Davis & Samuels, 2020). Many treatment programs rapidly changed their protocols, defying conventional wisdom surrounding the timeline needed for the implementation of newly developed interventions into practice. These treatment programs changed their services across each treatment type to allow for as safe practice as possible, including behavioral interventions (Becker et. al, 2021; Sadicario et. al, 2020) and medication for OUD (Buchheit et. al, 2021) often resulting in more flexible hours, different workflows (including the provision of telehealth), and thus potential expansion of access for those with transportation difficulties, as well as for those who live at a distance from their treating provider.. Early in the pandemic, one OUD treatment clinic reported that the switch to telehealth eliminated several barriers to behavioral health treatment including lack of childcare, lack of transportation, limited time to travel to the clinic, and stigma-related fear of being seen at a MOUD clinic (Hughto et. al, 2020) Others advocated for expanded roles for current recovery supports, like peer recovery coaches



(PRCs). PRCs may be able to address the anticipated increased burden of the disease, by reducing social isolation of those with OUD, building buy-in and trust, and promoting accurate COVID-19 information from within the community, in a time when individuals may be more distrustful of medical authority (Kleinman et. al, 2021)

Many providers and researchers have called on regulatory organizations to consider making these changes permanent (Davis et. al, 2020; Green et. al, 2021; Nunes et. al, 2021) while others advocate for data driven approaches to changes in treatment, calling for further analysis of the outcomes of these treatment changes before making them permanent (Livingston et. al, 2021). There are preliminary outcomes data on the impact of the pandemic on the treatment of OUD. One study that spanned states in the American South and Midwest compared 2019 and 2020 insurance claims data and found no significant differences in the amount of OUD visits a patient attended but did find that individuals received one less urine test between March 2020 and May 2020 in the corresponding time period a year prior (Huskamp et. al, 2020). Additionally, OUD visits delivered via telehealth increased from just under a half of a percentage point (.48%) in the first week of March to almost a quarter of visits occurring remotely in the 13<sup>th</sup> week of the pandemic (24%; Huskamp et. al, 2020). A national database analysis used by 92% of retail pharmacies in the United States found that buprenorphine prescriptions remained steady but did not decrease, however, the number of prescriptions that were filled decreased drastically (Nguyen et. al, 2021). Given these initial data, and the potential for long lasting changes, it is important to understand the impact of the pandemic on those individuals with OUD who are at higher risk.

### **COVID-19 & Substance Use Disorders among Sexual & Gender Minorities**

SGM individuals have a relatively higher prevalence of SUD than their non-SGM counterparts. Given the increased risk for SGM pre-pandemic, some studies have already examined how the ongoing COVID-19 pandemic is impacting mental and physical health behaviors, including substance use in SGM, and have found mixed results. One global study focusing on the health of gender minority adults found over a third of their sample had an active alcohol use disorder (35%) and found significant predictors for getting tested for COVID-19 included having limited access to gender-affirming surgery, having experienced discrimination due to gender identity in a health facility, and having an alcohol use disorder (Restar et. al, 2021). One study examining prevalence of mental health and substance use issues across SGM and non-SGM in major US metropolitan areas found that SGM reported greater increases (in relation to pre-pandemic) in levels of depression, anxiety, and “problem drinking” compared to their non-SGM counterparts (Akre et. al, 2021). Several studies focused on sexual and gender minority women (SMW) and substance use during the pandemic. Cerezo and colleagues (2021) found that happy hours and drinking games conducted via social media normalized alcohol consumption as a coping strategy to address boredom and stress during quarantine among SMW. A qualitative study examining experiences and perceptions of alcohol and cannabis use in the context of the pandemic in older (mean age=53.5), SMW echoed those sentiments, and found alcohol use to be a means of seeking recreation and relief during the pandemic (Bochicchio et. al, 2021). The participants in this study reported creating new patterns of drinking (drinking during work time, during the daytime, etc.) which has led to some beginning to self-monitor their alcohol use (Bochicchio et. al, 2021). A study of SGM university students found an increase in alcohol use across SGM, however, increased alcohol use was associated with greater psychological distress among SGM assigned female at birth (AFAB), complimenting previous

research, and demonstrating this phenomenon in gender expansive AFAB individuals as well (Salerno et. al, 2021). Many studies were cross-sectional, examining use retrospectively, with those with longitudinal data examining the differences in use pre and during the pandemic. One study focused on sexual minority men (SMM) and found that periods of increased sexual activity was associated with increases in substance use or binge drinking during the pandemic (Stephenson et. al, 2021). All of these studies did not specify if individuals met diagnostic criteria for SUD, rather, demonstrated prevalence of use during the pandemic.

Given the paucity of research, and difficulties with accurate surveillance, it is more difficult to ascertain the effect of COVID-19 on SGM with SUDs. Rather some studies have been completed of those individuals who have either endorsed “problematic” substance use or endorsed consistent use prior to pandemic use of substances. One study employed a longitudinal design, capturing two waves of data during the pandemic a month apart, as well as 30 days of ecological momentary assessment data of problematic substance use among SGM-AFAB. This study found that half of its participants reported an increase in the use of cannabis and alcohol. In that study, an increase in solitary use of alcohol and cannabis, as well as increases in SU use with a romantic partner, during the pandemic was associated with increase in both quantity and frequency of substance use. Those who reported using alcohol or cannabis alone also reported coping motives for use (Dyar et. al, 2021). A study of regular, adult cannabis users during COVID-19 found that rates of use of cannabis use did not differ between SGM and non-SGM, however, SGM cannabis users were more likely to report stress related to COVID-19 and concerning coping behaviors, including increased alcohol use (Gattamorta et. al, 2021). SGM cannabis users who reported depression and anxiety were also more likely to endorse more pandemic related stressors: worrying about health of international friends, family, or partners,

sleeping more, changes to sexual activity, and discrimination / stigma related to COVID-19 symptoms compared to their non-SGM counterparts (Gattamorta et. al, 2021). The majority of participants (~75%) indicated they use cannabis for medical reasons and the publication did not provide specific details regarding medical reasons; the authors also did not report use rates or compare use report with cannabis use disorder criteria (Gattamorta et. al, 2021). Another study of young, sexual minority men (93%) and transgender women (7%) found no changes in cannabis use and a decrease in overall non-cannabis drug use prevalence but an increase in frequency of non-cannabis drug use among those who continue to use drugs during the pandemic as compared with those who stopped use (Janulis et. al, 2021). While another study of SMM also found a decrease in drug use across all subtypes (i.e.: amphetamines, and “party” drugs); for those who continued to use drugs during COVID-19, they also identified a relationship identified between drug use and potentially, risky sexual behaviors (Starks et. al, 2020). A study of SMM found 10% increased overall drug use and 25% increased alcohol use during the pandemic, with younger SMM more likely to endorse an increase in use (Sanchez et. al, 2020). Finally, a qualitative study of sexual minority men sought the emerging themes related to the impact of COVID-19 on health behaviors, with one participant explicitly identifying potentially harmful alcohol use at the beginning of the pandemic and cutting back during quarantine (Rhodes et. al, 2020). Most of these research studies were concerned with trends in use among individuals who had a history of substance use, across SGM identity and across drug use types. However, little is known about the experience of SGM with SUDs in SUD treatment during the pandemic, with a noticeable lack of information on the experience of SGM who use opioids or have OUD during the pandemic.

### **Changes in treatment in COVID 19 for SGM with SUD**

As the COVID-19 pandemic is ongoing, research on the changes to treatment for SUD specifically during COVID-19 is not yet available. Prior to the pandemic, there was interest in the use of telehealth to address mental health concerns specific to SGM (Whaibeh et. al, 2019). Since the onset of the pandemic, commentaries have been advanced advocating for additional options for visits and flexible parameters to care for SGM with SUD (Tomar et. al, 2021). Extant literature has described changes to care for SGM individuals with SUD during the COVID-19 pandemic. One treatment program in Puerto Rico found changes to SUD care for COVID-19 had unintended consequences for transgender and gender nonconforming patients with OUD, as evening outreach hours to engage patients were no longer available, it was more difficult to re-engage transgender and gender non-conforming (TGNC) patients who were service disconnected (Melin et. al, 2021). It is imperative that programs, when able, tailor outreach efforts to those individuals' experiencing hardship magnified by layers of systemic oppression, especially in the time of COVID-19.

There are examples of clinics that have demonstrated flexibility and creativity with addressing the challenge of ongoing SGM patient engagement during the COVID-19 pandemic. One clinic offering affirming substance use and HIV+ care, split between two sites, found differential impacts on access related to treatment transitions when COVID-19 safety precautions were put in place. At one site, an STI clinic, individuals engaged in regular care transitioned well to teletherapy (initial uptake of 100%), as some individuals increased the frequency of their sessions to prevent setbacks in recovery and get support in adjustment to COVID-19 circumstances (Rogers et. al, 2020). However, no patients who typically engaged in care at their community-based site that offered drop-in services initially transitioned to telehealth at the onset of the pandemic (Rogers et. al, 2020). The program adapted outreach efforts to include a more

comprehensive role for peer recovery coaches (PRCs) to provide support to individuals during the pandemic in lieu of the ability to attend counseling, as PRCs have more flexibility in timing and method for engaging with patients (Rogers et. al, 2020). Further along in the pandemic, the clinic was able to provide secure space for teletherapy to be conducted within the community-based organization for those who did not have resources to have teletherapy in their homes. The clinic group reported in a later commentary that patients were attending therapy across both sites at a higher rate than pre-pandemic given the flexibility and access of telehealth (Arnold et. al, 2021). It remains to be seen, however, if additional adjustments to care provision and outreach become necessary as the pandemic advances. While the commentary detailed pandemic related symptomatology, little is still known about the subjective experiences of SGM patients in OUD treatment during or before the pandemic.

## **Methods**

### **The Present Study**

The purpose of this study was to gain a better understanding of the experiences of SGM in OUD treatment before and during the COVID-19 pandemic in order to inform future clinical and research efforts to serve this population. Given the paucity of research regarding SGM in OUD treatment settings, this study employed both qualitative and quantitative methods to characterize the population and understand the experiences of SGM with OUD in MOUD treatment settings. The present study was conducted in two phases. Phase one was a secondary data analysis of measures collected as a part of the SAMHSA funded BRITER program. In the analysis, demographic, psychosocial, mental health, and substance use variables are described for the sample of all SGM enrolled in the BRITER program at REACH for at least one month of the pandemic (March 2020 – April 2023).

Phase 2 of the study examined the subjective experiences of SGM in OUD treatment before and during the COVID-19 pandemic. Participants for Phase 2 were selected from the Phase 1 data set. Phase 2 used qualitative and quantitative approaches to answer the study aims. The qualitative portion of Phase 2 employed in-depth, semi-structured interviews using an inductive, descriptive phenomenological framework which intends to empower participants to share their perspectives of experiences in treatment (facilitators and barriers), before and during the COVID-19 pandemic.

The quantitative portion of the study characterized the participants using standard and tailored measures of psychosocial and health related variables. These data provide a richer description of the sample and add contextualization to the themes that emerged from qualitative analysis. This study was approved by the Virginia Commonwealth University's Institutional Review Board and informed consent was obtained from all participants.

Specific aims of the present study were as follows:

- A1.** Describe the population of SGM folks enrolled in BRITER at REACH, a substance use treatment facility in Baltimore, MD.
- A2.** Identify factors impacting treatment engagement and retention using subjective experiences and quantitative measures.
- A3.** Better understand the impact of COVID-19 on treatment in a sample of SGM individuals with OUD.

## **Methods: Phase 1**

### **Participants**

Participants were N=52 SGM individuals admitted to REACH who completed a baseline assessment for the BRITER program after March 2020 and before the end of the national public health emergency. Measures included in the dataset are summarized below; de-identified data were provided via a secure method to the research team (Two files: 06/24/2023 & 03/14/2023 via file locker). The principal trainee investigator analyzed this data to characterize the SGM participants in the BRITER program during the specified time period.

**Inclusion criteria.** The BRITER program focuses on improving MOUD treatment engagement and retention for Black women and SGM with OUD. For the present study, the data assistant selected only SGM participants who completed a GPRA baseline and participated in the program for at least one month after March 2020 and before the end of the public health emergency for the de-identified data set (March 14, 2023).

**Exclusion criteria.** Participants were ineligible if they did not complete the baseline assessment measures for the BRITER program.

## **Procedures**

In Phase 1, secondary data analysis of de-identified BRITER baseline measures and treatment participation for BRITER participants in SUD treatment including demographic, psychosocial and psychological variables, program participation data, and HIV risk assessments (see below).

## **Materials**

### ***Treatment Program***

Participant recruitment for BRITER took place at REACH (Recovery Enhanced by Access to Comprehensive Healthcare) Health Services program. REACH is a comprehensive, outpatient, substance use recovery program designed to deliver medication-assisted treatment



services (now referred to as medication for OUD or MOUD), to individuals in the community. More information on the treatment program can be found in Introduction Section entitled “The BRITER program at REACH.”

## Measures

**Government Performance and Results Act Client Outcome Measures for Discretionary Programs (GPRA)** (CSAT, 2012) is a standardized assessment interview that covers seven areas of physical, psychological and psychosocial functioning. As a part of a federal mandate, all SAMHSA (Substance Abuse and Mental Health Services) grantees are required to collect and report performance data using the GPRA. The majority of questions focus on the 30 days prior to completing the assessment. Domains include demographics, substance use and abuse, mental health and physical functioning, violence and trauma, and social connectedness.

**HIV/AIDS Risk Assessment Tool** was originally created by the Maryland Alcohol and Drug Abuse Administration assesses risk factors related to HIV/STDs. The questions focus on lifetime risk behaviors related to drug use (injecting drugs and sharing needles) and sexual behavior (condom usage, sex while high, sex with a person who has HIV or injects drugs, sex in exchange for drugs or money). In addition, HIV and HCV testing and treatment history are assessed and recorded.

**Life Events Checklist, for DSM-5 (LEC-5)** (Weather et. al, 2013) is a standardized measure of lifetime experience of 16 stressful events. For each event, participants report if it has happened to them personally, they have witnessed it, they learned about it happening to a close family member or friend, they were exposed to it as part of a job, or if that event in particular is

not applicable to their experience. Events of interest for this study included physical assault, assault with a weapon, sexual assault, unwanted/uncomfortable sexual experience, violent death, and accidental death. Participants also answered questions about what they consider to be worst event (lifetime), defined as the event that currently bothered them the most. There is no formal scoring protocol for this measure, and it did not yield a total or composite score. The original LEC (2004) demonstrated both convergent validity with other measures that assess traumatic event exposure and related psychopathology (Gray et. al, 2004) . Psychometric information is not currently available for the LEC-5, however the revisions were minimal, so the authors speculate few differences between the versions.

**PTSD Symptom Checklist DSM-5 (PCL-5)** (Weathers et. al, 2013) is a 20-item questionnaire, corresponding to the DSM-5 PTSD symptom criteria. Participants are asked to identify their worst traumatic event, similar to the LEC-5. Then participants rate how much they have been bothered by the 20 PTSD-related symptoms in the past month, in connection with this identified event. Responses for each item range from 0-4, with 0 representing “Not at all bothered” and 4 representing “Extremely bothered”. Examples of items include “repeated, disturbing dreams of the stressful experience,” “avoiding memories, thoughts and feelings related to the stressful experience,” “loss of interest in activities you used to enjoy,” and “being ‘super alert’ or watchful or on guard”. A total PTSD symptom severity score is calculated by summing the scores for each item. A provisional PTSD diagnosis was given if this score was above 33, in accordance with guidelines from the National Center for PTSD (Weathers et. al, 2013) .

**Program Engagement** Patient level measures of engagement with the BRITER program, included: time in treatment at REACH, treatment discharge from REACH, status at BRITER program discharge, methadone or buprenorphine dose, and urine drug screen results.

### **Data Analysis Plan**

Phase 1 statistical analyses were performed with SPSS version 28 (SPSS Inc., Chicago, IL, USA). Descriptive statistics (means, frequencies) were summarized to characterize the sample at baseline enrollment in BRITER.

### **Methods: Phase 2**

#### **Participants**

**Case Identification.** Participants were N=4 individuals who completed the BRITER baseline. The participants for the second phase were chosen via stratified randomly sampling by the BRITER data assistant from the participant pool created in Phase 1 ( N=52). In order to attempt to ensure representativeness of various lengths of treatment participation in the sample, the phase one data set variable for length of time at REACH was used to create a cut off variable to split individuals into those who were new to REACH (less than two years) and those who had received services for more than two years. Thus, inclusion and exclusion criteria remained consistent with Phase 1 of this study. The current research project planned to enroll 10 BRITER participants in the study, however four participants were included; despite this change in sample size, the total amount is still consistent with general guidelines for qualitative research studies performed by trainees (Groenewald, 2004; Creswell, 2007).

#### **Procedures**

**Permission to Contact** The BRITER data assistant contacted the participants (see sampling method above; by phone, text, in person) to get their permission to be contacted by a

member of the research team to learn about this research opportunity. The BRITER data assistant provided their contact information to the study team using a secure, Redcap survey. The research team contacted them via their preferred method(s) (phone or text message) and set up a time to tell them about the research study to determine their interest in participation.

The clinic referred 10 potential participants and 8 of those were reached by the trainee investigator. Of this group: one declined, three indicated interest but were lost to follow-up before completing the Phase 2 survey; four participants consented and completed the study. All participants who participated agreed after two or less phone calls. Every lost to follow-up participant was contacted at least five times.

**Informed Consent.** The trainee primary investigator reviewed the consent form with the participants and answered any questions they had. All respondents were remotely given a copy of the consent form that was verbally reviewed prior to measure administration and interview. The research team obtained consent for interview recordings and patients were informed that this information may be used for publications. Participants were asked to provide consent for the research team to make the data provided in the first phase of the study identifiable for the second phase of the study for analysis. No written consents were obtained as doing so may have inadvertently provided BRITER staff with the knowledge of which BRITER program participants were participating in the study, potentially compromising their confidentiality.

**Data Collection.** All 5 participants chose to complete the measures virtually. Participants were provided a weblink via email or text message, to access the online survey built using the Computerized Intervention Authoring System, Version 3 (CIAS 3.0) software. CIAS features a synthetic text to speech engine that reads survey content out loud for participants to listen. CIAS applications are HIPAA compliant with encryption of all data in transit and at rest and are hosted

on a HIPAA-compliant cloud server. This software has been used by our research team to collect survey data and for intervention delivery across a range of projects (Kelpin et. al, 2018; Martin et. al, 2022; Stephenson et. al, 2022). The measure took approximately 20-30 minutes to complete.

After completion of the initial measures, participants were contacted and scheduled to complete a semi-structured interview; participants were given the choice to complete the interview either by phone or video chat. These options were informed by recent clinic program evaluation efforts in which BRITER program participants indicated a preference for measure administration by phone (53%) or had no preference for being reached by phone or seen in person (47%). All participants elected to be seen via video chat for the current intervention. The trainee investigator then proceeded with the interview, which was recorded using two methods, the recordings of which were saved in Redcap. The semi-structured interview is described in the measures section below. The interview times length ranged from 47 to 83 minutes. The research team provided compensation after measure administration and interview administration via email.

**Participant Compensation.** Participants received a \$10 gift card for their time and effort in survey completion and a \$20 gift card for their participation in the semi-structured interview portion of the study.

## **Materials**

This mixed methods study involved the completion of quantitative measures and a semi-structured qualitative interview. Participant data from the BRITER record in phase 1 was linked to the study data collected in phase 2. All data was stored on secure servers. Quantitative measures were entered and stored initially in CIAS, with data exported to secure servers with no

identifiers attached. Recordings are stored on a secure server with no identifiers attached. A shadow key is kept by the primary investigator to link interviews, measures, and patient identifiers. This will be destroyed upon completion of data analysis. This study was reviewed and approved by the Institutional Review Board at Virginia Commonwealth University. The quality control section below details efforts the investigator took to ensure data quality, implemented prior to conducting interviews, including practicing the interview form with volunteers, bracketing, keeping process notes, which is presented further below as well. Study measures are in the Appendix.

### ***Quantitative Measures***

**Demographic Survey.** Demographic variables included age, race, gender, sexuality, education, employment, income, marital status, and current living situation. Adapted gender identity and sexual orientation measures were drawn from the Fenway institute clinical measures of gender identity and sexual orientation (See: [http://thefenwayinstitute.org/wp-content/uploads/COM228\\_SOGI\\_CHARN\\_WhitePaper.pdf](http://thefenwayinstitute.org/wp-content/uploads/COM228_SOGI_CHARN_WhitePaper.pdf)).

**Current Healthcare Status & Engagement.** Health care utilization will be assessed with the following questions (yes/no). “*Do see a medical provider at BRITER?*”; “*Do you have medical care outside of REACH?*” Data provided by the BRITER data assistant include time spent at REACH and time in BRITER. Additional questions about access to telehealth and in person interventions were asked as well.

**Brief Sense of Community Scale (BSCS)** is an 8-item Brief Sense of Community Scale that was developed to represent the “Sense of Community” dimensions of needs fulfillment, group membership, influence, and shared emotional connection (Peterson et. al, 2008). This scale uses six-point Likert scale scoring. Higher scores reflect a stronger sense of community

within each domain. In prior studies in adult populations, Cronbach's Alphas ranges from 0.85 to 0.92 (Peterson et. al, 2008). The BSCS will be used to assess the degree to which SGM individuals report feelings of belongingness or ability to depend on their SGM community.

**Short Recovery Capital Scale 10 (SRCS 10)** (Hanauer et. al, 2019) is a ten-item measure that will be used to assess both incoming resources and barriers to recovery. This scale is adapted from the 35-item Recovery Capital Scale (White & Cloud, 2008) and has accordingly demonstrated good convergent validity. Participants rate their agreement with each statement in from "Strongly Disagree" (with a value of 1) to "Strongly Agree" (with a value of 5). The score for each question is added together to create the participant's total score. Total scores can range from 10 to 50. The format of the SRCS was based on the BARC-10 (Brief Addiction Recovery Capital Scale) with a score of 47/60 being an indication of higher changes for sustained remission. Thus, scores of 38/50 and higher on the SRCS, that are sustained over time, may be associated with higher chances for long-term remission. The scale has been validated in SGM populations.

**Depression, Anxiety, and Stress Scale, 21 Items (DASS-21)** contains three self-report scales designed to measure the emotional states of depression, anxiety, and stress. The DASS-21 has demonstrated sound psychometric properties (Brown et. al, 1997) and has been successfully used in recent SUD treatment studies (Kok. et al, 2015). Unique items from each subscale are added then multiplied by two in order to identify scores ranging from normal to severe, with a max score of 42 for each subscale.

**The Trust in Physicians Scale** (Anderson & Dedrick, 1990) was be used to assess quality of relationship between providers and patients. The eleven included items are scored on a five-point Likert scale ranging from 1 ("Strongly Disagree") to 5 ("Strongly Agree"). Higher

total scores indicate greater trust in physicians. This scale has demonstrated good internal consistency (Anderson & Dedrick, 1990;  $\alpha = .85- .90$ ), and construct, content, and face validity (Anderson & Dedrick, 1990). This measure was provided with instructions for participants to rate the medical provider they see most often with BRITER.

**The Addiction Severity Index (ASI) Drug & Alcohol Use Sections.** The Addiction Severity Index (ASI) is a semi-structured interview that assesses seven domains impacted by alcohol and drug use disorders and possesses psychometrically good qualities (McLellan et. al, 1992). The seven domains assessed are: employment, medical, alcohol, drugs, legal, family/social, and psychological. In this study, only the alcohol and drug portion will be administered to collect participant lifetime and recent substance use.

### *Qualitative Measure*

**Semi-Structured Interview.** Semi-structured interviews are a primary method of qualitative data collection in psychological and health research (Galleta, 2013). These interviews allow for researchers to explore participant perspectives and in-depth accounts of experiences related to a specific research question, allowing for rich data to better understand a population and inform future research efforts (Galleta, 2013). Interviews in this study lasted between 47 minutes and 83 minutes. In the interest of consistent procedures that accommodate a variety of responses, the research team conducted interviews using open-ended prompts and probes (if needed) (Figure 1, Appendix B). Prompts for the participant interviews encouraged participants to share substance use treatment experiences, the experience of undergoing treatment for SUD during COVID-19, as well as their impressions of the BRITER program. Rationale for qualitative methods and analysis, as well as theoretical underpinnings are provided below.



## **Data Analysis Plan**

### **Quantitative Data Analysis.**

Statistical analyses were performed with SPSS version 28 (SPSS Inc., Chicago, IL, USA). Descriptive statistics were run for demographic data, psychosocial, mental health, or substance use variables, and the other measures administered by research team in order to characterize participants enrolled in the BRITER program completing this study.

### **Qualitative Data Analysis.**

All interviews were audio recorded and transcribed verbatim by the research team. Qualitative interview transcripts and research process notes will be analyzed using Taguette Software (Rampin et. al, 2021). In order to ensure the rigor of research, analyses were completed systematically using Colaizzi's (1978) seven-step content analysis method with the help of Taguette software version 2021 (Sanders, 2003; Rampin, 2021). In the first stage, the investigator read the transcriptions several times to understand the participant's feelings and experiences. The investigator underwent bracketing to try to suspend previous ideas, thoughts, and feelings about the phenomenon under study. The results of the bracketing interview can be found in the reflexivity statement. In the second stage, the investigator identified important phrases in the text of the interviews, namely whole quotes that when briefly contextualized allow a reader to more fully appreciate the experience of the participant. In the third step, the investigator extracted the concepts, or subthemes, that these phrases seemed to represent. During the fourth step, the investigator categorized concepts subthemes into larger categories of clusters based on the similarity of the concepts. The fifth stage involved combining the results to describe the phenomenon under study in terms of categories that are more general. The investigator met with a committee member to discuss and findings as they relate to the research question at hand,

and further clarify concepts. In the sixth stage, the structure of the comprehensive description of the phenomenon under study was constructed. In the final stage, the structure was validated by comparing it to the initial source data once more. Themes are presented alongside quantitative data for discussion. Further information about the rationale for approach is provided below.

### **Rationale for the use of Thematic Analysis based in Descriptive Phenomenology.**

Thematic Analysis is a qualitative data analysis method that involves identifying, understanding, and recording themes that emerge from qualitative data (Braun & Clarke, 2012). “Themes” can be best defined as patterns that are important to describing a phenomenon associated with the specific research questions, in rich detail. Though thematic analysis is a flexible tool that can be used across an array of epistemological approaches, this thematic analysis is grounded in phenomenological epistemology, specifically descriptive phenomenology. This approach to the data holds the participant’s experience as primary, with attention to the participant’s individual reality (“lifeworld”) as a way of elucidating the phenomenon in question (Holloway and Todres, 2003; McLeod 2001). Specifically, this research sought to understand the participant’s subjective experience of phenomena as containing a “meaning” and how that meaning is experienced (deemed “intentionality”). This approach does not necessitate interpretation of meanings, as it is descriptive of experiences.

In order to provide clarity for the data gathering and analytic process, a few guiding principles are clarified. Sundler and colleagues (2019) elucidated three principles to help guide the research process: emphasizing openness, questioning pre-understanding, and having a reflective attitude. Emphasizing openness prioritizes being attentive, sensitive, and observant to experiences of participants. It also implies the researcher actively questions their own understanding of the data, encouraging the researcher to acknowledge that they do not know

what their participants are experiencing and makes an effort to understand what is not happening. Doing so allows for researchers to question their pre-understanding, which involves “attempting to set aside one’s assumptions” in an effort to maintain a critical stance, but still recognizing that personal beliefs and assumptions completely is not possible (Gadamer, 2004). The researcher might find it difficult to acknowledge new themes and data if they are not interrogating their own prejudices, especially for those who may belong in part to the sample of interest. It is necessary to maintain a reflective attitude to interrogate our own initial understandings which allows us to be more open to the data. Maintaining an attitude of critical reflection can allow for the researcher to account for “pre-understandings” and adjust to being more open as the data bear out (Sundler et. al, 2019). Being critical of pre-understandings is particularly important when working with minoritized populations, like sexual and gender minorities, whose voices have been marginalized and are subject to both implicit bias and systemic discrimination (Singh & Shelton, 2011; Sweetman et. al, 2010). Thus, this approach to analysis is meant to empower participants, shining light on what they say explicitly rather than meanings imposed externally.

This thematic analysis is inductive, meaning that it seeks to understand themes emerging from analysis of the interview data. To that end, this semi-structured interview only contained prompts to guide the researcher and participant to addressing the research question at hand but is not based in any assumptions of lived experiences. The analysis is not so much concerned with the frequency of themes appearing (“patterns of meaning”) as a measure of importance instead rather how those themes speak to the research question. Thus, the process of analysis of qualitative data was dynamic, as the researcher continued to read the interviews in whole to inform how data will be analyzed.

### **Quality Control of Data.**

In order to ensure quality control of qualitative data collection, the primary investigator made a conscious effort to address the credibility, transferability, dependability, and confirmability of the current study results, based on the standards set by Lincoln and Guba (1985). In service of credibility, the investigator recorded and transcribed interviews verbatim, asking clarifying questions during the interview to accurately portray participant perspectives as well as possible. Though quantitative measures were provided to better characterize the population in general, they also serve as a method of triangulation for confirmation of the data provided in the interviews. In service of dependability, the investigator practiced administration of the interview twice with volunteers prior to participant enrollment. The investigator conducted regular process check ins during the course of the study and no changes in procedure were necessary. In service to transferability, the rationale for the current theoretical / analytic approach is included. There was an attempt to recruit eligible participants according to their proportional representation in the larger sample in order to best represent the variability present in the sample with a small number of participants, however the participants included in this study do not represent the sample proportionally. It should be noted that the timeframe of the research was extended beyond the initial inclusion of just those in treatment during the initial, pre-vaccination portion of the pandemic, the impact of vaccination is not clear in the data. However, the pandemic and associated health outcomes extended beyond initially expected, with vaccines losing efficacy for newly emerging strains of the virus (Vasireddy et.al, 2021). The primary investigator made efforts at ensuring confirmability before, during, and after data collection.

Before data collection, the primary investigator who administered interviews underwent a bracketing interview with Dr. Cathers in order to address investigator preunderstandings related to the current research question. During data collection, the investigator kept process notes

written after the interviews to better detect potential areas for bias and distortion within data by the investigator, supporting both confirmability and reflexivity. The results of this process were summarized in a reflexivity statement.

Additionally, the investigator continually checked procedures to ensure interviewer consistency in subject matter covered during interviews. After data collection, the investigator audited the data and made additional judgments about bias and distortions. Noted limitations during the study period are presented in the discussion.

**Results: Phase 1**

**Demographics.** Demographic characteristics for the 52 SGM participants are summarized in Table 1.1. The mean age was 41.56 years old, with a range from 26-65 years (SD 9.70). The sample was predominantly women (80.2%), with ciswomen N=38 (73%) transwomen = 4 (8%), with 19% cisgender men. The sample was 42.3% white and 57.7% Black. For Sexual Orientation, over half of the sample identified as bisexual/pansexual (27) (51.9%), 13.5% identified as gay men (7), and 19.2% identified as gay women (10). The sample also included 3 straight transwomen, and 5 women who identified as sexual minorities, but their specific identities are indeterminate.

**Table 1.1**

*Sociodemographic Characteristics of Participants at Baseline*

Baseline characteristic	Full sample (N=52)	
	<i>n</i>	%
<i>Gender</i>		
Female	42	80.2%
Cisgender Woman	38	73.1%
Transgender Woman	4	7.1%
Male (all cisgender)	10	19.2%
<i>Sexual Orientation</i>		
Gay Man	7	13.5%
Gay Woman / Lesbian	10	19.2%
Bisexual/Pansexual	27	51.9%

Straight Transwoman	3	5.8%
Unspecified sexual minority identity	5	9.6%
<i>Race</i>		
Black	30	57.7%
White	22	42.3%
<i>Hispanic/Latino</i>	4	7.7%

About two-thirds of the sample reported having at least 12 years of education (67.3%). Most of the sample was unemployed (87%), with a large proportion reporting disability (35%). Income source varied, with over three-quarters (78.8%) stating they did not receive any income from wages in the last month (Table 1.2). Over two-thirds of the sample reported that the money they received did not meet their needs (67%). The majority of the sample were housed (65%), with the remaining 45% experiencing instability in housing; over one third of the sample (36%) reported dissatisfaction with their living circumstances.

**Table 1.2***Sociodemographic Characteristics of Participants at Baseline Continued*

Baseline characteristic	Full sample (N=52)	
	<i>n</i>	%
<i>Highest educational level</i>		
Middle school / some high school	15	28.9%
High school	26	50%
Some College and beyond	9	17.3%
Unspecified	2	3.8%
<i>Employment Status</i>		
Employed	7	13.5%
Disability	18	34.6%
Unemployed	23	44.2%
Other	4	7.7%
<i>Does money meet need?</i>		
Not at all	35	67.3%
A little	3	5.8%
Moderately	3	5.8%
Mostly	3	5.8%
Completely	4	7.7%
Unknown	4	7.6%
<i>Income Sources*</i>		
No Reported Wages	41	78.8%

Disability	15	28.8%
SNAP benefits	27	51.9%
Non-Legal Income	4	7.7%
<i>Housing Status</i>		
Housed	34	65.4%
Shelter	13	25%
Homeless	3	5.8%
Institution	2	3.8%
<i>Living Circumstances Satisfaction</i>		
Dissatisfied	18	34.6%
Neutral	3	5.8%
Satisfied	27	51.9%
Unknown	4	7.7%

\* Individuals can have more than one source of income.

**Relationships and Family.** Over half of the sample (52%) reported being parents to at least one child, 44% had a family member in the military, and 29% reported receiving some financial support from a family member. The majority of participants reported they felt supported by their family (71%), and more than half stated they would turn to them in a time of need (58%). In terms of satisfaction, 71% reported feeling satisfied with their current relationships.

**Substance Use.** All BRITER program participants had a primary SUD diagnosis of Opioid Use Disorder. The most common secondary SUD diagnosis was Cocaine use disorder (44.2%) and Tobacco use disorder (34.6%) (See Table 1.3). In terms of treatment with Medication for Opioid Use Disorder, 90% were prescribed Methadone, and the remainder were prescribed Suboxone. Substance use in the 30 days preceding BRITER enrollment is represented in Table 2 below. Only 15.4% of participants reported experiencing inpatient SUD treatment in the 30 days prior to BRITER baseline. Injection Drug Use (IDU) was assessed as well, as 46% of the sample reported lifetime IDU history, with 26% endorsing IDU the year prior to BRITER baseline. Reported lifetime history of sharing needles for the purpose of IDU, was 25% of the sample, with 6% endorsing sharing needles in the year prior to baseline.

**Table 1.3***Substance Use Characteristics of Participants at Baseline*

Variable	Full sample (N=52)	
	n	%
<i>Primary SUD Diagnosis</i>		
Opioid Use Disorder	52	100%
<i>Additional SUD Diagnosis</i>		
Cocaine Use Disorder	23	44.2%
Cannabis Use Disorder	2	3.8%
Tobacco Use Disorder	18	34.6%
Sedative Use Disorder	5	9.6%
Alcohol Use Disorder	5	9.6%
<i>Recent Substance Use (30 days)</i>		
Any Drug	15	28.8%
Any Drug + Alcohol	8	15.4%
Alcohol	12	23.1%
Cocaine	22	42.3%
Cannabis	15	28.8%
Heroin	19	36.5%
Injection Drug Use	8	15.4%
<i>Recent SUD treatment (30 days)</i>		
Outpatient Treatment	52	100%
Inpatient Treatment	8	15.4%
Emergency Room	3	5.8%
Medication for OUD		

**Mental Health** Approximately 40% of the sample participated in outpatient mental health treatment; other mental health treatment attendance is represented in Table 1.4 below. Additionally, 63% of participants (n=33) took psychotropic medication every day in the last month prior to BRITER baseline; only 1 participant took psychotropic less than every day in the last month. Recent psychological distress was measured by asking participants how bothered they were on by distress a scale of 0 “Not at all bothered” to 4 “extremely bothered.” Participants indicated how many days in the past month (last 30) they felt depressed or anxious. The majority of the sample (62%) reported experiencing at least moderate psychological distress in the month preceding BRITER baseline. Almost one-third (31%) of participants reported feeling depressed



every day in the last 30, with half of the sample reporting feeling depressed at least half of the days in the last month. Similarly, 39% of participants reported feeling anxious every day in the last 30, with 58% of the sample reporting feeling anxious at least half of the days in the last month.

**Table 1.4**

*Recent Mental Health Characteristics of Participants at Baseline*

Recent Mental Health (30 days)	Full sample (N=52)			
	n	M	SD	%
<i>Any Recent Mental Health Treatment (30 Days)</i>				
Outpatient Treatment	21	1.29	2.46	40.4%
Inpatient Treatment	6	2.56	7.38	11.5%
Emergency Room	2	.23	1.00	3.8%
Psychotropic Medication	34	19.06	14.56	65.4%
Group Therapy	17	6.46	11.14	32.7%
<i>Recent Mental Health Symptoms (30 days)</i>				
Depression	42	14.87	11.87	80.8%
Anxiety	45	16.71	12.17	86.5%

**PTSD** The majority of SGM participants reported experiencing a “Criterion A” event in their lifetime, according to the Life Events Checklist (90%). The number of participants who experienced each traumatic event either personally, witnessing it, or learning about it happening to someone they care about. In terms of firsthand experiences, more than three-quarters of SGM participants (77%) reported experiencing a physical assault, just under two-thirds experienced assault with a weapon (62%), 67% reported having unwanted sexual experiences, and 58% reported experiencing sexual assault. Participants completed the PTSD Symptom Checklist (PCL-5) and were considered to screen positive for a possible PTSD diagnosis if they scored at least a 33 on this instrument (scores ranged from 0-80). Approximately 71% of participants

screened positive for PTSD, with the median and mode severity score being 50, and the mean symptom severity score being 47 (SD=18.6).

**Table 1.5**

*Life Events Checklist Experiences*

Event	Full sample (N=52)	
	n	%
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)	17	32.7%
2. Fire or explosion	24	46.2%
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)	39	75.0%
4. Serious accident at work, home, or during recreational activity	16	30.8%
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)	8	15.4%
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)	43	82.7%
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)	37	71.2%
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)	34	65.4%
9. Other unwanted or uncomfortable sexual experience	36	69.2%
10. Combat or exposure to a warzone (in the military or as a civilian)	7	13.5%
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)	18	34.6%
12. Life-threatening illness or injury	26	50.0%
13. Severe human suffering	25	48.1%
14. Sudden violent death (for example, homicide, suicide)	32	61.5%
15. Sudden accidental death	30	57.7%
16. Serious injury, harm, or death you caused to someone else	14	26.9%
17. Any other very stressful event or experience	13	25.0%

**Mental Health & SUD Associations** Associations between mental health and substance use variables were also investigated. Individuals who reported having no drug use in the 30 days preceding BRITER enrollment scored significantly higher on the PCL-5 PTSD, indicating more severe PTSD symptoms, than those who used drugs in the last 30 days ( $t = -2.23, p = .03$ ) (Table 1.6).

**Table 1.6**

*Associations recent drug use and PTSD symptom severity*

Any Drug Use	No Drug Use	<i>t</i> (df)	<i>p</i>
--------------	-------------	---------------	----------

	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
PCL-5 Score	43.15	18.58	55.79	15.87	-2.23(46)	.02

There was no significant difference between those who reported a history of being sexually assaulted and those that do not in past 30-day use of drugs or alcohol use days the 30 days before BRITER enrollment (See Table 1.7).

**Table 1.7**

*Associations between history of sexual assault and recent substance use*

<i>Number of days use in last thirty</i>	History of SA*		No History SA		<i>t(df)</i>	<i>p</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
# Days of Alcohol Use	1.71	4.85	1.8	5.09	.06(45)	.475
# Days of Drug Use	8.88	11.81	9.53	12.53	.18(45)	.475

\* SA = Sexual Assault

Additionally, the number of days using any drug out of the month preceding BRITER enrollment was correlated with the number of days participants reported feeling depressed ( $r=.37, p<.01$ ) but was not correlated with the number of days participants reported feeling anxious ( $r=.25, p=.08$ ). Finally, there was a correlation between level of psychological distress and number of days drugs were used in the past 30 before intake ( $r=.30, p=.04$ ).

**HIV Risk & General Sexual Health.** HIV Risk factors were assessed at BRITER baseline. About half of participants reported having sexual contact in the last year, (56%) with the majority of those individuals reporting multiple contacts in the last year. Approximately 93% of participants reported being tested for HIV in their lifetime, with the majority being tested at least once in the past 6 months (67%). Approximately 14% of the sample are HIV-positive; all

individuals were aware of their status prior to BRITER and all but one individual was connected to HIV care at BRITER baseline. In terms of condom usage, 25% of the sample reported using one “always) (Table 1.8). The majority of the sample reported having a lifetime history of having sex while high (86.5%) with 26.9% of the sample doing so in the year preceding BRITER baseline. More than one third of the sample (53.8%) has a history of HCV, with 7.7% of participants being HCV positive in the year prior to BRITER baseline.

**Table 1.8***Sexual Health Characteristics of Participants at Baseline*

Variable	Full sample (N=52)	
	n	%
<i>Condom Usage</i>		
Never	8	15.4%
Sometimes	16	30.8%
Usually	11	21.2%
Always	13	25.0%
Not reported	4	7.7%
<i>Lifetime</i>		
Sex while high	45	86.5%
Sex in exchange for drugs, shelter or money	22	42.3%
Sex with someone who has HIV	7	13.5%
Sex with someone who injects drugs	24	46.2%
<i>Past Month</i>		
Sex	26	50.0%
Unprotected Sex	25	48.1%
Sex while high	14	26.9%
Sex with someone who has HIV	3	5.8%
<i>Lifetime STI</i>		
HCV	28	53.8%
Gonorrhea	11	21.2%
Chlamydia	14	26.9%
Syphilis	9	17.3%
<i>Recent STI</i>		
HCV	4	7.7%
Gonorrhea	4	7.7%
Chlamydia	3	5.8%
Syphilis	3	5.8%

**Program Engagement.** Approximately 46% of participants had been engaged in MOUD at REACH for more than two months prior to enrollment in BRITER; range of days in treatment prior to BRITER enrollment was 1 day to 7,353 days. The mean days in treatment prior to BRITER enrollment was 700.25 (SD=1539), with the median number of days 50.. Approximately 38.5% of participants tested positive for fentanyl by UDS at both BRITER enrollment and REACH intake (Table 1.9). Approximately 50% of participants were still enrolled in treatment at REACH following their BRITER program involvement. In terms of discharge reason, 27% transferred services, 19% quit treatment, and the remaining individuals were incarcerated or deceased. Only 39% of participants were reached for six month follow up, and 29% were reached for 12-month follow-up during the yearlong BRITER participation period. Between REACH intake and BRITER baseline, the majority of participants increased in dose of their medication (73%).

**Table 1.9***Sexual Health Characteristics of Participants at Baseline*

<i>Positive UDS Result</i>	REACH INTAKE		BRITER ENROLLMENT	
	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>
<i>Fentanyl</i>	20	38.5%	20	38.5%
<i>Other Opiate</i>	17	32.7%	6	11.5%
<i>Cocaine</i>	23	44.2%	16	30.8%
<i>Cannabis</i>	11	21.2%	9	17.3%
<i>Sedative</i>	13	25.0%	11	21.2%

**Participant Characteristics**

The age range of participants was from 27-44 years, the majority were white, cisgender, and 3 of 4 had completed some college or bachelor’s degree. One participant was reported to be a cisgender woman in the initial data set and self- identified as a non-binary woman via self-report (Table 2.1). At the time of survey, all participants reported being in a relationship, with three indicating they are currently engaged. BRITER enrollment data are shown in standard type font. Data from Phase 2 surveys are presented in italics.

**Table 2.1**

*Sociodemographic Characteristics of Participants (n=4)*

Demographics	P1	P2	P3	P4
Age Range	25-29	40-44	35-39	25-29
Race	Black	White	White	White
Latine/o?	No	No	No	No
Gender				
At BRITER enrollment	Woman	Woman	Man	Man
<i>Per Self-Report</i>	<i>Non-binary woman</i>	<i>Woman</i>	<i>Man</i>	<i>Man</i>
Sex assigned at birth	<i>AFAB*</i>	<i>AFAB</i>	<i>AMAB*</i>	<i>AMAB</i>
Sexuality				
At BRITER enrollment	Gay Woman	Bisexual	Gay Man	Gay Man
<i>Per Self-Report</i>	<i>Lesbian</i>	<i>Bisexual</i>	<i>Gay</i>	<i>Gay</i>
Education (years)	12+	12+	16+	< 12
Employment				
Status at BRITER Enrollment	Seeking Employment	Part-time	Seeking Employment	Seeking Employment
Does money meet need?		Not at All	Not Specified	Not Specified
Income Sources	Moderately Other Income, Family	All Wages, SNAP	None Specified	None Specified
Housing				
Housing Status	Housed	Housed Very	Shelter	Housed
Housing Satisfaction	Very Dissatisfied	Satisfied	Not Specified	Not Specified
Current Probation? (y/n)	Yes	No	No	No

\*AFAB= Assigned Female at Birth, AMAB=Assigned Male at Birth

**BRITER enrollment data**

In the tables that follow, data for Phase 2 enrollees were abstracted from the Phase 1 database, which was collected at BRITER enrollment.

**Program Engagement.** Type of medication for opioid use disorder and dose at time of BRITER enrollment is shown below (Table 2.2). Three of the four participants in this study were in treatment at REACH less than two months before BRITER enrollment. All four participants were in the BRITER program during at least one month of the pandemic. All participants tested negative via urine drug screen for fentanyl, other opiates, cocaine, and cannabis and two of four tested positive for sedatives.

**Table 2.2**

*Program Engagement*

Variable	P1	P2	P3	P4
<i>BRITER</i>				
Days at REACH prior to BRITER enrollment	Less than 2 months	More than 5 years	Less than 2 months	Less than 2 months
BRITER Intake Year	2021	2019	2023	2023
<i>MOUD</i>				
Type at BRITER enrollment	Buprenorphine	Methadone	Methadone	Methadone
MOUD at BRITER enrollment	16	160	120	105

**Relationships, Family, and Social Connectedness.** Only one participant reported having at least one child, one had a family member in the military, and one reported receiving some financial support from a family member. Three out of the four participants reported they felt supported by their family. Three-fourths (75%) reported feeling “satisfied” or “very satisfied” with their current relationships, with one participant indicating dissatisfaction in this domain.

**Substance Use.** In addition to OUD, all four participants had a current Tobacco Use Disorder diagnosis. Only one participant had an additional diagnosis (Sedative Use Disorder). No participants had SUD-related inpatient or emergency room admissions. All participants had attended REACH for some SUD outpatient treatment, with two attending every day and 2 attending 16 days out of 30. Three participants went to group therapy at least once in that time frame. No participants reported recent cocaine, heroin, or IV drug use and only one participant endorsed both recent cannabis and alcohol use.

**Mental Health** All four participants reported recent use of psychotropic medications and one participant indicated a recent inpatient or emergency room visit related to mental health (Table 2.3).

**Table 2.3**

*Recent (past 30 days) Mental Health Characteristics of Phase 2 Participants at BRITER enrollment*

	P1	P2	P3	P4
<i>Recent Mental Health Symptoms</i>				
Depression	15	30	5	20
Anxiety	30	30	20	20
<i>Severity Psychological Distress</i>	slightly	extremely	slightly	moderately
<i>PTSD Screening</i>	Positive	Positive	Negative	Positive
<i>PCL-5 Score</i>	39	58	25	50

Two of four participants engaged in outpatient mental health treatment prior to BRITER enrollment. All four participants reported experiencing at least slight psychological distress, with two participants reporting daily anxiety and one participant reporting daily depression in the past 30 days. Three out of four participants screened positive for PTSD with their scores ranging from 39-58 on the PCL-5 (See Table 2.3).



**HIV Risk & General Sexual Health.** All Phase 2 participants tested negative for HIV in the 6 months preceding BRITER enrollment. All denied a history of Gonorrhea, Chlamydia, Syphilis, Hepatitis A, or Hepatitis B. One participant reported a history of Hepatitis C and treatment, which ended more than a year prior to BRITER enrollment. One participant reported never using a condom during sex and three out of the four participants reported having sex while high (lifetime), but only one endorsed doing so in the year before BRITER enrollment. One person reported having sex in exchange for “drugs, money, or shelter.”

### Phase 2 Survey Data

The interval of time between the BRITER enrollment data shown above and the survey data below ranges from 1 to 44 months. The following tables describe participant status in the month prior to their interviews.

**Program Engagement.** Participants self-reported engagement in treatment in the 30 days prior to survey completion. All participants had attended any SUD treatment and treatment at REACH at least once in the last 30 days (Table 2.4).

**Table 2.4**

#### *Self-Reported Program Engagement*

Variable	P1	P2	P3	P4
<i>Date of Survey Completion</i>	9/10/2022	12/6/2022	3/8/2023	3/8/2023
<i>Self-Reported Attendance Days</i>				
Any SUD Telehealth	8	0	0	0
Any SUD Outpatient	2	8	20	1
REACH Outpatient	1	10	20	20
REACH Telehealth	1	0	2	0

### Trust in Physicians Scale

Participant trust in the medical provider they most often see at REACH is indicated in the table below. Trust varied widely among participants across areas of trust. The statements where participants had the most concordance were “If my provider tells me something, then it must be true” and “My provider is a real expert in taking care of medical problems like mine.” The items that indicate lower trust in their provider are presented in italics.

**Table 2.5**

#### *Trust in Physicians Scale*

Variable	P1	P2	P3	P4
<i>I doubt that my provider really cares about me as a person</i>	Disagree	Agree	Disagree	Strongly Disagree
My provider is usually considerate of my needs and puts them first.	Disagree	Agree	Neutral	Disagree
I trust my provider so much I always try to follow their advice.	Disagree	Strongly Agree	Agree	Agree
If my provider tells me something, then it must be true	Agree	Strongly Agree	Strongly Agree	Strongly Agree
<i>I sometimes distrust my provider's opinion and would like a second.</i>	Disagree	Neutral	Disagree	Neutral
I trust my provider's judgements about my medical care.	Disagree	Strongly Agree	Neutral	Agree
<i>I doubt that my provider really cares about me as a person.</i>	Disagree	Strongly Agree	Agree	Disagree
My provider is usually considerate of my needs and puts them first.	Disagree	Agree	Disagree	Strongly Disagree
<i>I feel my provider does not do everything he/she should for my medical care.</i>	Disagree	Agree	Neutral	Disagree
I trust my provider to put my medical needs above all other considerations when treating my medical problems.	Disagree	Strongly Agree	Agree	Agree
My provider is a real expert in taking care of medical problems like mine.	Agree	Strongly Agree	Strongly Agree	Strongly Agree
I trust my provider to tell me if a mistake was made about my treatment..	Disagree	Neutral	Disagree	Neutral

*I sometimes worry that my provider may not keep the information we discuss totally private.*

Disagree      Strongly Agree      Neutral      Agree

**Brief Sense of Community Scale**

Participant ratings for sense of community in their current neighborhood are summarized in Table 2.6. All participants disagreed to some degree to the following statement: “I have a say about what goes on in my neighborhood.” Participants were evenly split between ‘Neutral’ and ‘Somewhat Agree’ to the following statement: “People in this neighborhood are good at influencing each another.”

**Table 2.6**

*Brief Sense of Community Scale*

Brief Sense of Community Scale	P1	P2	P3	P4
I can get what I need in this neighborhood.	Somewhat Agree	Somewhat Disagree	Somewhat Agree	Strongly Agree
This neighborhood helps me fulfill my needs.	Somewhat Agree	Somewhat Disagree	Neutral	Somewhat Agree
I feel like a member of this neighborhood.	Somewhat Agree	Strongly Disagree	Somewhat Disagree	Somewhat Disagree
I have a say about what goes on in my neighborhood.	Somewhat Disagree	Strongly Disagree	Strongly Disagree	Strongly Disagree
People in this neighborhood are good at influencing each another.	Somewhat Agree	Neutral	Somewhat Agree	Neutral
I feel connected to this neighborhood.	Somewhat Agree	Strongly Disagree	Neutral	Somewhat Disagree
I have a good bond with others in this neighborhood.	Somewhat Agree	Strongly Disagree	Somewhat Disagree	Somewhat Agree

**Substance Use.** At time of the survey, every participant endorsed having used alcohol at some point in their lifetime, but no one endorsed ever having an issue with alcohol. None of the participants endorsed recreational sedative use or ever having an issue with use. Only one

participant endorsed ever using cannabis (edible and smoking) or cocaine, with neither endorsing regular use nor ever having an issue with use of either substance. Substance use results related to heroin are below. Of note, two of four participants denied ever using heroin, only one participant reported history of IV heroin use, and only one participant denied ever having an issue with another opiate (not heroin). Every participant has experienced an overdose or has used Narcan in the past. In terms of recovery capital, two participants scored over the suggested cut-off of 38, which is associated with higher chances for long-term remission (Table 2.7).

**Table 2.7**

*Opioid Use History*

	P1	P2	P3	P4
<i>Opioid Use History</i>				
Have you ever used heroin?	No	Yes	No	Yes
Have you ever had a problem with heroin?	No	Yes	No	Yes
Have you ever used other opiates?	Yes	Yes	Yes	Yes
Have you ever had a problem with another Opiate?	Yes	Yes	Yes	No
Drug Overdoses	2	1	1	1
Narcan Use	1	2	2	2
Recovery Capital Score	42 (+)	21	45(+)	14

**Mental Health** At time of survey, only one participant was experiencing extremely severe symptoms of anxiety and depression. The remainder of the scores and symptom severity are available in Table 2.8.

**Table 2.8**

*Depression, Anxiety, and Stress Scale*

	P1	P2	P3	P4
<i>DASS Scales</i>				
Stress	Moderate (26)	Moderate (22)	Normal (6)	Mild (16)
Anxiety	Moderate (12)	Extremely Severe (22)	Normal (2)	Moderate (10)
Depression	Moderate (18)	Extremely Severe (38)	Normal (4)	Moderate (14)

### **Results: Phase 2 Qualitative**

This mixed-methods study was conducted on 4 SGM participants with OUD in a timeframe between the September 2022 and February 2023. This descriptive phenomenology study was conducted on 4 SGM participants with OUD in a timeframe between the September 2022 and April 2023. The federally declared, national public health emergency associated with COVID-19 pandemic ended on May 5, 2023. The participating individuals (n=4) were already experiencing substance use concerns and/or engaged with substance use treatment in advance of the pandemic. All participants were engaged in some form of care for OUD at the time of interview. The investigator acquired five cluster themes including self, family/friends, clinic staff, other patients, and clinic policy and procedures (Table 3.1). Subordinate themes were also identified and presented in relevant sections. To maintain anonymity, quotes have been de-identified in this document.

#### **Reflexivity Statement**

Reflexivity refers to an investigator's awareness of how the research process and therefore the data collected may be influenced by the biases, experiences, and assumptions of the investigator. To that end, a Bracketing Interview was completed prior to the commencement of the first interview of a participant. Themes and quotes relevant to the researcher's personal experiences, identity, and biases were elicited during this interview.

#### *Investigator previous professional experience*

Within the context of the current study, the trainee investigator who conducted interviews with study participants engaged in bracketing to determine how these interviews may be influenced previous professional experience and prior assumptions. The trainee investigator is a doctoral candidate with both an extensive research background as well as a clinical background in substance use disorder treatment. The trainee investigator considered the impact of being a

clinician on both how interviews would be conducted, the comfort level of participants, and the ethical implications of disclosure of clinician identity that made during the interviews. During the bracketing interview, this was discussed at length. Initially, the investigator discussed being an advocate for harm reduction and how that lens may influence the discussion of prior treatment experiences with patients. A few benefits were identified, including ability to empathize with dissatisfaction with moralizing treatment approaches. However, the investigator decided to make a concerted effort to monitor their reactions to discussion of the provision of approaches inconsistent with that paradigm, as to not alienate a participant should they find that approach helpful. Benefits of the investigator's current training status, more generally, were ascertained and reflect advanced clinical skills, an ability to manage both time and content in conversations, while remaining empathetic; this skill originated from conducting brief therapy sessions with individuals with substance use concerns.

*“ My ability to put my curiosity aside in favor of what the actual question at hand is, is helpful.”*

Additionally, the investigator identified how the influence of implementing manualized treatments is helpful in conducting semi-structured interviews, as they require following a specific outline in treatment but also being able to be dynamic within that frame. However, one concern the investigator identified was navigating emergent distress as a researcher rather than a clinician in the moment with a participant. This was discussed in bracketing and a plan for referral and connection was outline in the IRB.

#### *Investigator personal experience*

During the bracketing interview, the trainee investigator identified two salient points relevant to conducting participant interviews including (1) personal involvement in SGM community and (2) personal involvement with individuals with OUD. The trainee investigator discussed

personal, internalized stigma related to SGM identity and concerns about the propriety of disclosure of identity to participants.

*“I knew it could be a tool, but how to do it... [it could either be] disclosure as a means of helping people feel safe or non-disclosing as a means of helping people feel safe.”*

Through this conversation, the investigator decided to embed subtle disclosure while posing questions without explicit identification of an identity within the community. The investigator also concluded that using pronoun labels on the zoom meeting would normalize their use and encouraged participants to share as well. The investigator also identified experiences of discrimination for their identity from others within the SGM community, and how these experiences may bias the investigator during interviews. In light of this, the trainee investigator engaged in a process of self-reflection before interviews to identify areas of concern, to ensure they are accounted for during the interview.

*“My uncle had opioid use disorder and had a hospitalization [related to a medical concern] that involved the dispensing of opioids and then he ended up having a lapse.”*

The trainee investigator disclosed personal connections to recovery community, including connections through family members and chosen family as well. The trainee investigator discussed prior experiences of loss due to overdose. The investigator reflected on the meaning of personal loss and how it influences their passion for treatment engagement for those who experience discrimination and stigma. The investigator made an effort to acknowledge these experiences and be mindful of this while engaging in analyzing the data.

#### *Current political context*

When discussed theme identification, there was a brief conversation with Dr. Cathers regarding the current political climate as it relates to SGM rights. Although experiences of discrimination

are not new for SGM individuals, the past few years have represented an encroachment on rights. According to the Human Rights Campaign, here have been 525 anti-LGBTQ+ bills introduced in 41 states in 2023, with more than 75 have become law (Peele, 2023). This became particularly relevant for the investigator when processing interviews after they were completed. Process notes included emotions elicited during interview for the investigator on a personal level in relation to discrimination experienced by participants, which allowed for the investigator to identify the potential influence on subsequent data analysis.

**Cluster Themes**

This descriptive phenomenology study was conducted in a timeframe between the September 2022 and April 2023. The interviews varied in length from 47 to 83 minutes. The participants were already engaged in treatment for OUD with the referring clinic when they were recruited for the study. We acquired five themes that represent a cluster of factors that are associated with engagement in treatment for substance use disorders: self, family/chosen family/friends, treatment program staff, other patients attending the treatment program, and clinic & community resources and policy (Table 2.9). The subthemes from within each cluster are also identified below.

Table 2.9

*Factors associated with engagement in OUD treatment*

Cluster Themes	Subthemes
Self	1. Self-efficacy
Family/Chosen Family & Friends	1. Instrumental Support 2. Emotional Support
Treatment Program Staff	1. Basic Respect 2. Special Interest 3. Past Discriminatory or Non-Inclusive Experiences



## 4. Affirming Experiences.

Fellow Patients	<ol style="list-style-type: none"> <li>1. Finding community</li> <li>2. Being able to support other patients</li> <li>3. Past experiences of discrimination</li> </ol>
Policy and resources	<ol style="list-style-type: none"> <li>1. Clinic policy</li> <li>2. Connection to community resources and programs.</li> </ol>

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**Cluster 1: Self**

Participants discussed thoughts, feelings, beliefs about themselves that have an impact on treatment engagement. Specifically, participants discussed their concept self-efficacy, or what they believe they are capable of doing; this belief existed on a continuum from feeling confident in their ability to engage in treatment/recovery because of their own personal will/skill to do so, to those who feel their lack of belief in their ability is what pushes them to engage in treatment.

Participants discussed will to succeed in treatment as a support for engagement:

*“My own kind of self-will propelled me in that direction. I didn't have someone that held my hand to get there. I had to have the willpower to go on my own.”*

*“[There are] a lot of reasons people don't want to go into treatment. And it's because the rules—a lot of people don't want rules. Those rules are there to help you succeed, though. So it's really on the person. How bad they want recovery. Yeah. If they don't really want recovery, they're not going to they're not going to succeed. I want it. I know what I want, and I know what to expect out of it. And that's why I'm succeeding.”*

Another participant spoke to feeling able to engage when provided a resource (phone) that lets them enact a skill:

*“All you got to do is give me a phone or show me how to get there [to the resource or treatment being offered]. That's it. I'm there.”*

Another participant discussed how they felt they could not succeed alone, and that they only feel able to be in recovery when engaged in a program:

*“The only feeling of help when you have no one in your life is the hospital. And that’s it. That is who I have gone to many times.”*

This participant later explained how she has had consistent engagement in treatment with very few gaps in treatment. The participant expressed that she felt she needed to be engaged not because she believed in her ability to do so, but out of fear:

*“I stayed on it because I had no choice but to stay on that. Yeah. So, I just kept going to the clinic and getting treatment. And I’ve never stopped that. I’ve always been on it on the methadone. I did think I did it out of fear. It had nothing to do with anything else but fear.”*

### **Cluster 2: Family / Chosen Family & Friends**

Participants discussed how perceptions and experiences of support in relationships with family members and friends influence access to treatment. There are two subthemes within this cluster: instrumental support and emotional support.

#### *Instrumental Support*

Participants discussed how their perceptions and experiences of instrumental support influenced treatment engagement. Instrumental support is assistance that address tangible needs a participant might have as they relate to treatment.

Participants shared how support with transportation and packing was influential in getting to treatment:

*“I did rely on some close friends to help me... pack and... help me to get to the appointments and stuff like that.”*

*“I caught the train down [to treatment program] and then my friend she’d bring me back [to my lodging].”*

Another participant discussed their first experience taking any MOUD for OUD (methadone) as a result of instrumental support of his father:

*“I ended up talking to my dad about it. Now, this is when I had my first experience with methadone.... I wasn’t prescribed it, but my dad, he was getting, like, a month worth of take homes.... he was supposed to take four of those wafers a day... but he only needed two in*

*reality.... he started giving me half of everything.... That's how I got introduced to them for the first time because he was like, 'I'm not going to give you money to get heroin and watch you die because you could use it one time and be dead. I'll give you this. And if you don't want it, that's all this is all I can do for you. My dad's the one that officially started my road to recovery by doing that.'*

Another participant shared that while they initially experienced their parents as instrumentally supportive to engaging in treatment, as they connected the participant to methadone treatment, they eventually felt like the amount of instrumental support they received before their parents died impaired their ability to have a stable, independent life in recovery:

*"I started off [methadone] at a young age. I was only 19. I believe that I got— I went on and went into it too soon. I think that I should have went to more treatment to try to get a hold of it before I got on methadone. I thought that was crazy. Because I was still using. And I kept using for years. So it's like, I should have done something else. And, and I don't want to blame it on my parents. I don't want to say, well, it's their fault. Because I hate doing that. It was like, but my parents were like, well, go ahead. Just get on it. And it was like, they were still living. And everything was okay, then... You know, I still worked. I did do things, like I got, I accomplished things. And I kept accomplishing things. But then my mom died when I was 24. And it was like, that really screwed me up. And when you have two parents that basically give you everything, and don't tell you what the real world is, like, they—that screws you up really bad."*

Participant also shared that lack of instrumental support from family impacted ability to remain stable and engage in treatment:

One participant shared that she was not able to live with her mother, who the participant described as being unkind to her because she was gay and presented as masculine, and her mother really "[wanted] a daughter.":

*"As soon as I came home [from incarceration] I went to the halfway house out DC where I live because my mom didn't want me at home, which is weird... it was fine, but it was embarrassing... like our relationship not gonna ever be the same."*

*Emotional Support*

Participants discussed how their perceptions and experiences of emotional support influenced treatment engagement. Emotional support is assistance that acknowledges hardship and struggle with presence, empathy, and/ or encouragement.

Participants shared in the importance of support from their partners in motivated them to engage in recovery:

*“My fiancé, he's been there for me. Thick and thin— is always pushing me on during the day [to go to treatment], and he's like, “Come on, you can do it. It's only an hour and a half. Come on, let's go. It's right up the street. It's not far. Come on.”*

*“[My fiancé] she did time too, but she just not no average [woman]. She just not. She ain't going to stand for it.... she don't know, she's a stressor but she motivates me to stay clean that's what she don't realize.”*

### **Cluster 3: Treatment Program Staff**

Participants discussed how their interactions with treatment program staff influenced engaging in treatment, and what types of interactions were more helpful or more harmful to their engagement. The subthemes included in this cluster are Basic Respect, Special Interest, Past Discriminatory or Non-Inclusive Experiences, and Affirming Experiences.

#### *Basic Respect*

Participant's discussed experiences in treatment wherein they felt stigmatized for having OUD, and the experiences with treating providers where they felt respected. Participants described these experiences as supportive of engagement:

*“I love the BRITER program. I do. It's amazing. But I like REACH as a whole because. They treat everybody the same. Everybody is treated. That's what I like about them.”*

*“I do think they [REACH] care, I do. I really do. [for example] remember what you're good at, even says are you still writing your poetry, you know, stuff like that. That's positive. It makes you feel good.”*

*“You know, good vibe, I guess, the people [at REACH] were just very personable. They were respectful, knowledgeable [and] that made it guess easier to switch [treatment providers and*

*attend their clinic]. Yeah. Or made it, you know, appealing because I was like, okay, well, the people here are nice. They're treating me with respect, you know, so that was appreciated."*

### *Special Interest*

Participants discussed the benefit of a treatment provider taking a special interest or "going above and beyond" and how that influence their engagement with treatment. One participant discussed how a case manager from a community support program in Washington D.C. provided transportation to the clinic when their halfway house would not do so:

*"My case manager, like we had just met, but we had connected—she was driving me to Baltimore every week to get my medication and see my doctor."*

Another participant discussed how a counselor provided her both emotional support and shelter while engaged in a previous treatment program, and how this relationship supported treatment engagement.

*"I did meet a lady that I was with for a long time in treatment too and we got so close that I stayed with her at her house. She was a counselor. Yeah she helped me, I'm not gonna deny that. She got into my life to where, it's like she was a mother to me in a way."*

The participant further shared, however, that she was no longer able to attend this clinic due to this relationship:

*"But [the] clinic made me leave there because we were so close. It was like a couple of us that she really took us under her wing, but I thought that was a blessing. Not a bad thing."*

### *Past Discriminatory or Non-Inclusive Experiences*

Participants described past discriminatory experiences, prior to their time at REACH, with substance use treatment staff. The participants described these experiences as having a negative influence on their engagement in treatment:

Participants described experiences of overt queerphobia:

*"Some of the staff would say things, snide remarks, derogatory comments."*

One participant described experiencing intersectional discrimination on the basis of gender, race, and sexuality. This participant discussed how she was made to leave a halfway house due to her relationship with a white woman:

*“I didn't even know you can get put out of a halfway house like, I got put out [because] of the stigmas like ... they were mad because I'm Black but the girl I'm dating is white.”*

The participant further described:

*“They put me out about. it was racial and me being gay me not wanted to be with them... that was staff which is weird to me but that's everywhere I go.... we get them.... its life.... how many creepy men.”*

Participants described experiencing previous treatment programs as non-inclusive (heterosexist), or not addressing difference/tailoring services for SGM individuals:

*“Every other place I've been to, it seems like they didn't even put any effort to understanding people like me, me being a part of the LGBTQ community. It's like I was overlooked. They looked at me as an ordinary client, but I'm not a normal client. I'm different and I'm happy..”*

### *Affirming Experiences*

Participants described experiences in treatment that they found to be affirming of their identity as an SGM individual. Participants primarily discussed their experiences at REACH as participants in the BRITER program.

One participant described not only feeling accepted in REACH, but also being connecting to another affirming treatment program that served as sober living for the participant:

*“I found that REACH [BRITER] was very accepting. And they were able to assist me when I was looking for program to go to. they were able to connect me with the divine light, which was, you know, LGBTQ oriented, which has been extremely helpful.”*

Another participant offered that the explicit focus on supporting SGM made attending REACH more appealing:

*“ [The program is] LGBTQ oriented is one thing I love about REACH, because they have a great program and I love it.... [He told me] about REACH and [I]decided to go and check it out*

*and did the intake process. I switched from my program that I was in, and they told me about everything. And then the very next day I go in, I have a letter to him. They're like, 'You got to go and see [that person].. You got to speak with this person.' And it was the lady from BRITER, and she told me all about it and I was like, This is awesome."*

#### **Cluster 4: Fellow Patients**

Participants discussed the influence of fellow patients in treatment programs on their engagement in treatment. This cluster includes three subthemes: finding community (generally), being able to support other patients, and past experiences of discrimination experienced by participants from fellow patients in programs they attended.

##### *Finding community*

One participant spoke to the importance of knowing there were other SGM individuals attending a program.

*"[I knew I wasn't the only one at REACH] and that's like the last thing you want to think is gonna happen. You go there and you be the only LGBTQ person there."*

##### *Being able to support other patients*

One participant discussed the importance of patients being able to support each other in treatment as influencing their engagement:

*'Not only do we support each other, we can support other people as well, which, you know, giving back is always just as important.'*

##### *Past Experiences of Discrimination*

Participants discussed the influence of being discriminated against by fellow patients in prior treatment programs as SGM individuals, but also as individuals who participate in MOUD treatment.

One participant discussed experiences in past treatment programs where they experience overt homophobia from fellow patients:

*“ Discrimination. It's not like the like the people that run the groups and all the programs. It's the other clients....[It's] the other clients that get me down because just because I'm gay....that deters me from wanting to go somewhere. Like I'm not going to go somewhere where I'm going to be discriminated against, mocked, and put down for my sexual orientation*

Another participant described an experience of being discriminated against by a fellow SGM individual she knew from the recovery world due to her use of MOUD:

*“Some of them thought that I was copping out because I wanted to be on the medication, but that's my sobriety... It was only one person that judge me, and that person turned out to be on suboxone and an alcoholic.*

### **Cluster 5: Policy and resources**

Participants discussed how policy (clinic level, state/federal government level) and resources (clinic and community) can influence treatment engagement. The subthemes that emerged from this cluster are (1) clinic policy, (2) connection to community resources and programs. Relevant subthemes related to governmental policy and shift in service provision are represented in the subsequent section focused on COVID-19.

#### *Clinic policy*

Participants discussed the influence of clinic policy and therefore expectations, on the ability to engage in treatment. Patients expressed that clinic policy can be seen as supportive or presenting a barrier to engagement.

Participants discussed the importance of consistency in policy, as one participant shared frustration regarding not having clarity about the medication take home policy of their treatment program. Specifically, he was frustrated that he had not yet received a take home :

*“I wish they would stick their own rules of like you're supposed to earn a take home every 30 days... still waiting on that*



Another participant spoke to the supportive nature of clear, consistent the payment policy at REACH. This participant described experiences in treatment where she would be removed from a treatment program because she was having financial difficulties:

*[With other programs], if you didn't have certain things. I feel like they would just toss you out and it was okay. And REACH is a little different. Like if you lose your insurance they put you on a low pay, at least. A low amount of money you have to pay, it's not some like 90 dollars a week. Which I could not afford, you know what I mean*

There was nuance in responses from patients when it came to the impact of the requirement of urine drug screens on the ease of treatment engagement.

One participant shared that he appreciated the accountability and expectation of having drug screens and being expected to be abstinent to maintain his status in recovery housing facilitated engagement:

*"I like living in a situation where there is some accountability and we're not completely by ourselves where, like, you know, we were by ourselves alone.... There is a kind of a checks and balances system.*

Another participant reflecting on living in recovery housing, and how the rules associated with the housing served as a barrier to engaging in counseling with the program she was attending:

*"I had a curfew so I couldn't stay down there and talk to anyone, or he might have had 60 patients, and then all 60 were coming the same day I'm coming [so I could not wait]."*

This participant also discussed the redundancy of urine drug screen measures across service providers and when involved with the legal system, and how the lack of coordination / amount of urine drug screens caused inconvenience:

*"The less helpful [aspect] for me is [as] someone that's in a transitional home or in a shelter, and I gotta come down Baltimore to pick up my medication, or to give y'all a urine sample when y'all know clearly I'm on probation [and] Clearly you [could] get one of these staff members to piss me.*

That same participant further explained the redundancy:

*“I still had to piss it doesn't matter. I still gotta piss period. I gotta piss, probably like 4 times a month. Because I got a I got mental health, I got suboxone,. I got medication management. I have a PO so I still gotta do it. And sometimes my sponsors show up outta nowhere with a piss test.*

#### *Connection to Community Resources & Programs*

Participants described how connection and referral to community resources oriented toward recovery influenced their engagement in treatment. Community connection and referral include resources provided by the clinic or other agencies (or lack of) that help meet basic needs or shared knowledge or direct connection from one program/service to another.

Participants described how difficulty with transportation to appointments impeded their ability to attend, and spoke to the desire for resources to be available that address this need:

*“They don't help out with transportation. That's the one thing I didn't understand like or if I'm running out of medication, and it's a holiday and y'all know y'all closed but this when you sent my prescription, and I get there for me [and I has to deal with] the distance.”*

One participant described missing one appointment because of not having the means to pay for transportation impacting his ability to stay on suboxone, and creating precarity in his recovery:

*“I've been on Suboxone for years, at least four years. And then what happened was I missed an appointment. And I was like, Oh, week without Suboxone. I was in complete withdrawal.... And I got into methadone because I spoke to the doctor when I got to that program and it was like, mind you, it's Sunday and the doctor was like, 'I can't give you anything until Friday.' I said, you know, wait. I had money on me. Right. And I didn't want to go and get drugs and use. Yeah. So, I spoke to someone else there and they got me on the methadone program. One appointment. One appointment was all you needed to miss.... to mess everything up..... [because] I didn't have the money to get on the bus to get up there.”*

This participant also described additional instance of transportation serving as a barrier, in addition to insurance issues:

*“My first start on Suboxone, you know, there was in certain times was sometimes some Issues with the insurance company. You know, getting transportation to go get to the pharmacy to fill them.. So, transportation could be somewhat of an issue.”*

One participant described the influence of a community program on their ability to be consistent in treatment by supporting housing and access to resources following release from incarceration:

*“I have an excellent probation officer.... but he don't give me the services. I get services from all the [community] programs that I'm in that's where I get em from having offered no help. I had to come up a security deposit and they [the program for re-entry citizens] made it happen quick. “*

Participants discussed how the connection between treating providers/programs and services has an impact on the ability to engage in treatment:

*“[I got connected to treatment] in the hospital after surgery. They had a pain management specialist come and we decided it [methadone] was just something that was going to be a better fit [than suboxone given my chronic pain] over the long term... So, they're the ones who referred me to the very first clinic I went to.... they set it up and everything. So that way when I left, I left the hospital, I had an appointment that morning at the clinic to get registered and signed up. So, I mean, they set everything up for me and it was quite convenient.”*

### **Substance Use Disorder Treatment During COVID-19**

Participants discussed their experiences in treatment for OUD during COVID-19. When discussing their experience, two major subthemes emerged that were related to changes/interruptions in service provision: Isolation and Instability in recovery. These themes are presented after the cluster theme of organizational policy to signify their relationship to changes in policy at the onset of the pandemic.

#### *Isolation*

Participants discussed how changes in how services were provided resulted in feeling isolated from others. Participants discussed how not being able to see fellow patients or care providers impacted them during the pandemic.

One participant explained that she did not engage in any virtual support groups or counselor phone calls during the pandemic and the resulting isolation of all services being suspended:

*“I mean [it felt] like nobody could be there for you. It just felt that way. I mean we were just given all these take homes and just go home, sit at home, you know.”*

Another participant discussed how although he was engaged with online services at his treatment program that he experienced isolation following the changes in how services were provided:

*“[What] really affected me out of the whole thing was not being connected to other people.”*

This participant further shared:

*“We did groups.. on Zoom. We did zoom... I hated it. Everyone loved it because they didn't have to even leave their room or their bed. I'm like, I like groups because I get to get out. I get to talk to people face to face. That human interaction isn't the same over the phone.”*

An additional participant expressed similar feelings when he discussed his experience in NA during the pandemic:

*“Well, when the pandemic hit, it kind of became crazy. So then.... people they were doing a lot of these, like, online meetings. I just didn't feel as connected online as you would like in person. I just didn't enjoy them as much.”*

### *Instability in Recovery*

Participants described how the changes in policy regarding how services are provided impacted them in their recovery and maintaining their health:

One participant shared how the changes and isolation from the pandemic impacted his ability to engage in healthcare in general:

*“Everything got all messed up. Um, it was so hard to get appointments to see a doctor or anything...”*

Another reflected on previous success in treatment and how she felt it was curtailed by the changes in treatment:

*“I had graduated IOP [but was attending women’s group] and then I was doing good. And then that pandemic happened, okay? And it just it threw me off and I started using again.”*

However, experiences interruptions in treatment was not necessarily a universal experience. One participant described being incarcerated and receiving medical in prison at the beginning of the pandemic. This continued treatment in prison and the opportunity to keep her insurance active while she was incarcerated, facilitated continued engagement in treatment upon release, even during the pandemic closures:

*“I got out of prison... in the pandemic.. [and] because by the grace of God, even before I caught my charges, I was getting the medication.... when I came home my insurance was still active, all I had to do was call and get it like reactivated. That's it.”*

#### **Additional BRITER & REACH reflections from participants**

Although participants offered commentary regarding their treatment experience while engaged at the BRITER program at REACH, participants were also specifically asked to share their opinions on what aspects of the BRITER program they found helpful, and where there might be room for improvement.

One participant shared that the additional support from the BRITER outreach worker made engaging in treatment more pleasant before the pandemic:

*“When Josh was there? I loved it because I would go to him and just sit in his office, and we would joke and talk. Oh my God, I missed that little ball of energy. I do. He was great. I mean, he made me feel better. You know, I'm not saying that I really did anything with BRITER. I really didn't. But [I spent time] with Josh. “*

This participant shared that during the pandemic, she felt she did not need help making appointments, but may benefit from being texted or receiving home visits when she has disengaged from treatment:

*“So, the outreach person and being able to have somebody, it sounds like maybe on site as like a text would be helpful... When they try to help you make appointments and stuff with things like. Sorry, that's not helping me. I can make appointments. The problem is me going to these appointments. Okay? You know what I mean? Like, I need to get to these appointments, help me get up and get to these things. Yeah, because. Because sometimes I give up and I'm like, f\*\*\* it.”*

A participant shared how she was unable to engage in additional services offered by BRITER because of transportation issues (see Cluster 5 for more details), and described her experience as such:

*“I can't say[anything about] no programs it's just like it's just the people, it's like a dispensary so you just go in there, you piss. Then you get your medication you see your counselor.”*

Other participants described being new to the program, but finding the availability of multiple services in one location appealing:

*“Just started with BRITER, So I don't have like a whole lot I can say yet... they had pitched that they had a lot of different things [between REACH and BRITER], the services they offered. But yeah, the medical would be one. I'd be very interested in.”*

This participant also shared he would be interested in attending LGBTQ specific groups therapy sessions or any group session offered later in the day.

Another participant was a recent BRITER admission and discussed how his goal for his healthcare overall was to be connected with SGM affirming providers, and how having an outreach worker brought comfort, although he had not yet made use of this resource:

*“It's nice to know that if I need resources, they're there. and it's nice to know that there's going to be someone that understands my unique situation.”*

Within the cluster themes presented above, participants discussed aspects of care from their experience in BRITER that have been helpful, as well as resources that could have support treatment engagement. Further integration of these findings will be presented in the discussion.

### **Discussion**

The population of SGM folks enrolled in BRITER at REACH, were predominantly women and bisexual/pansexual. Because of the low sample size, between group analysis could not be completed to decipher differences in characteristics between individuals on the basis of sexual orientation. The majority of participants screened positive for PTSD at enrollment, have a recent history of being tested for HIV, and are receiving Methadone treatment. During interviews, the participants discussed having different barriers and facilitators to treatment engagement including how they think about themselves, their experience of support vs. discrimination during treatment by staff and fellow patients, the support they have from family and friends to engage in care, as well as policy associated with the context in which they are receiving treatment. The participants also discussed how changes in the provision of services during the COVID-19 pandemic resulted in service interruption, feelings of isolation, and instability in recovery. A discussion of these results is presented below.

### **Self**

Participant interviews emphasized the importance of self-efficacy in treatment engagement. Self-efficacy is “the belief that one has the ability to implement the behaviors needed to produce a desired effect” (Kadden & Litt, 2011). The importance of self-efficacy regarding abstinence to support treatment outcomes is evident, as higher abstinence self-efficacy before and during treatment has been associated with better outcomes in the literature (DiClemente et al., 2001; Ilgen et al., 2005; Miller and Longabaugh, 2003; Rychtarik et al., 1992; Stephens et al., 1993) and fostering self-efficacy is embedded in evidenced based approaches for addressing substance use concerns, like Motivational Interviewing (Miller & Rollnick, 2013). Many studies have focused on the role of self-efficacy in abstinence from

substances, with some specifically addressing how to increase self-efficacy to further recovery goals (See: Kadden & Litt, 2011 for review). Previous studies were concerned with self-efficacy as it related to abstinence and treatment outcomes, not as it related to treatment engagement.

However, Dillon and colleagues (2020) identified motivations for engagement in residential SUD treatment and found a connection between patient's self-efficacy to maintain abstinence and how that belief in themselves influenced treatment attendance. Participants shared that their self-efficacy maintained and enhanced through the learning of new skills in treatment, being in a supportive clinic environment, knowing what to expect from clinic policy, witnessing the success of others, and knowing that individuals who go through treatment keep in touch afterwards. Some of the themes identified in the current, mixed-methods study; namely treatment staff, fellow patients, and clinic policy mirror those identified by Dillon and colleagues (2020) as factors contributing to self-efficacy.

This was not universal, however. One participant in the current study discussed how low self-efficacy and doubt in their ability to maintain recovery contributed to her continued engagement in treatment. This individual participant cited their relationships with therapists and counselors in the clinic as strong motivators for engagement. It may be the case that low self-efficacy for treatment engagement with this one participant in particular has been counteracted by strong relationships with clinic providers. Previous research has found that a strong therapeutic alliance can sometimes counteract the negative impact of low baseline self-efficacy on treatment outcomes (Ilgen et. al, 2006). The researchers posited that among participants with low self-efficacy, the bond with their therapist may offset their pessimism about the likelihood of success in treatment and therefore improve treatment outcomes.



Mental health symptoms may play a role in treatment engagement as well. Nyamathi and colleagues (2018) found that depression secondary to poor emotional support was negatively associated with readiness to engage in SUD treatment among a sample of women upon re-entry following incarceration. Although anxiety and depression symptoms were prevalent among both the Phase 1 and Phase 2 samples, the previously discussed participant who reported low self-efficacy related to treatment attendance also endorsed extremely severe depression and anxiety symptoms, in contrast to the other participants who reported normal-moderate symptoms. Similar to how alliance may serve as a buffer for individuals with low self-efficacy in treatment, leveraging social support may help mitigate the negative impact of mental health symptoms on treatment engagement.

Participants in the current study also completed a measure of recovery capital, defined as individual resources that can be drawn upon to support sustained recovery over time. This concept aligns well with the theme of self-perception and self-efficacy that emerged in interviews. Self-efficacy can be seen as one example of “human” recovery capital which can also include “personal values and beliefs, education and credentials, self-esteem, hope, and interpersonal skills” (White & Cloud, 2008). Phase 2 participants reporting recovery capital at time of survey also voiced stronger feelings of self-efficacy in their interviews. These participants discussed how they believed in their ability to properly use resources, and this was an integral component of their efforts to attend treatment. Further research is needed to examine the potential relationships among self-efficacy, mental health, recovery capital, and treatment attendance.

**Family/Chosen family/Friends.**

Participant interviews highlighted the importance of support from family, chosen family, and friends in engaging with treatment. This is consistent with previous studies that found lower social support and greater social isolation were associated with treatment drop out (Stark, 1992; Dobkins et.al, 2002). Although little research exists on social support in SGM adults with OUD and substance use disorders, associations have been reported between lower general social support and having substance use concerns among SGM populations (e.g., Kahle et. al, 2019). Also, in SGM more generally, social support was found to contribute to positive mental and physical health outcomes (Tabaac et. al, 2015). This is particularly pertinent to the current study, as social support within general SUD populations is also associated with readiness to engagement in treatment (Nyamathi et.al, 2018).

The support described by participants seemed to be the most impactful when it involved meeting a need for the patient, whether it was provided in the form of emotional or instrumental support. Emotional support is defined as the expression of empathy, esteem, and caring. Instrumental support primarily involves more practical considerations and is more tangible (providing information, transportation, monetary support). However, instrumental support can also be perceived as emotionally supportive when it accurately meets the tangible need of the person being supported (Semmer et. al, 2008). To illustrate, one participant discussed being given half of his father's take home medication out of concern for that patient's life (instrumental) and how this empowered the patient to start on the path to treatment engagement (emotional). Conversely, one participant described feeling cared for by her parents and encouraged to engage in treatment but resents that her parents enrolled her without seeking her input about treatment modality. The participant experienced her parents as emotionally supportive but believed not having a choice as to treatment type made her feel less empowered to

care for herself later on in recovery. This suggests, when leveraging social support in clinical interventions to enhance treatment engagement, the importance of emphasizing autonomy.

Rejection from family and the need to create community outside of traditional family to cultivate support was identified from one participant interview. Family support specifically has been related to health outcomes in SGM individuals. Ryan et.al (2010) found that family acceptance of SGM was protective against depression and substance use issues in a sample of SGM young adults. While interventions that include family in substance use care for adults exist (See recent review: Hogue et. al, 2020), additional efforts should be made to support the inclusion of supportive others who may not fit the traditional family paradigm.

### **Treatment program staff.**

Participants emphasized the importance of being treated with basic respect by treatment staff in regard to treatment engagement. Perceived stigma and concern for judgment by treatment program staff has been found to influence treatment engagement (Crapanzano et. al, 2019; Radcliffe & Stevens, 2008). Strengths-based approaches to SUD treatment attempt to counteract the impact of stigma by prioritizing positive experiences with providers, and support outcomes for treatment including engagement (Ezell et. al, 2023). This is consistent with one participant's report in the current study, in which she discussed how the treatment staff at REACH recalls details and inquired about her life beyond OUD, including skills and hobbies, which has been supporting her engagement in treatment.

Participants discussed the influence of staff in previous treatment settings as well. Specifically, participants shared examples of staff going "above and beyond" for them in connecting to treatment and being able to stay engaged in treatment. Research has shown exceptional support from providers can foster hope and inspire the patients to engage in

treatment (Wenaas et. al, 2021). Similar to the emotional and instrumental support elicited from discussions of general social support above, it seems possible that the instrumental support clinicians may provide can also elicit the perception of being emotionally supported and may serve as a statement on their inherent value as human beings in a culture that systematically devalues individuals with SUDs. It should be noted that clinicians providing above and beyond support often do so using their own means (see Acevedo et. al, 2022) and sometimes placing their professional life /licensure at risk due to associated ethics concerns. This provision of support may lead to staff burn out and could contribute to higher turnover rates (Acevedo et. al, 2022). Revisiting ethical guidelines and potential compensation options to foster protection for clinical staff committed to supporting their patients, especially those with marginalized identities, should be considered.

It is important to recognize the influence of trust in providers on treatment engagement in the context of stigma and discrimination. This is especially pertinent for providers serving SGM with multiple marginalized identities who are more likely to experience intersectional discrimination. These experiences may result in a valid mistrust of providers engendered by a history of discriminatory practices in medicine that have led to dire consequences. When measuring trust in their providers at REACH within the Phase 2 sample, the statements where participants had the most concordance were “If my provider tells me something, then it must be true” and “My provider is a real expert in taking care of medical problems like mine.” However, participants answers varied in the type of trust they had in their providers, with no one participant indicating universal trust for REACH providers or staff. Opportunities to provide feedback can be supportive in improving trust between providers and patients.

Participants described instances of discrimination at previous treatment programs including heterosexism and overt queerphobia, not only in the form of snide remarks but also being thwarted from a place to live based on experiencing intersectional discrimination. Unfortunately, this is present in the literature with some studies finding SGM participants reporting experiences of being called derogatory names in the context of treatment by staff (Anvari et. al, 2022). Thus, in addition to the barriers all individuals with SUD face, the potential for discrimination amplifies the existing difficulty associated with engagement. Conversely, participants in this study also discussed how feeling affirmed by providers supported their treatment engagement as did knowing that a peer counselor was available who affirmed SGM identity. In fact, some studies showed that knowledge of a clinic affirming identity can be enough to encourage SGM individuals to engage in treatment (Cochran et. al, 2007). As the research on the impact of discrimination on engagement in treatment is burgeoning, further research on the importance of affirmation is needed.

The importance of clinician level factors and their role in relation to substance use outcomes is not a new concept and warrants further study. For example, a review of the available literature on clinician influence on treatment outcomes, including retention, from Najavits and colleagues (2000) encouragement for further investigation twenty-three years ago. More recent research has found that low therapist empathy has been associated with rates of return to use, weaker therapeutic alliance, change for patients, and lower retention (Moyers & Miller, 2013). Therapists who are able to provide this support can contribute meaningfully to engagement in treatment.

**Other patients attending treatment program.**

Participants discussed the influence of other patients on their engagement in treatment programs. In the current study, Phase 2 participants discussed discomfort with thinking they might be the only sexual and gender minority person in previous treatment settings. Previous studies have demonstrated the benefits of creating community among individuals of similar life experience within the context of SUD treatment. Godlaski and colleagues (2009) found that those in a SUD treatment program for women from rural areas felt more comfortable being in the clinic because there were others with experiences similar to their own, which helped them feel less isolated in their current circumstance. Previous studies have posited that this sense of community among fellow patients can be attained through the provision of tailored treatment. One study found that participants in a tailored SUD treatment program for sexual minority men felt more connected to their treatment program and were more likely to be retained than sexual minority men in a traditional SUD treatment program (Senreich, 2010).

Participants discussed how the ability to support others in SUD treatment has promoted treatment engagement in previous treatment settings. This is not necessarily surprising, as the importance of mutual support is the crux of ubiquitous peer recovery support organizations for those experiencing substance use concerns (AA and NA) (Tracy & Wallace, 2016). However, individuals in OUD treatment are often stigmatized by the larger Narcotics Anonymous organization, wherein their definition of abstinence does not include the use of medication (Narcotics Anonymous, 2016). Offering SGM patients the opportunity to provide mutual support in the context of outpatient treatment may promote engagement without risking imposing additional stigma associated with evidence-based practice of MOUD.

Participants described experiences of discrimination by other patients in previous treatment settings. Although there is a burgeoning literature on the impact of discrimination or

lack of culturally specific treatments on engagement across healthcare settings among SGM (Eliason & Hughes, 2004; Shipherd et. al, 2010), there is very little on the impact of fellow patients on care engagement. That is troubling, as it is possible these experiences can lead SGM individuals to not feel safe in their environment and could contribute to avoidance of treatment as a result, especially when there are no consequences for behavior among those who perpetrate discrimination. However, one commentary on supporting gender diverse individuals in inpatient MH treatment offered potential clinic policy efforts and suggested responses to protect gender diverse MH patients, included scripted language for clinic staff in the event a patient is being made to feel that they do not belong in treatment because of their gender identity (Walton & Baker, 2019). Further considerations for how clinics can help mitigate experiences of discrimination between patients through policy will be presented in the next theme, which addresses the influence of policy and resources on treatment engagement.

### **Clinic & community resources and policy.**

Participants discussed the influence of clinic policies and resources on treatment engagement. Although each participant named different practical considerations associated with treatment engagement, all of their comments related to clinic efforts to show respect and provide support that encourage engagement; specifically, participants focused on the importance of with clear expectations but also flexibility and opportunities for adjustment when in the clients' best interests. Participants described resources and circumstances relevant to treatment engagement including a wide variety of responses about having their needs met within their current community. For example, one participant discussed how previous treatment programs they attended would suspend treatment if insurance status changed, with the impact of insurance on treatment engagement previously demonstrated in the literature (Peterson et. al, 2010). The

participant communicated that REACH offered a low pay plan when her insurance status has changed, which supported her engagement in treatment.

It is worth noting, however, that even within a program that prioritizes flexibility and meeting patients where they are, there is always room for growth. Another participant discussed frustration with the urine drug screen policy (UDS), as they had to travel to both REACH and their probation officer to complete urine drug screens in the same week. The participant felt this redundancy could be avoided with establishing communication with the PO regarding UDS status, and suggested legal system involved individuals can spend less time trying to acquire transportation and travelling if it were adopted. This participant experience of policy that has made treatment engagement more difficult highlights the importance of empowering patients by allowing them to communicate potential preferences in care (see: Bartholow & Huffman, 2021). Offering potential opportunities for adjustments in policy is consistent with a trauma informed care approach, which aligns with the goals of REACH as a clinic and BRITER as a program.

#### *The impact of COVID-19*

Phase 2 participants discussed the impact of COVID-19 on recovery and treatment, which was experienced as an extension of clinic policy from a thematic perspective. While many providers and advocates hoped changes in medication dosing policies and rapid availability of telehealth offerings might be a boon for treatment engagement, particularly among underserved populations, by lowering the threshold to engage, it is not clear that this was the result. A multi-state survey of opioid treatment program leadership published in 2022 found that there was significant variability in the implementation of less restrictive guidelines for patients, with some clinics maintaining more conservative prescribing practices and others switching between more and less conservative guidelines over the course of months (Levander et. al, 2022). Consistent



with the multistate study, one phase 2 participant voiced frustration over inconsistency in take home medication policies at a previous treatment provider during the pandemic. While change in dosing policies raised fears of medication diversion, one recent qualitative systematic review of studies on the prescribing of medication for opioid use disorder in outpatient settings during the pandemic found no increase in diversion issues. Further, they found many patients benefited from flexibility and taking patient-center approach to medication take-home decision making (Adams et. al, 2023). Thus, patient centered policy flexibility can be a beneficial consequence of the flexibility afforded by the pandemic.

Although there is a paucity of research on the impact of COVID-19 on SUD treatment and outcomes among SGM specifically, available literature suggests an increase in substance use among SGM from pre to post pandemic. While some participants reported minor interruptions in care due to the pandemic, two participants in the current study identified isolation resulting from clinic policy changes. One participant discussed how the change to online group therapy at the beginning of the pandemic while participating in a prior OUD treatment program led to feelings of isolation but given having a supportive partner and stability in living circumstances, they did not experience instability in recovery. That was not the case for another participant who described how their clinic stopped offering group therapy at the onset of the pandemic which precipitated a period of isolation; the patient described group therapy and drop-ins with the outreach worker as their only, consistent social contact during the week. During the interview, this participant disclosed having a lapse and resuming heroin use after several years of abstinence alongside their partner. This participant conveyed a loss of hope following this lapse, and although they continued receiving medications consistently, they had difficulty engaging in therapy for over a year following the pandemic. Of note, this participant described having lower

self-efficacy, more intense mental health symptoms, relatively lower recovery capital and emphasized the importance of provider relationships during the Phase 2 interview. While we hope that service interruptions like those experienced because of the COVID-19 pandemic do not occur again, they highlight the tenuous nature of supports for patients who rely on social support embedded in treatment for encouragement.

### **A note on larger political context of OUD care for SGM**

In recent years there have been large efforts to mitigate the impacts of the opioid epidemic on the national level, and these efforts persist with continued funding being allocated to support individuals with OUD. However, current study findings and the literature affirm that addressing the opioid epidemic is not just about promoting treatment availability and access in traditional and obvious ways. Truly addressing the opioid epidemic would mean making an effort to eliminate or mitigate discriminatory practices that impact the lives of SGM, as many have unfortunately been codified as law. If we do not address discrimination that may make the lives of SGM individuals difficult outside of treatment, we are thus not doing what may be most supportive for our patients.

### **Summary of suggestions for the BRITER program**

During interview, participants offered opinions about what components of the BRITER program were helpful and offered suggestions on how to further support treatment engagement. Much of this discussion was embedded in the summary of themes extracted from the data. All of the participants spoke to the inclusive nature of BRITER and feeling that the program offered them basic respect. Two participants spoke to the importance of knowing that the individual needs of SGM individuals were being thoughtfully considered by the program. Three participants spoke to enjoying the presence of an outreach worker in the program, with two

emphasizing the benefits gleaned from just knowing that someone from similar circumstances is available should they be interested in reaching out for support. Additionally, two participants discussed how the provision of medical care from SGM affirming providers embedded in their OUD treatment program was an incentive for engagement at BRITER and REACH. One of the participants discussed how issues with transportation kept them from engaging in many aspects of the program outside of medication dispensing. Overall, participants expressed gratitude for being connected to REACH and enrolling in BRITER.

Participants offered several suggestions for the program. Consistent with practical concerns elicited in interviews, multiple participants noted the importance of providing transportation by the program as potentially supporting engagement, with one stating that a bus pass would be supportive in consistent attendance to care. Participants also discussed how consistent and expected phone calls or text messages from the outreach worker could be supportive of remaining engaged in care. One participant discussed how home visits might be helpful from the outreach worker, as she sometimes has difficulty leaving her house to attend treatment. Two participants suggested open, LGBTQ+ specific therapy groups held in evening hours alternate hours (in the afternoon or evening). Participants also discussed how having opportunities for recreation therapy with other patients might create an environment of mutual support; one they may not have outside of treatment. Participants also shared their thoughts on outreach, and how more formally leveraging word of mouth could be useful in recruiting a large number of eligible patients.

### **Limitations**

There were limitations to note in this study. The BRITER program, funded by SAMHSA, was in its second year of a five-year grant when the COVID-19 pandemic began. Many of the

components of the BRITER program were dramatically impacted by the pandemic, a period of many social changes and stressors. BRITER experienced a number of personnel changes, with three major staff leaving the clinic over the course of the program, and during the course of the current study.

#### *Data Collection*

Some potential limitations to the collection of the data for both phases of this study are notable. BRITER staff changes represent potential issues with Phase 1 data consistency, as a change in staffing occurred that both may have variability in how data was being collected from patients and data collection timing. Additionally, phase 1 data was collected as a part of a SAMHSA funded grant focused on enhancing clinic service provision and not in the context of a research trial. By virtue of this, no control group or individuals who were not yet engaged in treatment were available, for comparison.

In terms of the Phase 2 data, the quantitative portion of this study involved the use of self-report measures, which could be impacted by social desirability bias. This study also involved the use of semi-structured interviews that involved some flexibility in application and resulted in variability in the length of interviews. Strengths associated with Phase 2 data collection are noted in the ‘strengths’ section below.

#### *Challenges in Recruitment*

Despite significant efforts to interview a representative sample of the SGM community, the challenges experienced during recruitment and the smaller than proposed sample size for Phase 2 interviews, illuminate the challenges and barriers that need to be addressed in future research. Potentially resultant discrepancies between then Phase 1 sample and Phase 2 subsample potentially connected to recruitment challenges are provided below.

For phase 2 data, demographic variables were largely comparable including education level, employment status, housing status, financial status. In the Phase 1 sample, over half were bisexual women and only less than one-fifth were gay men. In the current mixed methods study, half of the participants were gay men. Similarly, the racial/ethnic makeup of this sample is majority white participants, while the initial sample was majority Black. More attention is warranted to investigate outcomes among SGM with OUD in treatment at different intersections of identity, especially those underrepresented in research like bisexual women and Black SGM.

Some differences in Phase 1 and Phase 2 substance use and treatment variables at BRITER should be noted. For Phase 1 sample, 42% of the sample reported cocaine use and 37% reported heroin use in the month prior. Additionally, 39% tested positive for fentanyl use and about 30% tested positive for cocaine use. In contrast, none of the Phase 2 participants reported recent cocaine or heroin use in the month prior; none of the participants in the subsample tested positive for fentanyl, other opiates, or cocaine as well. During Phase 2 data collection, no participants in the subsample reported active substance use. Although statistical analyses cannot be performed to identify significant differences, it is possible that those individuals who are suffering with more severe substance use problems are not being represented in the data.

The qualitative components of this project sought to learn more about facilitators to treatment among SGM in MOUD treatment. This subgroup of individuals has historically not been included in research and for whom treatment is often inaccessible. Given this population of individuals experiences layered discrimination and barriers to treatment, it is not surprising that recruitment was challenging. Therefore, the subsample completing interviews may represent a group of individuals with relatively less severe substance use disorder. It is also notable that during the course of the study, several staff members who patients viewed as trustworthy points

of contact within the clinic associated with the BRITER program had left the clinic. This also made for difficulty in recruiting across all eligible participants in the BRITER program. Two of the individuals recruited for the study were early BRITER enrollees, a result of referral from a staff member known to BRITER program participants. The additional two individuals recruited in 2023 were new to BRITER around the time that a new peer outreach staff member began working with the program; this person was one of their initial points of contact in BRITER, and they were provided information about the study within weeks of enrollment. Despite these challenges, a wealth of information provided by the four participants recruited in phase 2 helped the investigator meet saturation for the current study.

#### *Discrepancies in Phase 1 and Phase 2 Data*

Phase 1 data specific to the phase 2 participants revealed some notable differences. One participant (uses she/her) self-identified as a non-binary woman in the Phase 2 data, but she is reported as a woman in the Phase 1 data; it is possible that clinic confidentiality made this identity accessible to the REACH treatment team but not the BRITER program; however, this difference may be attributable to the multiple options for self-reporting gender provided in the current study, the different context in which this person was self-reporting gender, or fluidity in gender identity facilitated identity disclosure in the context of this study. Nondisclosure of sexual or gender minority status is a common proximal stressor associated with minority stress in which a concern related to discrimination and stigma around identity keeps people from self-identifying their gender identity which leads to increased discomfort and stress. This is important, as this discomfort with disclosure has been linked to use of substances in the literature as a means of escape (Stogner & Gibson, 2011). Additionally, another participant was noted as having a Sedative use disorder in the Phase 1 data but indicated having no history of sedative use in the

Phase 2 data. It is possible that stigma and/or method of data collection impacted the information provided.

### **Strengths**

Although there were several limitations to this study, there are also notable strengths. This study elucidates the lived experiences of SGM individuals with OUD, and the barriers and facilitators to treatment for OUD which is incredibly novel as there is limited research on SGM specifically in OUD settings. Given the unique aspects of OUD treatment as compared with other SUDs, research specific to OUD treatment settings among this population is necessary. Methodologically, many of the measures included in this study were validated and standardized measures may have minimized these effects of bias. Additionally, the questions on the Phase 2 survey of the study were asked by a computerized narrator, and not a human being, which may have facilitated disclosure of sensitive information from participants. In terms of the qualitative component, although interview lengths differed they were all conducted by the same, advanced clinical psychology doctoral trainee with expertise in clinical assessment. Additionally, this trainee had no formal affiliation with the clinic, and thus not a part of their care, which may have facilitated unbiased reporting.

### **Future Research**

As stated previously, research on SGM in OUD treatment is growing but very little has been published thus far. Unfortunately, additional barriers to affirming care for SGM individuals continue to be passed through as legislation, so it is not likely that the need for research and advocacy for this population will vanish. Given the difficulties in recruitment within this specific population, further identifying potential strategies for connecting with individuals in this population to capture the voices of those who have not been heard is a reasonable research target.

One approach that may prove beneficial is respondent driven sampling, which has been demonstrated to be helpful in recruitment of minoritized populations including SGM (Michaels et. al, 2023). Additionally, collecting qualitative data from individuals who work in the specified treatment clinic regarding their opinion on factors associated with treatment engagement may compliment the current study. Given the results of this study and the potential impact of staff on patient engagement, information regarding staff burnout and resources may help better inform future efforts. The investigator hopes to submit an IRB amendment to this effect, to compliment the current patient data.



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**Appendix A**

Commonly used terms for SGM

Table 1. Commonly used terms for SGM

<b>Concept</b>	<b>Definition</b>
Sexual and Gender Minorities	Refers to a group of people who identify as non-heterosexual and/or TGNC (trans and gender non-conforming) (see below definitions for clarification). SMW refers to sexual minority women, SMM refers to sexual minority men
Sexual Orientation	A part of person’s identity includes “a person’s sexual and emotional attraction to another person and the behavior and/or social affiliation that may result from this attraction. A person may be attracted to men, women, both, neither, or to people who are genderqueer, androgynous, or have other gender identities. Individuals may identify as lesbian, gay, heterosexual, bisexual, queer, pansexual, or asexual, among others.” (APA, 2015a)
“WSM,” “MSM,” “WSWM,” “MSMW” & “GBM”	These abbreviations (women who have sex with women, men who have sex with men, women who have sex with women and men, and men who have sex with women and men) are meant to define groups as being sexual minorities without labeling them with a specific associated identity. GBM is an acronym for “gay and bisexual men.”
Gender Identity	Refers to “one’s sense of oneself as male, female, or transgender” (APA, 2015). When one’s gender identity and assigned gender at birth are not congruent, the individual may identify as transsexual (outdated term) or as another transgender category (APA, 2015).
Transgender	An adjective that is an umbrella term used to describe the full range of people whose gender identity and/or gender role do not conform to what is typically associated with their sex assigned at birth. While the term “transgender” is commonly accepted, not all TGNC (trans and/or gender non-confirming) people self-identify as transgender. Transgender people do not need to have “top” (chest) or “bottom” (genitalia) surgery to be considered trans (APA,2015).
“MTF” & “FTM”	These abbreviations, meaning “Male to Female” and “Female to Male” were previously accepted ways of denoting a person’s gender assigned at birth vs. their gender identity.



**Appendix B**

Semi-Structured Thematic Interview Guide

Figure 1. Semi-Structured Thematic Interview Guide

The thematic interview guide begins with a focusing question that, depending on the participants’ responses, is followed by relevant probing questions. The interviews will therefore develop into conversations around specific themes. The purpose is to create an interview atmosphere that both guides participants in the content provided and empowers participants to share openly in their experiences.

Themes and probing questions:

Overall Prompt	Potential Probing Questions
<p><i>Tell me about your previous experience in SUD treatment.</i></p>	
<p><i>Tell me about your experience with SUD at Reach with BRITER.</i></p>	<p>How long have you been with REACH?</p> <ul style="list-style-type: none"> <li>• <i>Preferred aspects of care?</i></li> <li>• <i>What services are most helpful?</i></li> <li>• <i>What services have been less helpful?</i></li> </ul>
<p><i>Tell me about being in recovery during the global pandemic, COVID-19.</i></p>	<p>How has treatment changed since COVID-19 pandemic began?</p> <p>What do you think of treatment changes since COVID 19 ?</p>
	<p><u>Probe after:</u> are the changes helpful? Are any of the changes harmful?</p>
	<p>What gets in the way of attending treatment now? What helps you attend treatment?</p>
	<p>What recovery related resources have you engaged with during the pandemic?</p>
<p><i>Tell me about your experience in this program during the dawn of the pandemic.</i></p>	
<p><i>What strengths does BRITER have, where is there room for growth.</i></p>	

**Appendix C**  
GPRA Outcome Measure

Form Approved  
OMB No. 0930-0208  
Expiration Date 01/31/2020

**CSAT GPRA Client Outcome  
Measures for Discretionary Programs**

**(Revised 04/24/2017)**

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information, if all items are asked of a client/participant; to the extent that providers already obtain much of this information as part of their ongoing client/participant intake or follow-up, less time will be required. Send comments regarding this burden estimate or any other aspect of this collection of information to SAMHSA Reports Clearance Officer, Room 15E57B, 5600 Fishers Lane, Rockville, MD 20857. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The control number for this project is 0930-0208

A. Record Management

Client ID |\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|

Client Type:

- Treatment client
- Client in recovery

Contract/Grant ID |\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|

Interview Type [CIRCLE ONLY ONE TYPE.]

Intake [GO TO INTERVIEW DATE.]

6-month follow-up → → → Did you conduct a follow-up interview?  Yes  No  
 [IF NO, GO DIRECTLY TO SECTION I.]

3-month follow-up [ADOLESCENT PORTFOLIO ONLY] →  
 Did you conduct a follow-up interview?  No  
 [IF NO, GO DIRECTLY TO SECTION I.]

Discharge → → → Did you conduct a discharge interview?  Yes  No  
 [IF NO, GO DIRECTLY TO SECTION J.]

Interview Date |\_\_\_\_|\_\_\_\_| / |\_\_\_\_|\_\_\_\_| / |\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|  
 Month Day Year

[FOLLOW-UP AND DISCHARGE INTERVIEWS: SKIP TO SECTION B.]

Was the client screened by your program for co-occurring mental health and substance use disorders?

- YES
- NO [SKIP 1a.]

1a. [IF YES] Did the client screen positive for co-occurring mental health and substance use disorders?

- YES
- NO

[sbirt continue. all others go to section a “planned services.”]  
 THIS SECTION FOR SBIRT GRANTS ONLY [ITEMS 2, 2a, & 3 - REPORTED ONLY AT INTAKE/BASELINE].

How did the client screen for your SBIRT?

- NEGATIVE
- POSITIVE

2a. What was his/her screening score? AUDIT = |\_\_\_\_|\_\_\_\_|

CAGE = |\_\_|\_\_|

DAST = |\_\_|\_\_|

DAST-10 = |\_\_|\_\_|

NIAAA Guide = |\_\_|\_\_|

ASSIST/Alcohol Subscore = |\_\_|\_\_|

Other (Specify) = |\_\_|\_\_|

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Was he/she willing to continue his/her participation in the SBIRT program?

- YES
- NO

**A. Record Management - Planned Services [Reported by program staff about client only at intake/baseline.]**

Identify the services you plan to provide to the client during the client's course of treatment/recovery. [CIRCLE "Y" FOR YES OR "N" FOR NO FOR EACH ONE.]

Modality Yes No

[SELECT AT LEAST ONE MODALITY.]

- 1. Case Management Y N
- 2. Day Treatment Y N
- 3. Inpatient/Hospital (Other Than Detox)  
Y N
- 4. Outpatient Y N
- 5. Outreach Y N
- 6. Intensive Outpatient Y N
- 7. Methadone Y N
- 8. Residential/Rehabilitation Y N
- 9. Detoxification (Select Only One)  
A. Hospital Inpatient Y N  
B. Free Standing Residential Y N  
C. Ambulatory Detoxification Y N
- 10. After Care Y N
- 11. Recovery Support Y N
- 12. Other (Specify) Y N

[SELECT AT LEAST ONE SERVICE.]

Treatment Services Yes No

[SBIRT GRANTS: YOU MUST CIRCLE "Y" FOR AT LEAST ONE OF THE TREATMENT SERVICES NUMBERED 1 THROUGH 4.]

- 1. Screening Y N
- 2. Brief Intervention Y N
- 3. Brief Treatment Y N
- 4. Referral to Treatment Y N
- 5. Assessment Y N

- 6. Treatment/Recovery Planning Y N
- 7. Individual Counseling Y N
- 8. Group Counseling Y N
- 9. Family/Marriage Counseling Y N
- 10. Co-Occurring Treatment/  
Recovery Services Y N
- 11. Pharmacological Interventions Y N
- 12. HIV/AIDS Counseling Y N
- 13. Other Clinical Services (Specify) Y N

- Case Management Services Yes No
1. Family Services (Including Marriage Education, Parenting, Child Development Services)
 

Y	N		
---	---	--	--
  2. Child Care
 

Y	N		
---	---	--	--
  3. Employment Service
 

--	--	--	--
  - A. Pre-Employment
 

Y	N		
---	---	--	--
  - B. Employment Coaching
 

Y	N		
---	---	--	--
  4. Individual Services Coordination
 

Y			
---	--	--	--
  5. Transportation
 

Y	N		
---	---	--	--
  6. HIV/AIDS Service
 

Y	N		
---	---	--	--
  7. Supportive Transitional Drug-Free Housing Services
 

Y	N		
---	---	--	--
  8. Other Case Management Services (Specify)
 

Y	N		
---	---	--	--
- Medical Services Yes No
1. Medical Care
 

Y	N		
---	---	--	--
  2. Alcohol/Drug Testing
 

Y	N		
---	---	--	--
  3. HIV/AIDS Medical Support & Testing
 

Y	N		
---	---	--	--
  4. Other Medical Services (Specify)
 

Y	N		
---	---	--	--
- After Care Services Yes No
1. Continuing Care
 

Y	N		
---	---	--	--
  2. Relapse Prevention
 

Y	N		
---	---	--	--
  3. Recovery Coaching
 

Y	N		
---	---	--	--
  4. Self-Help and Support Groups
 

		Y	
--	--	---	--
  5. Spiritual Support
 

Y	N		
---	---	--	--
  6. Other After Care Services (Specify)
 

Y	N		
---	---	--	--
- Education Services Yes No
1. Substance Abuse Education
 

Y	N		
---	---	--	--
  2. HIV/AIDS Education
 

Y	N		
---	---	--	--
  3. Other Education Services (Specify)
 

Y	N		
---	---	--	--
- Peer-to-Peer Recovery Support Services Yes No
1. Peer Coaching or Mentoring
 

Y	N		
---	---	--	--
  2. Housing Support
 

Y	N		
---	---	--	--
  3. Alcohol- and Drug-Free Social Activities
 

Y	N		
---	---	--	--
  4. Information and Referral
 

Y	N		
---	---	--	--
  5. Other Peer-to-Peer Recovery Support Services (Specify)
 

Y	N		
---	---	--	--

A. Record Management - Demographics [Asked only at intake/baseline.]

1. What is your gender?

- MALE
- FEMALE
- TRANSGENDER
- OTHER (SPECIFY) \_\_\_\_\_
- REFUSED

Are you Hispanic or Latino?

- YES
- NO
- REFUSED

[IF YES] What ethnic group do you consider yourself? Please answer yes or no for each of the following. You may say yes to more than one.

	Yes	No	Refused
Central American	Y	N	REFUSED
Cuban	Y	N	REFUSED
Dominican	Y	N	REFUSED
Mexican	Y	N	REFUSED
Puerto Rican	Y	N	REFUSED
South American	Y	N	REFUSED
Other	Y	N	REFUSED [IF YES, SPECIFY BELOW.]

(Specify)

What is your race? Please answer yes or no for each of the following. You may say yes to more than one.

	Yes	No	Refused
Black or African American	Y	N	REFUSED
Asian	Y	N	REFUSED
Native Hawaiian or other Pacific Islander	Y	N	REFUSED
Alaska Native	Y	N	REFUSED
White	Y	N	REFUSED
American Indian	Y	N	REFUSED

What is your date of birth?\*

|\_|\_|\_|/|\_|\_|\_|/    [\*THE SYSTEM WILL ONLY SAVE MONTH AND YEAR.  
 Month            Day            TO MAINTAIN CONFIDENTIALITY, DAY IS NOT SAVED.]

|\_|\_|\_|\_|  
 Year

- REFUSED

**MILITARY FAMILY AND DEPLOYMENT**

Have you ever served in the Armed Forces, in the Reserves, or in the National Guard? *[IF SERVED]* What area, the Armed Forces, Reserves, or National Guard did you serve?

- NO
- YES, IN THE ARMED FORCES
- YES, IN THE RESERVES
- YES, IN THE NATIONAL GUARD
- REFUSED
- DON'T KNOW

***[IF NO, REFUSED, OR DON'T KNOW, SKIP TO QUESTION A6.]***

5a. Are you currently on active duty in the Armed Forces, in the Reserves, or in the National Guard? *[IF ACTIVE]* What area, the Armed Forces, Reserves, or National Guard?

- NO, SEPARATED OR RETIRED FROM THE ARMED FORCES, RESERVES, OR NATIONAL GUARD
- YES, IN THE ARMED FORCES
- YES, IN THE RESERVES
- YES, IN THE NATIONAL GUARD
- REFUSED
- DON'T KNOW

5b. Have you ever been deployed to a combat zone? *[CHECK ALL THAT APPLY.]*

- NEVER DEPLOYED
- IRAQ OR AFGHANISTAN (E.G., OEF/OIF/OND)
- PERSIAN GULF (OPERATION DESERT SHIELD/DESERT STORM)
- VIETNAM/SOUTHEAST ASIA
- KOREA
- WWII
- DEPLOYED TO A COMBAT ZONE NOT LISTED ABOVE (E.G., BOSNIA/SOMALIA)
- REFUSED
- DON'T KNOW

***[SBIRT GRANTEEES: FOR CLIENTS WHO SCREENED NEGATIVE, SKIP ITEMS A6, A6A THROUGH A6D.]***





<b>6d. Died or was killed?</b>	<input type="radio"/> YES	<input type="radio"/> YES	<input type="radio"/> YES	<input type="radio"/> YES	<input type="radio"/> YES	<input type="radio"/> YES
	<input type="radio"/> NO	<input type="radio"/> NO	<input type="radio"/> NO	<input type="radio"/> NO	<input type="radio"/> NO	<input type="radio"/> NO
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	REF	REF	REF	REF	REF	REF
	USED	USED	USED	USED	USED	USED
	<input type="radio"/> DON'T KNOW	<input type="radio"/> DON'T KNOW	<input type="radio"/> DON'T KNOW	<input type="radio"/> DON'T KNOW	<input type="radio"/> DON'T KNOW	<input type="radio"/> DON'T KNOW

**B. Drug and Alcohol Use**

	Number of Days	REFUSED	DON'T KNOW
1. During the past 30 days, how many days have you used the following:			
<b>a. Any alcohol</b> [IF ZERO, SKIP TO ITEM B1c.] _ _ _ _	<input type="radio"/>	<input type="radio"/>	
<b>b1. Alcohol to intoxication (5+ drinks in one sitting)</b>	_ _ _ _	<input type="radio"/>	<input type="radio"/>
<b>b2. Alcohol to intoxication (4 or fewer drinks in one sitting and felt high)</b>  _ _ _ _  <input type="radio"/> <input type="radio"/>			
<b>c. Illegal drugs</b> [IF B1a <u>OR</u> B1c = 0, RF, DK, THEN SKIP TO ITEM B2.]  _ _ _ _  <input type="radio"/> <input type="radio"/>			
<b>d. Both alcohol and drugs (on the same day)</b>  _ _ _ _	<input type="radio"/>	<input type="radio"/>	

**Route of Administration Types:**

1. Oral 2. Nasal 3. Smoking 4. Non-IV injection 5. IV  
 \*NOTE THE USUAL ROUTE. FOR MORE THAN ONE ROUTE, CHOOSE THE MOST SEVERE. THE ROUTES ARE LISTED FROM LEAST SEVERE (1) TO MOST SEVERE (5).

2. During the past 30 days, how many days have you used any of the following: [IF THE VALUE IN ANY ITEM B2a THROUGH B2i > 0, THEN THE VALUE IN B1c MUST BE > 0.]

	Number of Days	RF DK	Route* RF DK
<b>a. Cocaine/Crack</b>  _ _ _ _  <input type="radio"/> <input type="radio"/>	_ _ _	<input type="radio"/> <input type="radio"/>	
<b>b. Marijuana/Hashish (Pot, Joints, Blunts, Chronic, Weed, Mary Jane)</b>  _ _ _ _  <input type="radio"/> <input type="radio"/>	_ _ _	<input type="radio"/> <input type="radio"/>	
<b>c. Opiates:</b>			
<b>1. Heroin (Smack, H, Junk, Skag)</b>  _ _ _ _	<input type="radio"/>	<input type="radio"/>  _ _ _	<input type="radio"/> <input type="radio"/>
<b>2. Morphine</b>  _ _ _ _  <input type="radio"/> <input type="radio"/>	_ _ _	<input type="radio"/> <input type="radio"/>	
<b>3. Dilaudid</b>  _ _ _ _  <input type="radio"/> <input type="radio"/>	_ _ _	<input type="radio"/> <input type="radio"/>	
<b>4. Demerol</b>  _ _ _ _  <input type="radio"/> <input type="radio"/>	_ _ _	<input type="radio"/> <input type="radio"/>	
<b>5. Percocet</b>  _ _ _ _  <input type="radio"/> <input type="radio"/>	_ _ _	<input type="radio"/> <input type="radio"/>	
<b>6. Darvon</b>  _ _ _ _  <input type="radio"/> <input type="radio"/>	_ _ _	<input type="radio"/> <input type="radio"/>	
<b>7. Codeine</b>  _ _ _ _  <input type="radio"/> <input type="radio"/>	_ _ _	<input type="radio"/> <input type="radio"/>	
<b>8. Tylenol 2, 3, 4</b>  _ _ _ _  <input type="radio"/> <input type="radio"/>	_ _ _	<input type="radio"/> <input type="radio"/>	
<b>9. OxyContin/Oxycodone</b>  _ _ _   <input type="radio"/> <input type="radio"/>	_ _ _	<input type="radio"/> <input type="radio"/>	
<b>d. Non-prescription methadone</b>  _ _ _ _  <input type="radio"/>	<input type="radio"/>	_ _ _  <input type="radio"/>	<input type="radio"/>

e. Hallucinogens/psychedelics, PCP (Angel Dust, Ozone, Wack, Rocket Fuel), MDMA (Ecstasy, XTC, X, Adam), LSD (Acid, Boomers, Yellow Sunshine), Mushrooms, or Mescaline

|\_|\_|\_|        |\_|

f. Methamphetamine or other amphetamines (Meth, Uppers, Speed, Ice, Chalk, Crystal, Glass, Fire, Crank)|\_|\_|\_|

|\_|\_|     

B. DRUG AND ALCOHOL USE (continued)

**Route of Administration Types:**

1. Oral 2. Nasal 3. Smoking 4. Non-IV injection 5. IV

\*NOTE THE USUAL ROUTE. FOR MORE THAN ONE ROUTE, CHOOSE THE MOST SEVERE. THE ROUTES ARE LISTED FROM LEAST SEVERE (1) TO MOST SEVERE (5).

2. During the past 30 days, how many days have you used any of the following: [IF THE VALUE IN ANY ITEM B2a THROUGH B2i > 0, THEN THE VALUE IN B1c MUST BE > 0.]

g. 1. Benzodiazepines: Diazepam (Valium); Alprazolam (Xanax); Triazolam (Halcion); and Estazolam (Prosom and Rohypnol—also known as roofies, roche, and cope)|\_|\_|\_|

Number of Days RFDK      Route\* RFDK

|\_|\_|     

2. Barbiturates: Mephobarbital (Mebacut) and pentobarbital sodium (Nembutal) |\_|\_|\_|

|\_|\_|

3. Non-prescription GHB (known as Grievous Bodily Harm, Liquid Ecstasy, and Georgia Home Boy)

|\_|\_|\_|        |\_|\_|

4. Ketamine (known as Special K or Vitamin K)

|\_|\_|\_|        |\_|\_|

5. Other tranquilizers, downers, sedatives, or hypnotics

|\_|\_|\_|        |\_|\_|

h. Inhalants (poppers, snappers, rush, whippets)

|\_|\_|\_|        |\_|\_|

i. Other illegal drugs (Specify) \_\_\_\_\_

|\_|\_|

3. In the past 30 days, have you injected drugs? [IF ANY ROUTE OF ADMINISTRATION IN B2a THROUGH B2i = 4 or 5, THEN B3 MUST = YES.]

- YES
- NO
- REFUSED
- DON'T KNOW

*[If no, refused, or don't know, skip to Section C.]*

4. In the past 30 days, how often did you use a syringe/needle, cooker, cotton, or water that someone else used?

- Always
- More than half the time
- Half the time
- Less than half the time
- Never
- REFUSED
- DON'T KNOW

C. Family and Living Conditions

1. In the past 30 days, where have you been living most of the time? *[DO NOT READ RESPONSE OPTIONS TO CLIENT.]*

- SHELTER (SAFE HAVENS, TRANSITIONAL LIVING CENTER [TLC], LOW-DEMAND FACILITIES, RECEPTION CENTERS, OTHER TEMPORARY DAY OR EVENING FACILITY)
- STREET/OUTDOORS (SIDEWALK, DOORWAY, PARK, PUBLIC OR ABANDONED BUILDING)
- INSTITUTION (HOSPITAL, NURSING HOME, JAIL/PRISON)
- HOUSED: *[IF HOUSED, CHECK APPROPRIATE SUBCATEGORY:]*
  - OWN/RENT APARTMENT, ROOM, OR HOUSE
  - SOMEONE ELSE'S APARTMENT, ROOM, OR HOUSE
  - DORMITORY/COLLEGE RESIDENCE
  - HALFWAY HOUSE
  - RESIDENTIAL TREATMENT
  - OTHER HOUSED (SPECIFY)
- REFUSED
- DON'T KNOW

2. How satisfied are you with the conditions of your living space?

- Very Dissatisfied
- Dissatisfied
- Neither Satisfied nor Dissatisfied
- Satisfied
- Very Satisfied
- REFUSED
- DON'T KNOW

During the past 30 days, how stressful have things been for you because of your use of alcohol or other drugs? *[IF B1a OR B1c > 0, THEN C3 CANNOT = "NOT APPLICABLE."]*

- Not at all
- Somewhat
- Considerably
- Extremely
- NOT APPLICABLE *[USE ONLY IF B1A AND B1C = 0.]*
- REFUSED
- DON'T KNOW

During the past 30 days, has your use of alcohol or other drugs caused you to reduce or give up important activities? *[IF B1a OR B1c > 0, THEN C4 CANNOT = "NOT APPLICABLE."]*

- Not at all
- Somewhat
- Considerably
- Extremely
- NOT APPLICABLE *[USE ONLY IF B1A AND B1C = 0.]*
- REFUSED
- DON'T KNOW

**C. Family and Living Conditions (continued)**

During the past 30 days, has your use of alcohol or other drugs caused you to have emotional problems? *[IF B1a OR B1c > 0, THEN C5 CANNOT = "NOT APPLICABLE."]*

- Not at all
- Somewhat
- Considerably
- Extremely
- NOT APPLICABLE *[USE ONLY IF B1a AND B1c = 0.]*

REFUSED

DON'T KNOW

*[IF NOT MALE] Are you currently pregnant?*

- YES
- NO
- REFUSED
- DON'T KNOW

Do you have children?

- YES
- NO
- REFUSED
- DON'T KNOW

***[IF NO, REFUSED, OR DON'T KNOW, SKIP TO SECTION D.]***

a. How many children do you have? *[IF C7 = YES, THEN THE VALUE IN C7a MUST BE > 0.]*

\_\_\_\_|\_\_\_\_|  REFUSED  DON'T KNOW

b. Are any of your children living with someone else due to a child protection court order?

- YES
- NO
- REFUSED
- DON'T KNOW

***[IF NO, REFUSED, OR DON'T KNOW, SKIP TO ITEM C7d.]***

c. *[IF YES]* How many of your children are living with someone else due to a child protection court order? *[THE VALUE IN C7c CANNOT EXCEED THE VALUE IN C7a.]*

\_\_\_\_|\_\_\_\_|  REFUSED  DON'T KNOW

d. For how many of your children have you lost parental rights? *[THE CLIENT'S PARENTAL RIGHTS WERE TERMINATED.] [THE VALUE IN ITEM C7d CANNOT EXCEED THE VALUE IN C7a.]*

\_\_\_\_|\_\_\_\_|  REFUSED  DON'T KNOW

**D. Education, Employment, and Income**

1. Are you currently enrolled in school or a job training program? *[IF ENROLLED]* Is that full time or part time? *[IF CLIENT IS INCARCERATED, CODE D1 AS "NOT ENROLLED."]*

- NOT ENROLLED
- ENROLLED, FULL TIME
- ENROLLED, PART TIME
- OTHER (SPECIFY) \_\_\_\_\_
- REFUSED
- DON'T KNOW

What is the highest level of education you have finished, whether or not you received a degree?

- NEVER ATTENDED
- 1ST GRADE
- 2ND GRADE
- 3RD GRADE
- 4TH GRADE
- 5TH GRADE
- 6TH GRADE
- 7TH GRADE
- 8TH GRADE
- 9TH GRADE
- 10TH GRADE
- 11TH GRADE
- 12TH GRADE/HIGH SCHOOL DIPLOMA/EQUIVALENT
- COLLEGE OR UNIVERSITY/1ST YEAR COMPLETED
- COLLEGE OR UNIVERSITY/2ND YEAR COMPLETED/ASSOCIATES DEGREE (AA, AS)
- COLLEGE OR UNIVERSITY/3RD YEAR COMPLETED
- BACHELOR'S DEGREE (BA, BS) OR HIGHER
- VOC/TECH PROGRAM AFTER HIGH SCHOOL BUT NO VOC/TECH DIPLOMA
- VOC/TECH DIPLOMA AFTER HIGH SCHOOL
- REFUSED
- DON'T KNOW

Are you currently employed? *[CLARIFY BY FOCUSING ON STATUS DURING MOST OF THE PREVIOUS WEEK, DETERMINING WHETHER CLIENT WORKED AT ALL OR HAD A REGULAR JOB BUT WAS OFF WORK.]*  
*[IF CLIENT IS "ENROLLED, FULL TIME" IN D1 AND INDICATES "EMPLOYED, FULL TIME" IN D3, ASK FOR CLARIFICATION. IF CLIENT IS INCARCERATED AND HAS NO WORK OUTSIDE OF JAIL, CODE D3 AS "UNEMPLOYED, NOT LOOKING FOR WORK."]*

- EMPLOYED, FULL TIME (35+ HOURS PER WEEK, OR WOULD HAVE BEEN)
- EMPLOYED, PART TIME
- UNEMPLOYED, LOOKING FOR WORK
- UNEMPLOYED, DISABLED
- UNEMPLOYED, VOLUNTEER WORK
- UNEMPLOYED, RETIRED
- UNEMPLOYED, NOT LOOKING FOR WORK
- OTHER (SPECIFY) \_\_\_\_\_
- REFUSED
- DON'T KNOW

**D. Education, Employment, and Income (continued)**

Approximately, how much money did YOU receive (pre-tax individual income) in the past 30 days from... *[IF D3 DOES NOT = "EMPLOYED" AND THE VALUE IN D4a IS GREATER THAN ZERO, PROBE. IF D3 = "UNEMPLOYED, LOOKING FOR WORK" AND THE VALUE IN D4b = 0, PROBE. IF D3 = "UNEMPLOYED, RETIRED" AND THE VALUE IN D4c = 0, PROBE. IF D3 = "UNEMPLOYED, DISABLED" AND THE VALUE IN D4d = 0, PROBE.]*

		RF	DK
a. Wages	\$  ____  ,  ____	<input type="radio"/>	<input type="radio"/>
b. Public assistance	\$  ____  ,  ____	<input type="radio"/>	<input type="radio"/>
c. Retirement	\$  ____  ,  ____	<input type="radio"/>	<input type="radio"/>
d. Disability	\$  ____  ,  ____	<input type="radio"/>	<input type="radio"/>
e. Non-legal income	\$  ____  ,  ____	<input type="radio"/>	<input type="radio"/>
f. Family and/or friends	\$  ____  ,  ____	<input type="radio"/>	<input type="radio"/>
g. Other (Specify)	\$  ____  ,  ____	<input type="radio"/>	<input type="radio"/>

Have you enough money to meet your needs?

- Not at all
- A little
- Moderately
- Mostly
- Completely
- REFUSED
- DON'T KNOW

**E. Crime and Criminal Justice Status**

1. In the past 30 days, how many times have you been arrested?

|\_|\_|\_| TIMES  REFUSED  DON'T KNOW

**[IF NO ARRESTS, SKIP TO ITEM E3.]**

In the past 30 days, how many times have you been arrested for drug-related offenses? *[THE VALUE IN E2 CANNOT BE GREATER THAN THE VALUE IN E1.]*

|\_|\_|\_| TIMES  REFUSED  DON'T KNOW

In the past 30 days, how many nights have you spent in jail/prison? *[IF THE VALUE IN E3 IS GREATER THAN 15, THEN C1 MUST = INSTITUTION (JAIL/PRISON). IF C1 = INSTITUTION (JAIL/PRISON), THEN THE VALUE IN E3 MUST BE GREATER THAN OR EQUAL TO 15.]*

|\_|\_|\_| NIGHTS  REFUSED  DON'T KNOW

In the past 30 days, how many times have you committed a crime? *[CHECK NUMBER OF DAYS USED ILLEGAL DRUGS IN ITEM B1c ON PAGE 7. ANSWER HERE IN E4 SHOULD BE EQUAL TO OR GREATER THAN NUMBER IN B1c BECAUSE USING ILLEGAL DRUGS IS A CRIME.]*

|\_|\_|\_| TIMES  REFUSED  DON'T KNOW

Are you currently awaiting charges, trial, or sentencing?

- YES
- NO
- REFUSED
- DON'T KNOW

Are you currently on parole or probation?

- YES
- NO
- REFUSED
- DON'T KNOW

**F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY**

1. How would you rate your overall health right now?

- Excellent
- Very good
- Good
- Fair
- Poor
- REFUSED
- DON'T KNOW

During the past 30 days, did you receive:

**a. Inpatient Treatment for:**

		<i>[IF YES]</i> <b>Altogether for how many nights</b>	<b>NO</b>	<b>RF</b>	<b>DK</b>
	<b>YES</b>				
	<b>S</b>				
i. Physical complaint	<input type="radio"/>	_____ nights	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
ii. Mental or emotional difficulties	<input type="radio"/>	_____ nights	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
iii. Alcohol or substance abuse	<input type="radio"/>	_____ nights	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**b. Outpatient Treatment for:**

		<i>[IF YES]</i> <b>Altogether for how many times</b>	<b>NO</b>	<b>RF</b>	<b>DK</b>
	<b>YES</b>				
	<b>S</b>				
i. Physical complaint	<input type="radio"/>	_____ times	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
ii. Mental or emotional difficulties	<input type="radio"/>	_____ times	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
iii. Alcohol or substance abuse	<input type="radio"/>	_____ times	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**c. Emergency Room Treatment for:**

		<i>[IF YES]</i> <b>Altogether for how many times</b>	<b>NO</b>	<b>RF</b>	<b>DK</b>
	<b>YES</b>				
	<b>S</b>				
i. Physical complaint	<input type="radio"/>	_____ times	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
ii. Mental or emotional difficulties	<input type="radio"/>	_____ times	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
iii. Alcohol or substance abuse	<input type="radio"/>	_____ times	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY (continued)**

During the past 30 days, did you engage in sexual activity?

- Yes**
- No** → [SKIP TO F4.]
- NOT PERMITTED TO ASK** → [SKIP TO F4.]
- REFUSED** → [SKIP TO F4.]
- DON'T KNOW** → [SKIP TO F4.]

**[IF YES] ALTOGETHER, HOW MANY:**

	Contacts	<b>RF</b>	<b>DK</b>
a. Sexual contacts (vaginal, oral, or anal) did you have?	_ _ _ _	<input type="radio"/>	<input type="radio"/>
b. Unprotected sexual contacts did you have? <i>[THE VALUE IN F3b SHOULD NOT BE GREATER THAN THE VALUE IN F3a.] [IF ZERO, SKIP TO F4.]</i>	_ _ _ _	<input type="radio"/>	<input type="radio"/>
c. Unprotected sexual contacts were with an individual who is or was: <i>[NONE OF THE VALUES IN F3c1 THROUGH F3c3 CAN BE GREATER THAN THE VALUE IN F3b.]</i>			
1. HIV positive or has AIDS	_ _ _ _	<input type="radio"/>	<input type="radio"/>
2. An injection drug user	_ _ _ _	<input type="radio"/>	<input type="radio"/>
3. High on some substance	_ _ _ _	<input type="radio"/>	<input type="radio"/>

Have you ever been tested for HIV?

- ..... **Yes** [GO TO F4a.]
- ..... **No** [SKIP TO F5.]
- ..... **REFUSED**[SKIP TO F5.]
- ..... **DON'T KNOW**[SKIP TO F5.]

a. Do you know the results of your HIV testing?

- Yes**
- No**

F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY (continued)

How would you rate your quality of life?

- Very poor**
- Poor**
- Neither poor nor good**
- Good**
- Very Good**
- REFUSED**
- DON'T KNOW**

How satisfied are you with your health?

- Very dissatisfied**
- Dissatisfied**
- Neither satisfied nor dissatisfied**
- Satisfied**
- Very satisfied**
- REFUSED**
- DON'T KNOW**

Do you have enough energy for everyday life?

- Not at all**
- A little**
- Moderately**
- Mostly**
- Completely**
- REFUSED**
- DON'T KNOW**

How satisfied are you with your ability to perform your daily activities?

- Very Dissatisfied**
- Dissatisfied**
- Neither Satisfied nor Dissatisfied**
- Satisfied**
- Very Satisfied**
- REFUSED**
- DON'T KNOW**

How satisfied are you with yourself?

- Very Dissatisfied**
- Dissatisfied**
- Neither Satisfied nor Dissatisfied**
- Satisfied**
- Very Satisfied**
- REFUSED**
- DON'T KNOW**

F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY (continued)

In the past 30 days, not due to your use of alcohol or drugs, how many days have you:

Days                      RF              DK



- a. depression Experienced serious \_\_\_\_\_ | \_\_\_\_\_ |
- b. tension Experienced serious anxiety or \_\_\_\_\_ | \_\_\_\_\_ |
- c. hallucinations Experienced \_\_\_\_\_ | \_\_\_\_\_ |
- d. remembering Experienced trouble understanding, concentrating, or \_\_\_\_\_ | \_\_\_\_\_ |
- e. behavior Experienced trouble controlling violent \_\_\_\_\_ | \_\_\_\_\_ |
- f. Attempted suicide \_\_\_\_\_ | \_\_\_\_\_ |
- g. problem Been prescribed medication for psychological/emotional \_\_\_\_\_ | \_\_\_\_\_ |

**[IF CLIENT REPORTS ZERO DAYS, RF, OR DK TO ALL ITEMS IN QUESTION F10, SKIP TO ITEM F12.]**

How much have you been bothered by these psychological or emotional problems in the past 30 days?

- Not at all
- Slightly
- Moderately
- Considerably
- Extremely
- REFUSED
- DON'T KNOW

**VIOLENCE AND TRAUMA**

Have you ever experienced violence or trauma in any setting (including community or school\ violence; domestic violence; physical, psychological, or sexual maltreatment/assault within or outside of the family; natural disaster; terrorism; neglect; or traumatic grief?)

- YES
- NO [SKIP TO ITEM F13.]
- REFUSED
- DON'T KNOW

**[IF NO, REFUSED, OR DON'T KNOW, SKIP TO ITEM F13.]**

**F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT/RECOVERY (continued)**

Did any of these experiences feel so frightening, horrible, or upsetting that, in the past and/or the present, you:

12a. Have had nightmares about it or thought about it when you did not want to?

- YES
- NO
- REFUSED
- DON'T KNOW

12b. Tried hard not to think about it or went out of your way to avoid situations that remind you of it?

- YES
- NO
- REFUSED
- DON'T KNOW

12c. Were constantly on guard, watchful, or easily startled?

- YES**
- NO**
- REFUSED**
- DON'T KNOW**

12d. Felt numb and detached from others, activities, or your surroundings?

- YES**
- NO**
- REFUSED**
- DON'T KNOW**

In the past 30 days, how often have you been hit, kicked, slapped, or otherwise physically hurt?

- Never**
- A few times**
- More than a few times**
- REFUSED**
- DON'T KNOW**

**G. Social Connectedness**

1. In the past 30 days, did you attend any voluntary self-help groups for recovery that were not affiliated with a religious or faith-based organization? In other words, did you participate in a non-professional, peer-operated organization that is devoted to helping individuals who have addiction-related problems such as: Alcoholics Anonymous, Narcotics Anonymous, Oxford House, Secular Organization for Sobriety, or Women for Sobriety, etc.?

- YES[IF YES] SPECIFY HOW MANY TIMES  
|\_|\_|\_|       REFUSED  DON'T KNOW
- NO
- REFUSED
- DON'T KNOW

In the past 30 days, did you attend any religious/faith-affiliated recovery self-help groups?

- YES[IF YES] SPECIFY HOW MANY TIMES  
|\_|\_|\_|       REFUSED  DON'T KNOW
- NO
- REFUSED
- DON'T KNOW

In the past 30 days, did you attend meetings of organizations that support recovery other than the organizations described above?

- YES[IF YES] SPECIFY HOW MANY TIMES  
|\_|\_|\_|       REFUSED  DON'T KNOW
- NO
- REFUSED
- DON'T KNOW

In the past 30 days, did you have interaction with family and/or friends that are supportive of your recovery?

- YES
- NO
- REFUSED
- DON'T KNOW

To whom do you turn when you are having trouble? [SELECT ONLY ONE.]

- NO ONE
- CLERGY MEMBER
- FAMILY MEMBER
- FRIENDS
- REFUSED
- DON'T KNOW
- OTHER (SPECIFY) \_\_\_\_\_

How satisfied are you with your personal relationships?

- Very Dissatisfied
- Dissatisfied
- Neither Satisfied nor Dissatisfied
- Satisfied
- Very Satisfied
- REFUSED
- DON'T KNOW

**I. Follow-Up Status**

**[REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT FOLLOW-UP.]**

1. What is the follow-up status of the client? [THIS IS A REQUIRED FIELD: NA, REFUSED, DON'T KNOW, AND MISSING WILL NOT BE ACCEPTED.]

- 01 = Deceased at time of due date
- 11 = Completed interview within specified window
- 12 = Completed interview outside specified window
- 21 = Located, but refused, unspecified
- 22 = Located, but unable to gain institutional access
- 23 = Located, but otherwise unable to gain access
- 24 = Located, but withdrawn from project
- 31 = Unable to locate, moved
- 32 = Unable to locate, other (Specify) \_\_\_\_\_

Is the client still receiving services from your program?

- Yes
- No

***[IF THIS IS A FOLLOW-UP INTERVIEW, STOP NOW; THE INTERVIEW IS COMPLETE.]***

J. Discharge Status

***[REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT DISCHARGE.]***

1. On what date was the client discharged?

/  /   
 MONTH DAY YEAR

What is the client's discharge status?

- 01 = Completion/Graduate
- 02 = Termination

If the client was terminated, what was the reason for termination? *[SELECT ONE RESPONSE.]*

- 01 = Left on own against staff advice with satisfactory progress
- 02 = Left on own against staff advice without satisfactory progress
- 03 = Involuntarily discharged due to nonparticipation
- 04 = Involuntarily discharged due to violation of rules
- 05 = Referred to another program or other services with satisfactory progress
- 06 = Referred to another program or other services with unsatisfactory progress
- 07 = Incarcerated due to offense committed while in treatment/recovery with satisfactory progress
- 08 = Incarcerated due to offense committed while in treatment/recovery with unsatisfactory progress
- 09 = Incarcerated due to old warrant or charged from before entering treatment/recovery with satisfactory progress
- 10 = Incarcerated due to old warrant or charged from before entering treatment/recovery with unsatisfactory progress
- 11 = Transferred to another facility for health reasons
- 12 = Death
- 13 = Other (Specify)

Did the program test this client for HIV?

- Yes[SKIP TO SECTION K.]
- No[GO TO J4.]

*[IF NO]* Did the program refer this client for testing?

- Yes
- No

K. Services Received

***[REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT DISCHARGE.]***

**Identify the number of DAYS of services provided to the client during the client’s course of treatment/recovery. [ENTER ZERO IF NO SERVICES PROVIDED. YOU SHOULD HAVE AT LEAST ONE DAY FOR MODALITY.]**

- | Modality                                 | Days    |
|--|---------|
| 1. Case Management                       | _ _ _ _ |
| 2. Day Treatment                         | _ _ _ _ |
| 3. Inpatient/Hospital (Other Than Detox) | _ _ _ _ |
| 4. Outpatient                            | _ _ _ _ |
| 5. Outreach                              | _ _ _ _ |
| 6. Intensive Outpatient                  | _ _ _ _ |
| 7. Methadone                             | _ _ _ _ |
| 8. Residential/Rehabilitation            | _ _ _ _ |
| 9. Detoxification (Select Only One):     |         |
| A. Hospital Inpatient                    | _ _ _ _ |
| B. Free Standing Residential             | _ _ _ _ |
| C. Ambulatory Detoxification             | _ _ _ _ |
| 10. After Care                           | _ _ _ _ |
| 11. Recovery Support                     | _ _ _ _ |
| 12. Other (Specify) _____                | _ _ _ _ |

**Identify the number of SESSIONS provided to the client during the client’s course of treatment/recovery. [ENTER ZERO IF NO SERVICES PROVIDED.]**

Treatment Services      Sessions  
**[SBIRT GRANTS: YOU MUST HAVE AT LEAST ONE SESSION FOR ONE OF THE TREATMENT SERVICES NUMBERED 1 THROUGH 4.]**

- |  |         |
|--|---------|
| 1. Screening                                   | _ _ _ _ |
| 2. Brief Intervention                          | _ _ _ _ |
| 3. Brief Treatment                             | _ _ _ _ |
| 4. Referral to Treatment                       | _ _ _ _ |
| 5. Assessment                                  | _ _ _ _ |
| 6. Treatment/Recovery Planning                 | _ _ _ _ |
| 7. Individual Counseling                       | _ _ _ _ |
| 8. Group Counseling                            | _ _ _ _ |
| 9. Family/Marriage Counseling                  | _ _ _ _ |
| 10. Co-Occurring Treatment/Recovery Services   | _ _ _ _ |
| 11. Pharmacological Interventions              | _ _ _ _ |
| 12. HIV/AIDS Counseling                        | _ _ _ _ |
| 13. Other Clinical Services<br>(Specify) _____ | _ _ _ _ |

Case Management Services      Sessions

1. Family Services (Including Marriage Education, Parenting, Child Development Services) |\_\_|\_\_|\_\_|
2. Child Care |\_\_|\_\_|\_\_|
3. Employment Service
- A. Pre-Employment |\_\_|\_\_|\_\_|
- B. Employment Coaching |\_\_|\_\_|\_\_|
4. Individual Services Coordination |\_\_|\_\_|\_\_|
5. Transportation |\_\_|\_\_|\_\_|
6. HIV/AIDS Service |\_\_|\_\_|\_\_|
7. Supportive Transitional Drug-Free Housing Services |\_\_|\_\_|\_\_|
8. Other Case Management Services (Specify) |\_\_|\_\_|\_\_|

Medical Services      Sessions

1. Medical Care |\_\_|\_\_|\_\_|
2. Alcohol/Drug Testing |\_\_|\_\_|\_\_|
3. HIV/ AIDS Medical Support & Testing |\_\_|\_\_|\_\_|
4. Other Medical Services  
(Specify) \_\_\_\_\_ |\_\_|\_\_|\_\_|

After Care Services      Sessions

1. Continuing Care |\_\_|\_\_|\_\_|
2. Relapse Prevention |\_\_|\_\_|\_\_|
3. Recovery Coaching |\_\_|\_\_|\_\_|
4. Self-Help and Support Groups |\_\_|\_\_|\_\_|
5. Spiritual Support |\_\_|\_\_|\_\_|
6. Other After Care Services  
(Specify) \_\_\_\_\_ |\_\_|\_\_|\_\_|

Education Services      Sessions

1. Substance Abuse Education |\_\_|\_\_|\_\_|
2. HIV/AIDS Education |\_\_|\_\_|\_\_|
3. Other Education Services  
(Specify) \_\_\_\_\_ |\_\_|\_\_|\_\_|

Peer-to-Peer Recovery Support Services Sessions

1. Peer Coaching or Mentoring |\_\_|\_\_|\_\_|
2. Housing Support |\_\_|\_\_|\_\_|
3. Alcohol- and Drug-Free Social Activities |\_\_|\_\_|\_\_|
4. Information and Referral |\_\_|\_\_|\_\_|
5. Other Peer-to-Peer Recovery Support Services (Specify)  
\_\_\_\_\_ |\_\_|\_\_|\_\_|

**Appendix D**  
Life Events Checklist LEC-5 Standard

<b>Event</b>	<b>Happened to me</b>	<b>Witnessed it</b>	<b>Learned about it</b>	<b>Part of my job</b>	<b>Not sure</b>	<b>Doesn't apply</b>
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)						
2. Fire or explosion						
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)						
4. Serious accident at work, home, or during recreational activity						
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)						
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)						
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)						
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)						
9. Other unwanted or uncomfortable sexual experience						
10. Combat or exposure to a war-zone (in the military or as a civilian)						
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)						
12. Life-threatening illness or injury						
13. Severe human suffering						
14. Sudden violent death (for example, homicide, suicide)						
15. Sudden accidental death						
16. Serious injury, harm, or death you caused to someone else						
17. Any other very stressful event or experience						

**Appendix E**  
**PTSD Checklist 5 (PCL-5)**

<b>In the past month, how much were you bothered by:</b>	<b>Not at all</b>	<b>A little bit</b>	<b>Moderately</b>	<b>Quite a bit</b>	<b>Extremely</b>
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being “superalert” or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4



**Appendix F**

## Brief Sense of Community Scale Item Wording

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<b>Item</b>	<b>Item Wording</b>
BSCS1	I can get what I need in this neighborhood.
BSCS2	This neighborhood helps me fulfill my needs.
BSCS3	I feel like a member of this neighborhood.
BSCS5	I have a say about what goes on in my neighborhood.
BSCS6	People in this neighborhood are good at influencing each another.
BSCS7	I feel connected to this neighborhood.
BSCS8	I have a good bond with others in this neighborhood.

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**Appendix G**  
Short Recovery Capital Scale – 10 Item (SCRS-10)

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Short Recovery Scale Item Wording

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Item 1: Today I have a clear sense of who I am

Item 2: I know that my life has a purpose

Item 3: I have recovery rituals that are now part of my daily life

Item 4: I feel like I have meaningful, positive participation in my family and community

Item 5: I have friends who are supportive of my recovery process

Item 6: I now have goals and great hopes for my future

Item 7: I live in an environment free from alcohol and other drugs

Item 8: I have an active plan to manage any lingering or potential health problems

Item 9: I have established close affiliation with a local recovery support group

Item 10: My personal values and sense of right and wrong have become clearer and stronger in recent years

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**Appendix H**  
 Depression, Anxiety, and Stress Scale – 21 Items (DASS-21)

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you **over the past week**. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

- 0 Did not apply to me at all
- 1 Applied to me to some degree, or some of the time
- 2 Applied to me to a considerable degree or a good part of time
- 3 Applied to me very much or most of the time

---

1 (s)	I found it hard to wind down	0	1	2	3
2 (a)	I was aware of dryness of my mouth	0	1	2	3
3 (d)	I couldn't seem to experience any positive feeling at all	0	1	2	3
4 (a)	I experienced breathing difficulty (e.g., excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5 (d)	I found it difficult to work up the initiative to do things	0	1	2	3
6 (s)	I tended to over-react to situations	0	1	2	3
7 (a)	I experienced trembling (e.g., in the hands)	0	1	2	3
8 (s)	I felt that I was using a lot of nervous energy	0	1	2	3
9 (a)	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10 (d)	I felt that I had nothing to look forward to	0	1	2	3
11 (s)	I found myself getting agitated	0	1	2	3
12 (s)	I found it difficult to relax	0	1	2	3
13 (d)	I felt downhearted and blue	0	1	2	3
14 (s)	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15 (a)	I felt I was close to panic	0	1	2	3
16 (d)	I was unable to become enthusiastic about anything	0	1	2	3
17 (d)	I felt I wasn't worth much as a person	0	1	2	3
18 (s)	I felt that I was rather touchy	0	1	2	3
19 (a)	I was aware of the action of my heart in the absence of physical exertion (e.g., sense of heart rate increase, heart missing a beat)	0	1	2	3
20 (a)	I felt scared without any good reason	0	1	2	3
21 (d)	I felt that life was meaningless	0	1	2	3

**Appendix I**  
The Trust in Physicians Scale

Below are some statements referring to your primary care provider. Please rate how much you agree or disagree with each statement. Response choices range from "strongly disagree" to "strongly agree"  
*En la siguiente tabla se presentan varias frases con referencia a su médico de cabecera. Por favor indique qué tan de acuerdo o en desacuerdo está con lo que dice cada una de las frases. Las respuestas varían desde "muy en desacuerdo" hasta "muy de acuerdo".*

		<b>Strongly Disagree</b> <i>Muy en Desacuerdo</i> 1	<b>Disagree</b> <i>En Desacuerdo</i> 2	<b>Neutral</b> <i>Neutral</i> 3	<b>Agree</b> <i>De Acuerdo</i> 4	<b>Strongly Agree</b> <i>Muy en Acuerdo</i> 5
1.	I doubt that my doctor really cares about me as a person. <i>Dudo que mi doctor(a) realmente se preocupe de mí como persona.</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.	My doctor is usually considerate of my needs and puts them first. <i>Mi doctor(a) generalmente se preocupa por mis necesidades y las pone por delante.</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3.	I trust my doctor so much I always try to follow his/her advice. <i>Yo confío tanto en mi doctor(a) que siempre trato de seguir sus consejos.</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4.	If my doctor tells me something is so, then it must be true. <i>Si mi doctor(a) me dice que las cosas son de una manera, entonces, debe ser verdad.</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5.	I sometimes distrust my doctor's opinion and would like a second. <i>A veces desconfío de la opinión de mi doctor(a) y me gustaría tener una segunda opinión.</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6.	I trust my doctor's judgement about my medical care. <i>Confío en el juicio de mi doctor(a) con respecto a mi cuidado médico.</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

		<b>Strongly Disagree</b> <i>Muy en Desacuerdo</i> <sup>1</sup>	<b>Disagree</b> <i>En Desacuerdo</i> <sup>2</sup>	<b>Neutral</b> <i>Neutral</i> <b>3</b>	<b>Agree</b> <i>De Acuerdo</i> <b>4</b>	<b>Strongly Agree</b> <i>Muy en Acuerdo</i> <b>5</b>
7.	I feel my doctor does not do everything he/she should for my medical care. <i>Siento que mi doctor(a) no hace todo lo que debería hacer con respecto a mi cuidado médico.</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8.	I trust my doctor to put my medical needs above all other considerations when treating my medical problems. <i>Confío en que mi doctor(a) ponga mis necesidades médicas por encima de cualquier otra consideración a la hora de tratar mis problemas médicos.</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9.	My doctor is a real expert in taking care of medical problems like mine. <i>Mi doctor(a) es un(a) verdadero experto(a) tratando problemas médicos como el mío.</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10.	I trust my doctor to tell me if a mistake was made about my treatment. <i>Confío en que mi doctor(a) me avisaríasi hubiera ocurrido algún error relacionado a mi tratamiento.</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11.	I sometimes worry that my doctor may not keep the infomation we discuss totally private. <i>A veces me preocupa que mi doctor(a) no mantenga completamente privada la información compartida durante nuestra conversación.</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>