Medications for Opioid Use Disorder among Culturally Diverse People with HIV

Epidemiology of Opioid Use and HIV among African Americans and Latinos/Latinas

In 2018, African-Americans had the highest rate of new HIV infections of all racial/ethnic groups in the United States.[1] In Los Angeles County, African-American males represent approximately 4% of the population but over 16% of People with HIV (PWH). Also in LA County, Latino males represent approximately 24% of residents but almost 40% of PWH.[2] In one year (2015-2016), drug overdose deaths among the U.S. population increased by 21%, but they increased among African-Americans by approximately 40%.[3] Synthetic opioids like fentanyl account for many of these deaths.[4] Opioid painkillers are more commonly prescribed to PWH than those without HIV and PWH are more likely to receive higher doses of these medications than the general population, increasing the risk of misuse and overdose.[5]

Social Determinants of Health

Social determinants of health are conditions in the environment in which people are born, live, learn, work, play, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Examples include safe and affordable housing, access to education and healthcare, and public safety. When stratified by race/ethnicity, we see disparities, particularly among the African American and Latino/Latina populations. These disparities are observed with regard to the opioid crisis and access to prevention and evidence-based treatment.[3] Only approximately 10% of people in the general population seek treatment for a substance use disorder (SUD), and this is magnified in the African American and Latino/Latina communities, where significant mistrust of the healthcare, social services, and criminal justice system exists. The historical context of the disparities in medication treatment for opioid use disorder (OUD) include the passage of the Rockefeller Laws of 1973, which became the basis for the national "war on drugs." The laws mandated extremely harsh prison sentences for possession of relatively small amounts of drugs. Penalties for possession of small amounts of crack cocaine were equivalent to penalties for large amounts of powder cocaine, and resulted in extreme racial/ethnic disparities in prison populations that largely continue to this day.

The Gold Standard Treatment for OUD: Medications for OUD (MOUD)

Three FDA-approved medications exist to treat opioid use disorders (OUD), and one exists to reverse overdose. Methadone is a full opioid agonist, meaning if you take too much of it you can overdose. It suppresses opioid withdrawal symptoms and cravings, is used to treat both severe pain and OUD, and requires daily dosing at a federally-regulated clinic.[6] People with OUD on methadone treatment display reduced participation in crime and reduced transmission of blood-borne viruses such as HIV and HCV.[7] Buprenorphine is a partial opioid agonist, which means that it provides opioid effects up to a limit. It is designed to prevent withdrawal symptoms and cravings without the overdose risk of methadone. When naloxone is added, it becomes very difficult to dilute and inject, which reduces diversion and allows for take-home doses. It is usually prescribed in physicians' offices and thus has less stigma attached to it than methadone.[8] Naltrexone is an opioid antagonist, so unlike methadone and buprenorphine, it blocks opioid effects. It is available orally or as an extended-release injection (Vivitrol ®) that lasts one month. It has been shown to reduce cravings and relapses and increase opioid abstinence and retention in treatment.[9] Naloxone is also an opioid antagonist, which when administered after an overdose reverses the central nervous system and respiratory depression caused by opioids (thus reversing the overdose).[10] It is most commonly available as a nasal spray that has been distributed to first responders around the country.

Culturally-Tailored Interventions

Numerous examples exist of effective OUD interventions tailored to the African-American and Latino/Latina populations, including multiple faith-based initiatives. A SAMHSA task force provides grants for faith-based initiatives, where healthcare professionals work with local faith organizations to deliver substance use and mental health prevention and treatment. These "trusted messengers" are vital to reaching these underserved populations.

Examples of interventions tailored to the African-American community include the Bellevue Hospital Addiction Clinic in New York, Prime Time Sister Circles, and Bridges to Care and Recovery. Strategies for expanding access to MOUD treatment in Latino/Latina communities include translating public awareness and media campaigns into Spanish, partnering with community-based organizations, utilizing schools and faith-based organizations, and the use of peer recovery coaches and community health workers.[3]

Recommendations for Increasing Access to Care

Recommendations for increasing access to MOUD treatment for the African American and Latino/Latina populations include the following: reorient U.S. drug policy toward a public health approach for the entire population, not just the White middle and upper class populations; expand MOUD and psychosocial treatments into all communities; provide incentives for physicians, nurse practitioners, and physician assistants to acquire the buprenorphine prescribing waiver; decriminalize personal possession of drugs; expunge arrest records of low-level drug-related offenses; and require cultural impact statements whenever policy is being made that affects the healthcare, drug treatment, and criminal justice systems.[11] It is also recommended that we increase the development and dissemination of culturally-tailored interventions that are likely to help reduce the disparities that exist in MOUD treatment for these populations.[12]

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This fact sheet was prepared and reviewed by: James Peck, PsyD, Beth Rutkowski, MPH, and Thomas Freese, PhD – Pacific Southwest Addiction Technology Transfer Center/UCLA Integrated Substance Abuse Programs; Tom Donohoe, MBA; Sandra Cuevas; Maya Gil Cantu, MPH; and Kevin-Paul Johnson – Pacific AIDS Education and Training Center, Los Angeles Region.

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