Extending the Reach: Implementing a Community-Based Peer Recovery Coach Model to Reach Underserved, Minority Individuals Not Engaged in Care in Baltimore City

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Jessica Magidson, PhD
Assistant Professor, Department of Psychology
University of Maryland, College Park

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Co-authors:

Mary B. Kleinman, Kelly Doran, Julia W. Felton, Emily N. Satinsky, Dwayne Dean, Valerie Bradley

Participants

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GMAP

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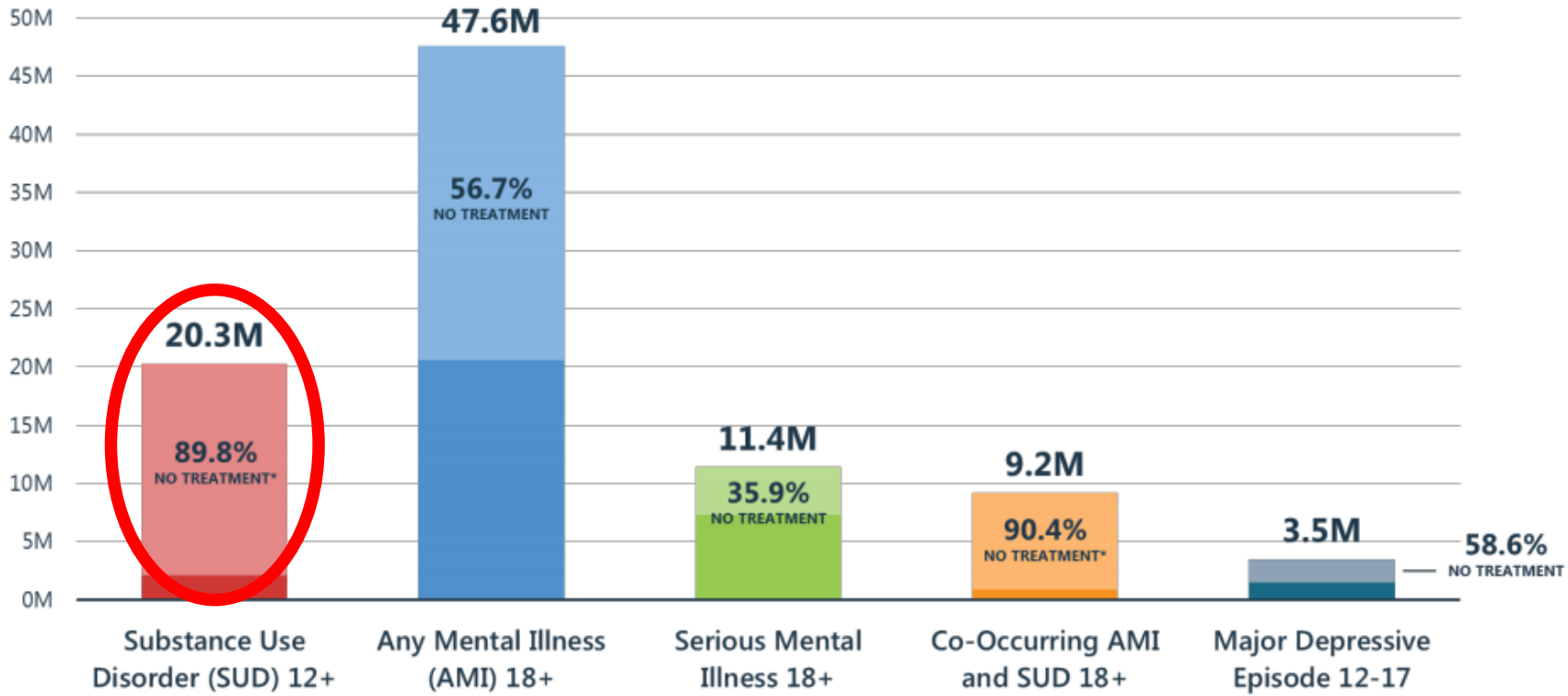
Despite Consequences and Disease Burden, Treatment Gaps Remain Vast

PAST YEAR, 2018 NSDUH, 12+



* No Treatment for SUD is defined as not receiving treatment at any location, such as a hospital (inpatient), rehabilitation facility (inpatient or outpatient), mental health center, emergency room, private doctor's office, self-help group, or prison/jail.

SAMHSA
Substance Abuse and Mental Health Services Administration

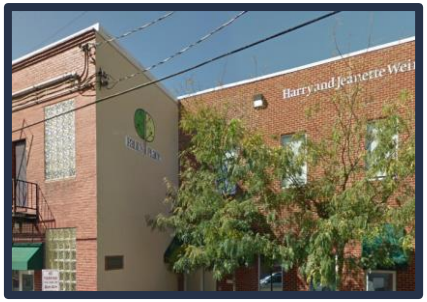
WHY IS THERE A SUBSTANCE USE TREATMENT GAP?

- How do you engage these individuals?
- *Particularly low-income, minority individuals not engaged in other services*

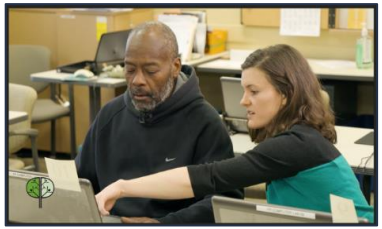
- **Not ready to stop**
- **Cost/ Insurance coverage**
- **Stigma in work/community**
- **Don't know where to go**
- **Structural barriers**
- **No access to desired approach**

PARTNER: *Community resource center in Baltimore*

- Programs and services
  - Hot lunch, laundry, showers, nursing clinic, case management
  - ~200 people served lunch daily
  - 20-50 utilize “guest engagement” daily



- High rates of poverty and unemployment
  - 60% homelessness/housing instability



- 40% report alcohol and/or illicit drugs in past 24 hrs
  - 70% ‘mostly’ or ‘absolutely’ ready for tx
  - Majority not connected to services

EXPANDING ROLE OF PEER RECOVERY COACHES

- Who are peer recovery coaches (PRCs)?[1,2]
  - Individuals with lived experience who are hired as part of SUD care team
  - Support SUD treatment linkage, retention, and ongoing recovery
  - Address unique barriers faced by low-income, underserved patients
  - Provide inspiration and motivation for recovery

- Recent scale up of PRCs in the US[3,4]
  - Majority are in the ED and other clinical settings
  - Few PRC programs have been evaluated in non-clinical, community settings

[1]Bassuk et al., 2016; [2]Reif et al., 2014; [3]Magidson, Regan, Jack, & Wakeman, 2018; [4]Eddie et al., 2019

OVERALL AIM

- Evaluate the implementation of a community-based, peer recovery coach model to support linkage to substance use treatment and early retention
  - *Proof of concept, feasibility study to engage underserved, low-income, minority individuals not engaged in care*

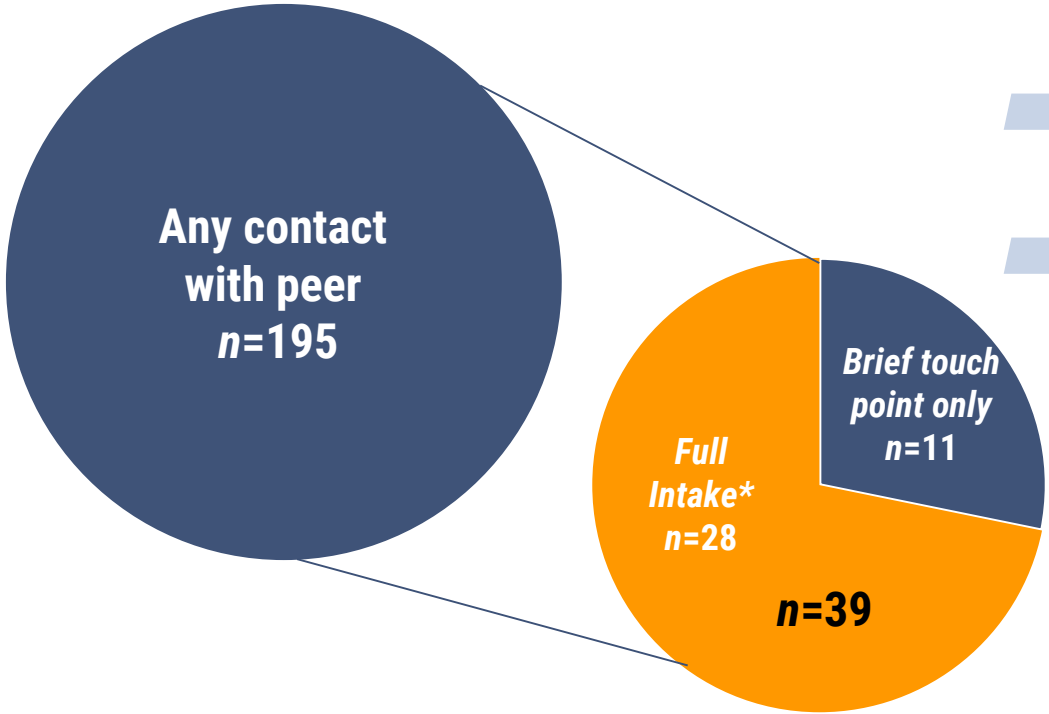
INTEGRATING A PEER RECOVERY COACH

- Gathered stakeholder input (*n*=41; guests, peers, staff)
- Hired a part-time, certified peer recovery coach (PRC)
  - Motivational interviewing (MI), problem solving structural barriers
- Integrated the peer role and increased awareness
  - Daily attendance at guest engagement hours
  - Flyer (with photo of peer) and business cards
  - Casual conversation with guests in the lunch line
    - *"Do you know anyone who needs help with substance use?"*
  - Worked with staff to increase awareness, promote referrals

ASSESSMENTS

- **PRC Intake assessments**
  - Brief touch point: Frequency/type of drug use in past 3 months, readiness to change – *how can a peer support you?*
  - Structured intake: In-depth assessment of drug use history, readiness to change, goals for PRC, barriers to treatment, tailored referral
- **Primary outcome:** Linkage to care and early retention in treatment (verified by medical records)
- **Contact points (post linkage):** 24-48 hours, 2 weeks, and 1 month

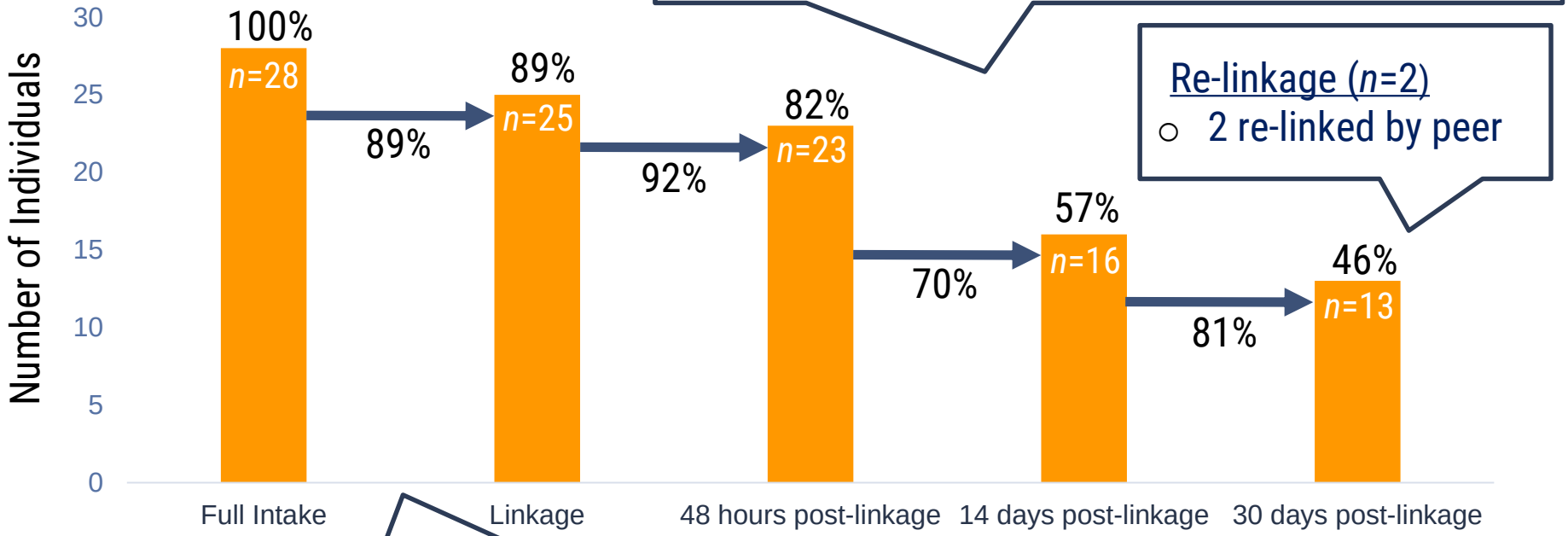
RESULTS



- Implemented over 6 months (Oct 1, 2018–April 1, 2019)
- PRC interacted with *n*=195 over 101 days
- Low threshold approach:
  - Meeting people where they were at, literally and figuratively
  - Yet also documenting reach (daily tally)

*N=5 with full intake had brief touch point first then later had full intake.

RESULTS



Lost to follow up over one month post-linkage (*n*=12)

- Dropped out of tx, still in contact with peer (*n*=10)
- Dropped out of tx, no further peer contact (*n*=2)

Re-linkage (*n*=2)

- 2 re-linked by peer

Lost to follow up pre-linkage (*n*=3)

- Not ready for treatment (*n*=1)
- Did not present to tx intake (*n*=2)

PARTICIPANTS AND PEER CONTACTS

- Demographics and clinical characteristics*
  - 75% male; 57.1% Black/African American; Mean age 47.5 (*SD* 11.5)
  - Mean DAST-10 = 8.4 (*SD* 1.5)
  - 60.7% crack/cocaine; 57.1% heroin or other OUD
  - Mean self-reported readiness for change: 9.3 (*SD*=1.1)
- Mean 3.5 (*SD*=1.8) contacts per participant

**Data available among individuals who completed a full intake (n=28)*

TYPES OF LINKAGE

- 60% of those linked to treatment were linked to intensive outpatient programs with housing (15/25)
- 100% of individuals linked to treatment for OUD (*n*=16) were linked to receive medications for opioid use disorder (MOUD)
- Goals addressed with the peer included housing, linkage to medical and behavioral health care, documents (ID, birth certificate, etc.) and risk factors for relapse

LESSONS LEARNED

- Peer presence helped to facilitate linkage for people at varying levels of and fluctuating readiness
  - Not a linear process and requires client-centered adaptation based on individual goals and readiness fluctuation
- Hard-to-reach, hard-to-engage population with multiple barriers to enter and stay in care
- Continuity from community to early retention was a strength
- **Re-linkage and ongoing support needed to support retention**

LIMITATIONS AND NEXT STEPS

- **Limitations**
  - Small sample, lack of generalizability, limited and short-term assessments
- **Other evidence-based strategies for peer training (Phase 3 – ongoing)**
  - Training peer in behavioral activation (BA) to examine whether this may further improve linkage and early retention
  - Longer-term follow ups, assessment of SUD
- **HEAL BRIM: Peer Recovery for Opioid Use Disorder (HEALing PROUD)**
  - Peer-delivered BA to support longer-term retention in methadone

Thank you!

Questions?

jmagidso@umd.edu

Shameless plug…. Please send talented postdoc applicants our way!