



# Opioid recovery initiation: Pilot test of a peer outreach and modified Recovery Management Checkup intervention for out-of-treatment opioid users



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## ABSTRACT

The recent surge in opioid-related overdoses and related fatalities underscores the need for assertive mechanisms for linking individuals with opioid use disorders (OUD) to medication-assisted treatment (MAT). This pilot study investigated the feasibility of an intervention that used peer outreach workers to identify out-of-treatment individuals with OUD combined with a modified version of the Recovery Management Checkup to link individuals to methadone treatment. The study was conducted in high-risk communities in Chicago over 8 weeks; peer outreach workers identified 88 active opioid/heroin users; 72 were screened as eligible, and 70 showed to the study intake/initial linkage meeting. Most participants were male (73%) and African American (94%), with an average age of 52.0 (sd = 7.6). Nearly all (67/70, 96%) were admitted to methadone treatment; median time from initial linkage meeting to treatment admission was 2.6 days. Most were still in treatment at 30 and 60 days post-intake (69% and 70%, respectively). A high-risk sub-group was identified that had ever received naloxone for an opioid overdose; they had one third of the odds of being in treatment at 30 days post-intake compared with others. The intervention model holds promise as an assertive method for identifying and engaging individuals with OUD into treatment.

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## 1. Introduction

The recent surge in misuse of prescription opioids and, relatedly, increase in heroin use associated with its relatively lower cost and wide availability, has been extensively documented within the U.S. (Cicero, Ellis, Surratt, & Kurtz, 2014; Compton, Jones, & Baldwin, 2016). Data from the National Survey on Drug Use and Health (NSDUH) shows that although the rate of nonmedical use of prescription opioids declined from 2003–05 to 2012–14, following the imposition of stricter prescribing practices that limited supply and raised prices, the prevalence of past-year opioid use disorders (OUD) actually increased over this time (Jones, 2017). Concurrently, there were dramatic increases in drug-related deaths due to prescription opioid overdose (Han, Compton, Jones, & Cai, 2015). The most recent data from the Centers for Disease Control and Prevention (CDC) show that between 2013 and 2014 the death rate from the most commonly prescribed opioid pain relievers (natural and semisynthetic opioids) increased by 9%, the death rate from heroin increased 26%, and the death rate from

synthetic opioids, which includes illicitly manufactured fentanyl and synthetic opioid pain relievers other than methadone, increased 80% (CDC, 2016).

The state of Illinois has not been immune to these increases. In Illinois, 2135 drug-related overdose deaths were reported from January 1, 2014 through October 31, 2015. Heroin (including when combined with fentanyl) use accounted for 59.3% (1266) of these drug overdose deaths and other opiates accounted for an additional 36.9% (788) of these fatalities. This represents a 60% increase in the number of opiate-related overdose deaths among Illinois residents between 2010 and 2015. Cook County, which includes the City of Chicago, accounted for nearly half ( $n = 607$ , 47.9%) of the statewide heroin overdose deaths. In 2011, the Chicago Metropolitan Area ranked first nationally for both emergency department (ED) mentions (24,627) for heroin (Substance Abuse and Mental Health Services Administration [SAMHSA], Drug Abuse Warning Network, 2011) and percentage (18.6%) of individuals who were arrested and tested positive for heroin (Arrestee Drug Abuse Monitoring Program, 2012). Chicago also reported the highest number of heroin ED mentions (13,178) among African Americans in the country. These data are consistent with a recent study analyzing trends in prescription opioid and heroin-related overdose hospitalizations showing that the highest rates of increase among African Americans for heroin-related overdose hospitalizations

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are in the East North Central census region, which is inclusive of Illinois (Unick & Ciccarone, 2017).

### 1.1. Challenges of linking individuals with OUD to treatment

Despite the increasing numbers and visibility of individuals using opioids and surge in opioid-related overdoses, there is a dearth of mechanisms for helping people with OUD to access and stay in treatment, particularly following an overdose. The efficacy of medication-assisted treatment (MAT) for OUD is well-established for reducing opioid use and associated adverse health outcomes, including death, and positive outcomes are enhanced with longer duration in treatment (Ball & Ross, 1991; Mattick, Breen, Kimber, & Davoli, 2014). However, numerous barriers to accessing MAT (i.e., methadone, buprenorphine) for OUD have been identified. These include (1) limited treatment capacity due to lack of qualified physicians/treatment programs (Jones, Campopiano, Baldwin, & McCance-Katz, 2015; Knudsen, 2015); (2) financial barriers, such as lack of insurance coverage of MAT or inability to self-pay (Burns et al., 2016); (3) regulatory barriers stemming from restrictions on number of patients that qualified individual physicians who dispense these medications can treat or on the licensing of programs (Knudsen, Abraham, & Oser, 2011); (4) geographic barriers, including limited availability of treatment providers or programs in some areas, particularly in rural areas (Rosenblatt, Andrilla, Catlin, & Larson, 2015); (5) attitudinal barriers, including negative attitudes regarding the use of medications to treat opioid use disorders (Alanis-Hirsch et al., 2016) as well as persistent stigma regarding these disorders (Schwartz et al., 2008); and (6) logistical barriers, such as lack of transportation to treatment programs and limited hours of operation (Sharma et al., 2017). One study of over 900 injection drug users in Baltimore showed that a minority (26.2%) had sought drug treatment in the 30 days following their last overdose; the odds of entering any kind of treatment were significantly higher among individuals who had spoken with someone (i.e., spouse or partner, crisis counselor or hospital staff) about drug treatment after the overdose. This suggests that more assertive mechanisms are needed to facilitate treatment entry, particularly following an overdose.

Most efforts to link individuals with OUD to treatment following an overdose have focused on screening patients in hospital ED or inpatient settings, which have shown preliminary evidence of successful engagement. Yet many individuals who overdose and receive emergency intervention from first responders either refuse to go to an ED or, if admitted, leave prior to any effective intervention or referral to treatment. In the absence of treatment following an overdose rescue, there remains a high likelihood that individuals will resume heroin/opioid use and the risk of death increases with successive overdose experiences (Mueller, Walley, Calcaterra, Glanz, & Binswanger, 2015; Stoové, Dietze, & Jolley, 2009). Moreover, individuals who are at risk for multiple overdoses are most in need of assistance, as they typically have co-occurring mental health problems, lack resources or family/social support, and report polysubstance use, particularly involving benzodiazepines (Boscarino et al., 2016; Yarborough et al., 2016).

### 1.2. Peer outreach workers to identify opioid users in the community

Use of peer outreach workers is a promising way to identify individuals with OUD in the community who are not currently in treatment and at risk of overdose, and may be receptive to efforts to help them access it. Dating to the 1980s, NIDA funded a large portfolio of research on developing interventions to identify individuals at risk of HIV, such as injection drug users, engage them in brief informational interventions, and, if receptive, refer them into treatment or other health and social services (Needle, Coyle, Normand, Lambert, & Cesari, 1998). Peer outreach workers commonly work with treatment and other service providers in the target community, make contact with individuals in areas identified as high-risk, and distribute flyers or brochures, thus

increasing access to the target population through referrals from peer networks within the community.

Typically, peer outreach workers are individuals who have experienced the same challenges as the target population; in this case, individuals who have a history of heroin/opioid use, but who have a demonstrated history of treatment participation and are currently in recovery and stably functioning in the community. Their own knowledge of the community, including the venues targeted for recruiting opioid users at risk of relapse and the local treatment/service system, is instrumental in establishing rapport with prospective participants based on common knowledge and understanding (Marshall, Dechman, Minichiello, Alcock, & Harris, 2015). This approach has been validated by a systematic review of over 40 studies using the peer outreach worker model, which concluded that “the evidence for the effectiveness of a community-based outreach strategy is strong” (Needle, Burrows, Friedman, & Latkin, 2005, pg. 45).

### 1.3. Recovery management checkup intervention

An existing evidence-based intervention, the Recovery Management Checkup (RMC; Scott & Dennis, 2003), holds potential for linking out-of-treatment individuals with OUD to MAT. The RMC was developed to engage and link individuals with substance use disorders (SUD) to treatment and support their treatment engagement and recovery. The conceptual framework is based on the public health theory that long-term monitoring through regular checkups and early (re)intervention will facilitate early detection of relapse, reduce the time to treatment re-entry, and, consequently, improve long-term outcomes (Scott & Dennis, 2009, 2010; Scott, Dennis, Laudet, Funk, & Simeone, 2011). This approach does not rely on participants having to initiate help-seeking. Using standard motivational interviewing techniques (Apodaca & Longabaugh, 2009), the Linkage Manager (LM) meets participants in person and discusses with them the benefits of going to treatment, engages in problem solving about their expressed barriers to treatment, and provides assertive linkage (e.g., making appointments, providing transportation, and negotiating access). For individuals who initially refuse the referral to treatment, the LM explores the benefits, consequences, and/or inconveniences of the person's current substance use as well as explores the person's motivation for treatment. Using open-ended questions, the LM explores not only reasons the participant may opt out of the treatment referral but also the potential benefits of treatment. The LM seeks to develop discrepancy between how the participant currently perceives his/her situation and stated goals, and uses the technique of “rolling with resistance” to enhance treatment motivation. The LM assures the participant that the decision is up to him/her regarding treatment, thereby empowering the patient in the decision process and encouraging “change talk.”

The RMC model has been evaluated and shown to be effective in two randomized trials in which individuals were recruited from SUD treatment and received quarterly checkups for 2 to 4 years (Dennis & Scott, 2012; Dennis, Scott, & Funk, 2003; Scott & Dennis, 2009; Scott, Dennis, & Foss, 2005), one randomized trial in which individuals were recruited at discharge from jail and received quarterly checkups for 3 years (Scott & Dennis, 2012; Scott, Dennis, & Lurigio, 2017), and one quasi-experiment with patients recruited from Federally Qualified Health Centers (FQHC), with RMC focused on the initial referral to treatment, rather than treatment re-entry (Scott, Grella, Dennis, & Nicholson, 2017). Across these four studies, which included participants with a range of types of SUDs, RMC was used to provide ongoing monitoring, early re-intervention and, when indicated, linkage back to SUD treatment for over 1300 individuals. In the longest trial, which included quarterly checkups for 4 years, individuals assigned to RMC were significantly more likely ( $p < 0.05$ ) than those assigned to a control group to enter SUD treatment sooner (13 vs. 45 months  $d = -0.61$ ), enter treatment at any time (70% vs. 51% any admissions,  $d = 0.50$ ), and stay in treatment longer (112 vs. 79 days,  $d = 0.23$ ; Dennis & Scott, 2012). The latter

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