

A Case Study on the Impact of COVID -19 and Social Capital on the Delivery of Medication - Assisted Peer Support

Keywords: Opioid use recovery; COVID - 19; Medication - assisted peer support; Opioids, Social capital, Case study

Abstract

Introduction: The COVID - 19 pandemic has interfered with innumerable services in different sectors of the healthcare industry, including the opioid use disorder recovery community. This community-based empirical study explored the impact of the COVID-19 pandemic and the mutually reinforcing variable of low social capital on the distribution of medication - assisted peer support.

Methods: Six interviews with leaders of a combined medication - assisted and peer support group were conducted to identify the impact of COVID - 19 and low social capital on the substance use disorder recovery community. Specifically, the recovery community is incarcerated individuals receiving buprenorphine treatments and individuals who have been released into the community. Using a comparative analysis of these interview transcripts we identified key areas for procedural changes to reduce the impact of the COVID - 19 pandemic and low social capital on the delivery of medication - assisted peer support.

Results: Two major themes were elucidated through interviews with six peer support organization executives (PSOE) and recovery peer support specialists (PSS): the effect of the COVID-19 pandemic on the delivery of medication - assisted peer support services and the effect of low social capital factors on the delivery of substance use recovery resources. Secondary to these themes, services have dropped from daily group activities to difficult-to-schedule weekly one-on-ones, and constant barriers in communication with participants secondary to the COVID-19 pandemic.

Discussion: Losing interpersonal relationships of medication - assisted peer support has disproportionately affected those who otherwise have none, resulting in a loss of accountability in recovery efforts. By increasing the duration and frequency of meeting times and hiring additional service leaders to take on these responsibilities, there can be a restoration in the value of the program. Additional studies are needed to further clarify the impact of COVID - 19 on the SUD recovery community, the complications of low social capital on the SUD recovery community, and strategies to help mitigate the impact of COVID - 19 on these issues.

Conclusion: In the opioid recovery community, the distribution and efficacy of medication - assisted peer support programs have been severely reduced by COVID - 19 and social capital related factors - and often a combination of the two. Through this case study, we have identified targeted areas of improvement to optimize medication - assisted peer support and other recovery resources.

Introduction

In the United States, the past thirty years have seen an increase in the use of prescription opioids that is commonly known as the opioid epidemic. The 2019 National Survey on Drug Use and Health indicates that 8.3% of people, 12 years old or over, have used illicit drugs in the past year. One approach to treating individuals with an opioid use disorder is peer support services (PSS). Peer support involves providing non-clinical assistance from individuals with



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similar conditions to patients who are recovering from conditions such as opioid addiction, alcohol addiction, and certain mental health illnesses. Some programs combine these peer support services with medication - assisted treatment to help promote “whole - person” recovery in individuals with substance use disorder. Medication assisted treatment (MAT), is the combination of opioid agonist treatment (i.e., methadone) or partial agonist (buprenorphine) with counseling and other forms of therapy for the treatment of opioid use disorder. The combination of PSS and MAT is referred to as “Medication - assisted peer support” [1-3].

Certain programs focus on administering peer support and clinical treatment to individuals recovering from substance use disorder who are incarcerated [4]. These programs address the impact of economic restraints on substance use disorder, breaking cycles of problematic opioid use, and criminal justice system involvement. Peer support programs are also imperative for previously incarcerated individuals who are released from prison as they have a high risk of post - release opioid - related overdose mortality [5,6].

Social capital framework

Social capital is a concept that focuses on social relationships between people that include a variety of factors such as community networks, civil engagement, and personal connections [7,8]. Community programs that provide recovery support services to individuals suffering from opioid use disorder (OUD) rely heavily on social capital. Social capital factors such as a lack of social capital (i.e., lack of access to stable income, education, and housing) and lack of access to civic resources (i.e., community centers and libraries) may lead to higher rates of opioid - related deaths [9]. Researchers found that countries with the lowest amounts of social capital tend to have the highest overdose rates [7].

In addition to the lack of access to social capital resources, there are mass incarcerations of individuals for drug crimes that further reduce the social capital of individuals with substance use disorder. Mass incarcerations limit access to social capital resources such as peer support, educational opportunities, and community resources

[7]. In Abbott et al. (2019), researchers found that social capital in the form of peer networks was important for the promotion of well - being. Furthermore, researchers found that social capital plays an important role in the recovery process, which is described using the concept of “social recovery” [5]. In addition, barriers to social capital and ultimately “social recovery” negatively impact the recovery process [6].

Access to programs that provide clinical and peer support recovery services are also subjected to barriers posed from racism or bias. Minority communities are disproportionately affected by substance use disorder and require clinical and peer support recovery services. And yet, they are also subjected to barriers posed from discrimination due to race or bias. Researchers found that physician bias, coupled with inherent healthcare system biases led to obstacles for minority groups in accessing healthcare providers that offer medication - assisted opioid recovery.

COVID - 19 has created new challenges for the opioid recovery community through disrupting many social networks (i.e., in - person recovery programs) that are central to building social capital. Benton et al., (2020) details that social capital is valuable and there needs to be creative methods to support social networks during the COVID - 19 pandemic [10]. This study indicates that there is a new set of concerns that focus on the current COVID - 19 pandemic in terms of social capital and ultimately the recovery community.

The COVID - 19 pandemic has strained financial and clinical resources for healthcare institutions throughout the United States [1]. One aspect of the healthcare industry impacted by COVID - 19 is the delivery of opioid recovery resources. Specifically, the delivery of both clinical treatment and peer support services are vulnerable to the impact of COVID - 19 [11-13]. However, the impact of COVID - 19 on the delivery of combined clinical treatment and peer support services to individuals who are incarcerated has not been fully elucidated. This study explores the impact of COVID - 19 on the combined medication - assisted and peer support using a social capital lens to better understand the relationship between the opioid epidemic, treatment, and recovery.

Methods

The IRB institution from a Southern metropolitan university reviewed the study and deemed it exempt. Six peer support organization executives (PSOE) and recovery peer support specialists (PSS) from a community-based organization with knowledge of combined medication - assisted peer support were selected for interviews. We conducted interviews virtually due to the COVID - 19 pandemic.

Since its inception, this recovery - community organization has provided service provider navigation, linkages with treatment providers and community resources, advocacy, harm reduction training, recovery planning, and support groups. This organization delivers 15,000 hours of recovery support services and 12,264 hours of outreach annually and serves 1100 individuals experiencing SUD in the local county each year. Services are tailored to support long-term, sustained recovery and self-sufficiency; the average length of participant engagement is 123 days. The staff includes 17 certified peer specialists, along with 2 full - time Case Management Personnel

and two executives. They have also partnered with the county to offer peer support services in the local jail, coordinated with stakeholders to provide housing for unsheltered persons residing in an encampment in a local park, and established a partnership with the Department of Children and Families to provide services for adults with child welfare and dependency court cases.

The inclusion criteria included organization leaders who were involved in implementing the program, such as the CEO of the recovery program and the clinical director who oversee the medication - assisted peer support service. To gain insight on the daily operations of the prison recovery program we included interviews from four peer leaders who were involved in delivery of medication - assisted peer support. Peer leaders not involved with the medication - assisted peer support division of the recovery program were not included.

The research team has an ongoing university-community partnership with the recovery community organization (RCO) one area of equal interest is a forthcoming evaluation of the medication - assisted peer support program. The data collection procedures consisted of six interviews ranging in length from 30 - minutes to 1 - hour using the CISCO video software WebEx. Participants agreed to an informed consent and answered six questions listed in below. We digitally recorded the interviews, and audio files were safely saved on a password protected computer. Following the interviews, we uploaded the audio files to the audio - transcription service REV.com. We then transferred the transcripts to the analysis program NVivo.

Interview questions used to collect data from peer - support organization executives and peer leaders.

- How has delivery of medication - assisted peer services changed due to the recent COVID - 19 pandemic?
- What challenges have you faced in delivering peer services to participants during the COVID - 19 pandemic?
- What changes have you noticed in medication - assisted peer services participant engagement and satisfaction during the COVID - 19 pandemic?
- What feedback have you received from participants about delivery of peer services during the COVID - 19 pandemic?
- Do you have examples of successful strategies that improved delivery of peer services during the COVID - 19 pandemic?
- How do you navigate delivering peer services to participants who are different from you?

Upon completion of the interviews, we used constant comparative analysis methods to analyze the results and develop concepts and themes via coding information from transcribed interviews (Glaser et al. 2017). The interview transcripts were uploaded to the NVivo analytical software and additional coding was performed to generate themes. After data saturation using a social capital framework, themes were decided upon after discussion with PSOE and PSSs. To promote credibility, we worked closely with the CEO and operations manager of the peer support organization who provided further insight to the development of these themes. After member checking, the community stakeholder agreed that the themes represented common concerns found in the majority of cases.

Given the questions that still remain as to what exactly constitutes good qualitative work; several guidelines for writing and disseminating qualitative manuscripts were followed [11].

Results

Participant Characteristics

There were N=6 peer support organization executives (PSOE) and peer support specialists (PSS) who met the inclusion criteria for participation in the interviews. All peer support specialists were certified to work in the peer support field and actively work for a community - based peer support organization in the Southern United States. Table 1 identifies the interview participants based on position and gender identification.

Themes

Two major themes were elucidated through interviews with PSOE’s and PSS’s (considered major if identified in at least half of the interviews):

- The effect of the COVID-19 pandemic on the delivery of medication - assisted peer support services and
- The effect of low social capital factors on the delivery of substance use recovery resources.

These themes are represented in Figures 1 and 2, below, along with specific issues (subthemes) related to these themes impeding access to necessary services.

Theme 1: The effect of the COVID-19 pandemic on the delivery of medication - assisted peer support services.

Table 1: The sex and position of the six members interviewed for this study.

Peer support organization executive	Peer support specialist
1 male	3 males
1 female	1 female
N = 2	N = 4

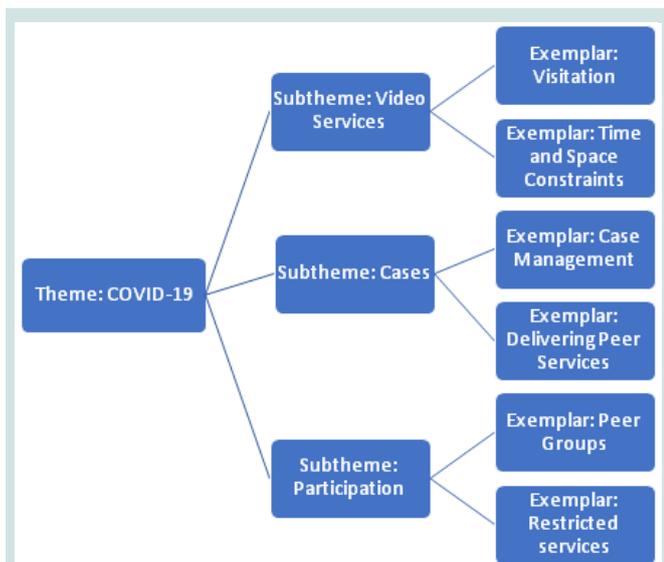


Figure 1: The subthemes and exemplars under the COVID – 19 theme.

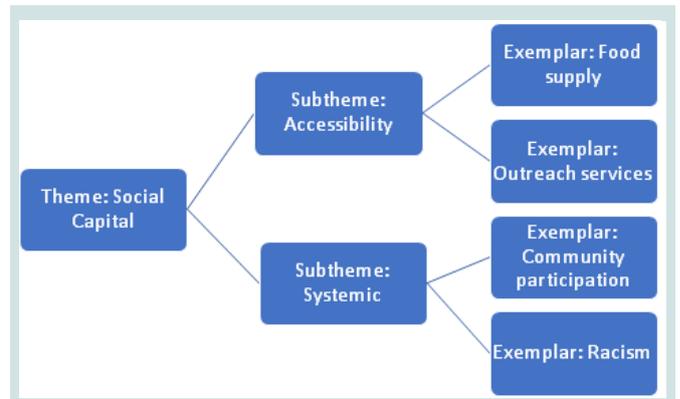


Figure 2: The subthemes and exemplars under the Social Capital theme.

In reference to the COVID-19 pandemic, we identified video services, cases, and participation as critical subthemes that represented barriers to medication - assisted peer support.

Video Services:

Within the subtheme of video services, visitation (n=5) and time & space constraints (n=3) were mentioned by interviewees as issues reducing access to interpersonal relationships necessary for keeping program participants motivated and accountable. A PSOE stated that: “The program participants did not always play nice, everybody does not communicate well, we were getting mixed messages on how we could still see them, how we could talk to them, can we have video conference and what that looks like for delivering services.” This constant miscommunication with program participants was compounded by higher-ups telling service leaders that they were: “...only able to conduct direct services periodically through a video telecommunications center.” (as stated by a PSS).

A PSS mentioned that specifically in the prison dorms, there is only one video visitation room, a limitation related to COVID-19. This has, according to a PSOE, caused “A huge shift, that we’re not able to make the same impact with individuals using substances over the phone or video call that we would be in person because there are certain intricacies about when you’re speaking to them that just don’t translate well over video or other lines of digital communication.”

The new video services format, secondary to COVID-19, has caused time and space constraints that, although do not sound like a huge hindrance, create an extra barrier to interpersonal relationships at the core of peer support. A PSS stated that: “It’s a whole thing to the set up a fifteen-minute visitation when I can normally just drive to the prison and go see who I want to see.” A PSOE mentioned a more severe, yet not uncommon, case: “It took probably six to eight weeks before we could actually set up a video conference with the guys.”

Cases

The second subtheme encompasses issues with case management and the delivery of peer services, secondary to COVID-19 case changes. When comparing organizational cohesiveness prior to and during the current pandemic, a PSS stated: “Just staying connected as an agency and letting our case managers and our supervisors know what was going on, made it a lot easier for everyone to be on the same

page to continue to provide services.”Now that case management is being done completely remotely, there is disjointedness within the organization, which has led to vital information regarding participants’ recovery progress go unnoticed, causing a reduction in needed services being distributed to those who need them immediately [15].

A PSOE stated the following that highlights the shift from live meetings with providers to the distance - based format, which has caused an overextension of service leaders’ duties outside of the norm: “We had our case managing entity hold calls with all the providers that are in this network every week. Having these calls in place where everybody was that gets paid by the managing entity here; we were all on calls at 8:30 every morning on Monday, Wednesday and Friday” [17-19]

Prior to the pandemic, peer services themselves were delivered in a variety of different ways, including “outreach work from going into the local communities, all the respite facilities” (according to a PSS). This scope has now been severely limited. This again has changed the efficacy and crux of the program itself. An additional PSS stated that: “Obviously, when I received peer services, before I became a peer counselor, I was able to make better connections with folks face to face, person to person; you’re able to read body language better, and all in all just build trust a little bit easier” [20,21].

Participation

The final subtheme elucidated by interviewees (n=3) is a reduction in participation from program participants themselves, within peer groups and the other restricted services. Loss of the central interpersonal relationships provided by medication - assisted peer support due to difficulty scheduling visits, reduced visitation time, and one-on-one meetings (rather than daily face-to-face group work based on The Wellness Recovery Action Plan) has caused participants to devalue the program itself. A PSS mentions: “I’ve had one individual a couple months ago that didn’t want to continue participating in peer services upon release from the program because he wanted to know what he could get from our organization.”

An additional PSS juxtaposes the highly involved curriculum before and during the current pandemic: “We went from doing several groups a day collectively and doing several one-on-ones, keeping constant updates, down to only being able to meet with a participant via telecommunications maybe once a week for 10 to 15 minutes at a time.”In the same vein, a PSS says: “Delivering services in the medication - assisted peer support program, it almost became nonexistent, because we went from doing several groups a day to none at all” [22,24].

Theme 2: The effect of low social capital factors on the delivery of substance use recovery resources.

In reference to low social capital, we identified accessibility and systemic issues as barriers to medication - assisted peer support.

Accessibility Issues

Participants (n=5) mentioned accessibility to resources as a barrier to the delivery of medication - assisted peer support. A PSOE mentions the interruption of the 60-day program (which involves buprenorphine treatment, peer group activities, and self- reflection):

“Frustration with not being able to access to services or for folks who want to sign up, frustration having their services cut, essentially in the middle of what’s supposed to be a 60-day program.”

Many participants, incarcerated individuals specifically, are affected by a restriction in program resources. A PSOE mentioned: “That was a huge shift, but specifically with the medication - assisted peer support program is that incarcerated individuals are not given access to phones and computers that would even allow for the delivery of tele health services in any form” [25].

Issues with access are not localized to program services, however. Interviewees mentioned general reduced access to food supply as a barrier faced by those with low social capital. A PSS shared the following: “People I’ve worked with have always struggled with obtaining food stamps and following through certain obligations that they need to, to get these services.” This shifts the program participant’s focus from recovery efforts to basic survival, further limiting access to peer support due to participant’s inability to attend meetings. This compounded with the loss of interpersonal relationships central to the program itself greatly reduces willingness to participate.

Outreach services have also been severely reduced secondary to the COVID-19 pandemic, and disproportionately affect those with low social capital. In reference to the reduction of services themselves, A PSS mentioned the following: “I don’t know if it’s just because no contact or we haven’t been able to perform as many outreach services as of late, but I’ve noticed at least on my end, that there’s been a pretty significant drop off of participants coming through and signing up for services.” In reference to how this affects those with low social capital, A PSOE mentions the difficulty in providing resources to individuals who are homeless during the COVID-19 pandemic: “It’s harder to get somebody into housing, because COVID has diverted a lot of housing money towards individuals who work part time and have been laid off. We are utilizing a lot of resources, to take care of ensuring that rent protections are put in, when they’re laid off through no fault of their own, which means that less individuals are accessing those things who don’t have jobs.”

Systemic Issues

Interviewees (n=3) mentioned systemic barriers that further impede the delivery of medication - assisted peer support. Community spread of COVID-19 within prisons, compounded with the lack of telehealth resources for peer support and other recovery services cause a positive feedback loop for individuals with low social capital who are becoming more and more disadvantaged in their journey to recovery. A PSOE states:“Individuals are being arrested for petty crimes, small time drug possession, that are still being introduced into the jail and are being exposed to COVID through community spread, and they’re trying to isolate it as best as possible when realistically had they adopted a lot of these tactics that we’re using, with the rest of our community participants much farther back instead of trying to intentionally bar access for inmates from telehealth services, they could have potentially prevented an outbreak from even happening because there would be less contact.”

This compounded with race inequities puts minorities at a higher disadvantage when it comes to accessing recovery services. A PSOE stated the following:“They explicitly impact black and brown

communities at a higher rate than they do white communities because incarceration and the crimes that are listed on the exemption list, we know that black and brown people are charged or arrested for those crimes at a higher rate than white people despite data showing an equal rate of committing of crimes across white people to black and brown people.”

In addition, interviewees mentioned that community participation is imperative for keeping individuals involved in medication - assisted peer support. Without this collaboration, individuals are not being motivated or held accountable for their recovery efforts. A PSEO mentioned the following: “It’s more difficult to stay in contact with individuals who are suffering from opioid use disorder if they’re not being referred back into the community program, which is where most of the navigation of care would take place upon release.”

Discussion

Two main themes, the effect of COVID-19 and the effect of low social capital, were found to greatly impede the delivery of medication - assisted peer support services and substance abuse recovery resources. Within these issues, specific subthemes were identified that uphold these barriers: time and space constraints, reduced efficacy in communication and case management, almost complete loss of interpersonal activities, reduced outreach services to those disproportionately affected by COVID-19 and low social capital, and, in the case of prison inmates, restriction of necessary resources altogether. These results are consistent with other findings in literature that highlight the impact of COVID - 19 on the separate delivery of medication - assisted treatment and peer support [13].

There is little fidelity in delivering adequate services in “15-minute sessions,” especially via video systems. One area of improvement is increasing frequency and duration of these meetings, resuming the building of interpersonal relationships and support systems for program participants. This may require hiring of additional service leaders to accommodate their rising responsibilities since the COVID-19 pandemic began. Increasing frequency of meetings can also improve the case management issues identified; specifically: more frequent meetings between service leaders and program participants can increase the amount of case-relevant information being relayed to case managers and supervisors who can make important decisions regarding a participants’ care.

Interviews conducted with peer service leaders indicate the necessity of initiatives that address the lack of face - to - face interaction and outreach services that occur secondary to the COVID - 19 pandemic. The Wellness Recovery Action Plan (WRAP), a personalized and structured wellness process, was implemented as a substitute for live interaction with peer leaders and has been shown to have positive outcomes for recovery participants [6]. Service outreach has been greatly reduced secondary to COVID-19, and this disproportionately affects individuals with low social capital (ex. incarcerated or previously incarcerated individuals and individuals experiencing homelessness). Recent studies have shown that the creation of solutions for these individuals would increase program enrollment, reduce the chance of relapse or overdose, and reduce the possibility of these individuals, who are also at a higher risk of being arrested for petty drug-related crimes, from entering prison

systems where there is a risk for community COVID-19 infection and lack of telehealth services and other recovery services [8]. The crux of medication - assisted peer support services is its creation of interpersonal connections for those who otherwise have none. With the services that foster these connections currently running at a small fraction of what once was, participants from lower socioeconomic backgrounds are struggling to see the point of continuing in the program, especially when other more pressing issues, like accessing food, shelter, and safety are at the current forefront of their day-to-day [25-27]. Further studies can elucidate the effect a lack of interpersonal connections has on individuals of minority groups.

Limitations

The results of this case study are limited by the structure of the study, sample size, and potential for bias. The interview structure of this study allows the risk for error bias based on interview questions and interviewee response. The relatively small sample size (N=6) is a limitation for making generalized conclusions. However, this small sample size is typical of case studies, especially those studies of new ideas, and may be transferable to other community recovery organizations (Bacchetti et al., 2011). Accounting for these limitations, important conclusions are identified from the results of this study.

Conclusion

During the COVID - 19 pandemic, obstacles have arisen throughout the healthcare field. One specific demographic that has been negatively affected is the opioid recovery community. In the opioid recovery community, the distribution and efficacy of medication - assisted peer support programs have been severely reduced by COVID - 19 and social capital related factors - and often a combination of the two. This empirical study has led us to identify targeted areas of improvement to optimize medication - assisted peer support and other recovery resources. Further studies are necessary to create specific solutions and to identify additional areas of these recovery programs that are being negatively affected. These can in turn lead to the improvement of medication - assisted peer support, aiding those battling substance abuse and helping to reduce relapses and drug - related injuries during this pandemic. Ideally, these targeted improvements would result in far-reaching and lasting improvements in the system that would benefit the substance use recovery community beyond the COVID - 19 era.

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