AIDS and Behavior (2020) 24:2999–3002
https://doi.org/10.1007/s10461-020-02933-y

NOTES FROM THE FIELD

Adapting Substance Use Treatment for HIV Affected Communities During COVID-19: Comparisons Between a Sexually Transmitted Infections (STI) Clinic and a Local Community Based Organization

Brooke G. Rogers[1,2] · Trisha Arnold[3,4] · Anna Schierberl Scherr[3,5,6] · Sabrina H. Strong[2] · Rich Holcomb[7] · Colleen Daley Ndoye[7] · Megan Pinkston[2,3,6] · Philip A. Chan[1,2]

Published online: 27 May 2020

COVID-19 has disrupted our daily routines and may be particularly detrimental to individuals using substances, and in particular opioid and crystal methamphetamine users according to the National Institutes of Drug Abuse [1]. There is high co-occurrence of crystal methamphetamine and HIV incidence among men who have sex with men (MSM) [2–4] and growing concern about susceptibility to COVID-19 [5]. Though, to date, there are few community resources for evidence-based treatment.

Project BREAK is a substance use treatment program for individuals in New England who are at-risk for or living with HIV, predominantly for MSM who use stimulants, including crystal methamphetamine, and/or opioids. Project BREAK offers substance use treatment in non-traditional settings. The program's sites include a Sexually Transmitted Infection (STI) Clinic and a Community Based Organization (CBO) that provides services to individuals using substances and engaging in sex work. This integrated model of care aims to: (1) reach populations at-risk or living with HIV underserved by existing behavioral health services and (2) to increase capacity at both sites to provide behavioral health services. This manuscript describes changes to the program in response to COVID-19 and implications for other substance use treatment programs.

Project BREAK: An Affirming Substance Use Treatment Program

Project BREAK is theoretically grounded in minority stress theory, which posits that individuals with sexual minority identities and behaviors experience undue mental health burden as a result of systemic discrimination [6–8], and resiliency theory, which recognizes that in order to overcome societal marginalization, individuals have developed resiliency coping that can be leveraged to improve psychosocial functioning [9, 10]. The program is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and was in the process of establishing its treatment program when COVID-19 emerged (February 2020).

The STI Clinic Site provides a range of ambulatory care clinical services (e.g. STI testing and treatment, HIV testing and counseling, and linkage treatment) while the CBO Site offers case management, basic needs (e.g. clothing, food), and harm reduction supplies (e.g. clean needles, naloxone, condoms) and free HIV and Hepatitis C Virus (HCV) testing during "drop-in" center hours. Both sites offer evidence-based psychotherapy delivered by clinical psychologists who utilize an integrated approach grounded in cognitive behavioral therapy; however, therapy is flexibly tailored. The STI Clinic Site has offered traditional, 30–60-min therapy sessions weekly, bi-weekly, or monthly dependent upon client needs. Comparatively, the CBO Site has operated as

✉ Brooke G. Rogers
brooke_rogers@brown.edu

1 Department of Medicine, Warren Alpert Medical School of Brown University, Providence, RI, USA

2 Department of Medicine, The Miriam Hospital, Providence, RI, USA

3 Department of Psychiatry and Human Behavior, Warren Alpert Medical School of Brown University, Providence, RI, USA

4 Department of Psychiatry, Rhode Island Hospital, Providence, RI, USA

5 Department of Psychology, University of Massachusetts, Dartmouth, Dartmouth, MA, USA

6 Department of Psychiatry, The Miriam Hospital, Providence, RI, USA

7 Project Weber/RENEW, Providence, RI, USA

"drop-in" psychotherapy with less consistent session structure and timing.

Prior to COVID-19, at the STI Clinic Site, several clients engaged in ongoing psychotherapy. Most had already completed multiple sessions (ranging from 3 to 10), had established rapport, and were meeting weekly, bi-weekly, or had transitioned to monthly check-ins. All STI clients engaged in ongoing psychotherapy had stable housing and some regular form of work or school with one exception for a retired individual. Most clients were in remission or had significantly reduced substance use.

Conversely, at the CBO Site few clients were engaged in ongoing psychotherapy. More frequently, clients at this site attended sessions spontaneously at the drop-in center during "office hours" on a first-come-first-serve basis. None of the clients had stable housing; instead, they were staying with family, living with casual sexual partners, or living in a recovery house paid for by the grant. Almost all clients reported difficulties in their current living environment. None of them had a steady source of income or were enrolled in school.

Program Transitions: Differential Adoption of Telemedicine

As COVID-19 became a public health crisis both the sites instituted new policies that shifted the program to telemedicine to protect both providers and clients in line with recommendations made by the American Psychological Association [11, 12]. Capacity to provide telemedicine was scaled in weeks. First, the clinical psychologists involved in the program attended telehealth best practices webinars from professional organizations to ensure adequate competency. Second, HIPAA-compliant web conferencing software was acquired for communication with clients. Third, existing safety protocols were updated to include measures for remote therapy: consent from clients to complete telehealth sessions and acquire client addresses for safety risks. Fourth, guidelines were developed to share with clients around telehealth etiquette and privacy considerations. Finally, clients were offered the opportunity to engage in teletherapy. We made this transition to continue to support clients in treatment. Many clients experienced heightened urges to use substances in response to increased stress and uncertainty. Given social isolation is a risk factor for relapse or increased substance use, continuing to offer services through this time was critical [13].

This transition resulted in increased access for those at the STI Clinic Site, but unfortunately decreased access for those at the CBO Site. At the STI Clinic Site, 100% of clients successfully transitioned to teletherapy and many chose to increase the number of weekly sessions they attended. Conversely, at the CBO Site, efforts to translate care to a virtual model were made but have proven unsuccessful. Initially, we considered offering telehealth at the drop-in center, but in response to COVID-19 the center significantly limited hours, staff, and client access, which eliminated this care option. Subsequently, a systematic effort was made to outreach clients via phone call, email, text message, and social media to offer telemedicine appointments. Many clients had incorrect information, several others chose not to respond, and the few that did respond never followed through on appointments. At this time, none of the clients at the CBO Site have received care via telemedicine.

Program Transitions: Adaptations Made to Substance Use Treatment Content

Given the increased stress participants were under and potential for relapse, intervention content was modified across settings. At the STI Clinic Site where psychotherapy continued via telehealth, clinicians included "pandemic specific" intervention targets. The additional pandemic psychosocial intervention included keeping regular routines, managing stress, engaging in pleasant activities, sleep hygiene, and normalizing and accepting emotional responses [14]. In many cases, the number of sessions was also increased depending on clients' needs. Clients were encouraged to schedule additional sessions to help support their adjustment to quarantine and prevent relapse.

Program Transitions: Adoption of Task Sharing at CBO Site

The CBO Site adapted to COVID-19 by transitioning to a task-sharing approach**.** The long-standing drop-in center where clients typically met with the therapist significantly reduced its hours and restricted access for clients. However, staff remained engaged in community outreach efforts to provide basic needs, harm reduction supplies, and services to those in need. Because clients did not have a way to connect to telehealth, the psychotherapy treatment model was adjusted so that Peer Recovery Coaches (PRCs) could fill this gap. Because peer-based recovery can be more flexible with regards to delivery of coaching (e.g. Facebook calls or texting or stopping by their place of residence in-person), timing of coaching (e.g. late nights and weekends); and, frequently utilize additional community resources (e.g. online 12-step recovery meetings) this was an appropriate option. So far, this model has been successful and PRCs routinely report 15–20 contacts per week and communication with 5–10 clients.

In lieu of direct client care, the program therapist who had been seeing clients at that site has worked with the PRCs to establish weekly meetings during which PRCs provide updates on clients. Discussions include substance use and mental health challenges of clients as well as intervention techniques (e.g. building motivation, responding to discord) and process elements of clinical work (e.g. countertransference, reactance). PRCs also communicate with this provider through e-mail and phone calls throughout the week to discuss referrals and services (e.g. residential treatment, sober housing) for enrolled clients. Throughout these meetings the provider has taken a collaborative stance towards treatment planning that values and respects PRCs' feedback and recommendations.

Similar models of "task sharing" have been used in low- and middle-income countries and low resource settings for delivery of behavioral health care in HIV settings and has proven successful [15–17]. This model has demonstrated preliminary feasibility, acceptability, and effectiveness during the COVID-19 pandemic at this local CBO and may be sustainable beyond this period. This approach could optimize provider outreach while also building capacity among PRCs who have lived experience, but less formal training in behavioral health.

Lessons Learned and Future Directions

COVID-19 has systematically changed the way we deliver substance use services to our clients at-risk for and living with HIV. Clients at the STI Clinic Site were able to maintain care via telehealth, while clients at the CBO Site lost touch with the provider. We need to be mindful of the power of the social determinants of health and how this pandemic is shaping not only health care disparities, but also behavioral health care disparities [18]. The difference in access to eHealth services is not surprising. There are significant social inequities that exist between these two client groups and COVID-19 has illuminated these differences with eHealth being an example of a service that may inadvertently widen health disparities [19]. In the meantime, we have been able to effectively use task sharing with PRCs to continue to provide behavioral health services for those at-risk and living with HIV during COVID-19.

Acknowledgements Author time for Dr. Arnold was also supported by T32MH078788 and R25MH083620.

Funding This project was funded by SAMHSA grant #H79TI080656.

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