The Risk Avoidance Partnership (RAP): The Story of a Peer Harm Reduction Intervention for Drug Users

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The RAP Model

RAP is designed to train active drug user as Peer Health Advocates (PHAs) to disseminate HIV prevention intervention through drug user networks to high risk drug-use sites.

- **PHA training curriculum** focuses on role modeling for dissemination and demonstration of prevention practices and practice of persuasive communication techniques.

- Trained PHAs provide the **RAP Peer-led Intervention** to their drug-using peers and others in their communities, based on harm reduction and health promotion approaches.

- **Community Advocacy Group** monthly meetings support trained PHAs to participate in health advocacy in their communities on behalf of themselves and their peers.
Formative Research for RAP Development:
The Study of High Risk Sites (HRS)

AIMS:
To document:
• High risk drug use sites
• Drug users’ risk networks
• Site users’ receptivity to on-site prevention intervention
• Potential diffusion of peer-led, on-site prevention messages

METHODS:
• Street outreach and intensive ethnographic observation of drug-use sites
• Exploratory in-depth interviews
• Site survey check list
• Epidemiological/network survey
Social networks have been studied in order to:

- Look at the social context (personal, group) of behavioral risk
- Explain HIV prevalence differences in subpopulations (e.g., by looking at differences in network structure and HIV prevalence in the network core)
- Predict future movement of the virus
- Identify specific social-level prevention needs or options (e.g., diffusion of benefits through networks)
- Implement peer-focused prevention interventions
High Risk Sites Drug User Social Network: Recommended Peer Educators

Key
Central network members (non-overlapping)  

- African Am. Cluster
- Puerto Rican Cluster
- White Cluster
High Risk Sites Drug User Social Network: Peer Educators’ Direct Contacts

Key
Central network member
Direct contact
Indirect contact

Puerto Rican Cluster
African Am. Cluster
White Cluster
HRS Social Network Findings

- Training 14 non-overlapping drug users in the HRS network to deliver intervention to their immediate contacts could reach over 66% of the total HRS network.

- PHAs need to be recruited from each of the main sectors of the HRS network because of the small number of bridges across sectors.

Based on HRS findings, we developed and piloted a PHA training curriculum with 10 drug users from the HRS network to create the RAP peer intervention design.
RAP Peer Health Advocate (PHA) Training Program Goals

- **Provide information on transmission and prevention** of HIV, STDs, and hepatitis so trainees can answer questions of peers.

- **Provide understanding of health “advocacy”** at the personal level (as role models) and at the community level, so trainees can become effective Peer/Public Health Advocates.

- **Provide effective tools and practical approaches** to disseminate harm reduction and health promotion messages and methods.
RAP PROGRAM DESIGN: PHA Training Curriculum

10-Session Training Program:

- **Session 1** (in-office): introduce key concepts and project goals
- **Session 2** (in-office): provide basic information on HIV, STD, TB, transmission/prevention; initiate public health advocacy project
- **Session 3** (in-office): provide basic information on hepatitis; role play risk scenarios
- **Session 4** (in-office): role play intervention scenarios; prepare for field sessions
- **Session 5** (field, in-office): conduct intervention with staff partner; regroup in office for discussion
- **Sessions 6-10** (field): conduct intervention with staff partner
- **Community Advocacy Group** (monthly, in-office): PHA meetings
RAP Peer-Led Intervention Goals

- Reach high-risk individuals with harm reduction and health advocacy messages and materials.
- Introduce and promote methods for harm reduction and disease prevention.
- Reduce harm and increase safety, health, and well being of drug-users through the social network and community-level health promotion and advocacy.
- Bring benefits of the PHA program directly into hidden drug use sites and diffuse benefits through social networks.
Peer-led Intervention Components

Education:
- information on HIV, STI, TB, HBV, HCV
- educational games (Transmission Game)
- health promotion “slogans”

Demonstration:
- syringe disinfection with bleach
- proper condom use
- use of rubber tips for crack pipes/stems
- cooking drug solution to deactivate viruses

Materials:
- health kits (bleach, condoms, wipes, water, etc.)
- rubber tips for crack pipes/stems
- male and female condoms
- brochures, social/health service references, etc.
RISK AVOIDANCE PARTNERSHIP

PEER HEALTH ADVOCATE
INFORMATIONAL FLIPBOOK

Institute for Community Research
Hispanic Health Council

IF FOUND PLEASE RETURN TO:
THE INSTITUTE FOR COMMUNITY RESEARCH
2 HARTFORD SQUARE WEST SUITE 100
HARTFORD, CT 06106

Materials  Slogans  Education  Demonstration
Community Advocacy Group (CAG) Meetings

- Monthly meetings in which trained PHAs discuss and organize themselves around community issues that are of concern to active drug users.
- Topics discussed include access to housing, drug treatment and health care.
- Group meetings also provided opportunities for PHAs to receive additional training on harm reduction techniques, infectious diseases, and how to access services in the community.
- Meetings provided an opportunity to replenish PHAs’ prevention supplies.
Theoretical Framework of RAP Intervention Components

- **Dynamic Social Impact Theory (DSIT) & Social Learning Theory**: strength of communicator (close tie, influential, convincing/appropriate message); immediacy (social/physical proximity); number of peers repeating message.

- **Diffusion of Innovations Theory**: process of adoption/rejection of innovations over time (trustworthy change agents, key opinion leaders, stages from knowledge, to persuasion, decision, implementation, and confirmation)

- **Health Promotion Theory**: empowerment as a strategy for enhancing health, advocating for community participation in addressing health problems
RAP Outcome Evaluation

- Baseline Risk Assessment (pre-training of PHAs):
  - with Peer Health Advocate candidates
  - with 2 Contact Referrals (CRs) [PHA’s network members]

- Ethnographic observations & interviews about:
  - In-office training sessions
  - Staff-partnered field sessions
  - Daily activities regarding risk and prevention in drug use settings

- Post-training (3-month) Closing Interview (PHAs only)

- 6-month Follow-up Risk Assessment (PHAs & CRs)
## PHA Participation in RAP Project Activities

<table>
<thead>
<tr>
<th>Activity</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHA baseline interviews:</td>
<td>174</td>
<td></td>
</tr>
<tr>
<td>Started Session 1 training:</td>
<td>129</td>
<td>(74% of 174)</td>
</tr>
<tr>
<td>Completed Sessions 1-5:</td>
<td>112</td>
<td>(87% of 129)</td>
</tr>
<tr>
<td>Completed 1 or more field sessions:</td>
<td>100</td>
<td>(81% of 129)</td>
</tr>
<tr>
<td>Completed 3 or more field sessions:</td>
<td>69</td>
<td>(56% of 124)</td>
</tr>
<tr>
<td>Participation in CAG meetings:</td>
<td>79</td>
<td>(71% of 112 trained PHAs)</td>
</tr>
<tr>
<td>1 meeting:</td>
<td>32%</td>
<td>(of 79)</td>
</tr>
<tr>
<td>2 meetings:</td>
<td>18%</td>
<td>“</td>
</tr>
<tr>
<td>3-5 meetings:</td>
<td>29%</td>
<td>“</td>
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<tr>
<td>6+ meetings:</td>
<td>22%</td>
<td>“</td>
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</table>
Baseline Survey:
Total Reported Intervention Ties among Study Participants

RAP Drug User Social Network: Intervention Ties Baseline

KEY:
Triangles: PHAs
Circles: Contacts
Black: HAI (highly active interventionists)
Black or Grey: Returned for 6-month survey
White: No 6-month survey
RAP Drug User Social Network: Intervention Ties 6-months

Total Reported Intervention Ties among Study Participants

**KEY:**
- Triangles: PHAs
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RAP Drug User Social Network: Intervention Ties 6-months

6-month Survey: Additive and Cluster Effects of PHAs in Network

KEY:
- Triangles: PHAs
- Circles: Contacts
- Black: HAI (highly active interventionists)
- Black or Grey: Returned for 6-month survey
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Broader PHA Activities Beyond Training and Outside Project

- Participated in CAG meetings, bleach kit parties and other RAP/ICR/CIRA activities
- Provided information to community members on housing
- Demonstrated at legislative offices regarding continuing medical benefits for urban unemployed, especially drug users
- Volunteered in shelters and clinics
- Worked with youth and pastors in churches
- Talked to peers in prison about PHA/RAP
Barriers to Completing Training

- Arrest
- Homelessness and residential instability
- Addiction
- Relationship factors
Motivations to Engage in PHA Work

- Desire to do something positive for the community
- Public recognition and praise for PHA work
- Cut down or abstain from drug use
- Stepping stone for future employment
- Improve relationships with family
- Preventing HIV was for many of secondary importance, although improving health and well-being in their communities was common
- Staff as a role model
Field Observations of PHA Intervention Activity in the Field

- Types of sites selected for RAP interventions included streets, parking lots, shelters, soup kitchens, abandoned buildings, laundromat, restaurant, personal apartments.

- Each PHA established his or her own style to approach friends, acquaintances, and strangers comfortably (one-on-one, gathering a small group, conversational, insistent, etc.).

- PHAs reported feeling proud, important and valuable when engaged in the work, and pleased when friends asked how to become a PHA.

- Staff identified “role change” in PHAs in relation to their peers, indicated by PHA-recognized need to act responsibly regarding risk behavior as model to peers, and peers’ recognition of them as source of prevention and health information and materials.
Outreach Times and Places

PHAs become known to their drug using peers as people with intervention materials.

• Ron: I’m being called the condom man and stuff like that. I have people in my building knocking on my door asking for condoms. So I have to tell them to knock at a reasonable time because 12:00, 1:00 at night, knocking on your door for condoms...During the summer I’d go out on my own because I go to the park anyway, so I just bring my bag and just sit around, play cards...When they see me with my bag, they automatically know I got condoms in it.
Summary of Original RAP Findings

• Peer-led interventions like RAP increase exposure to health promotion and support harm reduction among active drug users.

• The PHA training program was highly acceptable to drug users and encouraged them to advocate for better health among their peers and in their communities.

• RAP significantly changed PHAs’ self-perception as able to contribute positively to the community.

• RAP peer intervention reached places and people through PHA networks that are not open to outreach workers and other health care providers.
Reasons for Translating RAP to Implement it in Drug Treatment Clinics

• Drug treatment clinics have ready access and maintain involvement with drug users.

• Drug treatment clinics often build trusting positive relationships with drug users around health.

• Drug treatment itself has HIV/hepatitis/STD risk reduction benefits.

• HIV prevention interventions in drug treatment settings are additionally beneficial over treatment alone, given high attrition, drug-use relapse and ongoing exposure to HIV risk from engaging in risky behaviors.
Reasons for Translating RAP to Implement it in Drug Treatment Clinics

• Original RAP demonstrated high PHA entry into drug-treatment.

• While in treatment, PHAs continued delivering RAP intervention to not-in-treatment drug users in their networks because of continued proximity in their daily lives and because they valued their new role as a PHA.

• Training in-treatment drug users to reach not-in-treatment drug users in their networks with harm reduction may increase both PHAs’ treatment retention and network members’ decisions to seek treatment and other health care.
RAP Clinic Research Questions

• When conducted with drug users in treatment, how might the following affect the RAP implementation process and outcomes:
  • Treatment clinic organization characteristics (“organizational readiness for change”);
  • Clinic staff characteristics (capacity, attitudes, availability);
  • Clinic patients’ relations to their drug using peers and the community setting (networks)?
• How must RAP be modified to “fit” clinic settings while maintaining essential core components?
• What changes and challenges will RAP implementation in drug treatment clinics bring to those clinics?
Aims of the RAP-Clinic R34 (pilot) Study

• Develop/pilot pre-implementation measures to assess:
  • Organizational readiness/context of the clinics
  • Community context of the new study sites

• Use a participatory process with clinic staff and patients to:
  • Create RAP-Clinic by modifying RAP to fit clinic context
  • Develop capacity building Training of Trainers for clinic staff facilitators of RAP PHA training
  • Develop implementation tracking measures

• Pilot the adapted RAP-Clinic intervention for feasibility and test all instruments and forms during the pilot

• Manualize the modified “RAP-Clinic” intervention and finalize instruments and fidelity documentation forms
Supplementary Information from Clinic Staff and Patient In-Depth Interviews

• Attitudes toward harm reduction and belief in the congruence of RAP with clinic policies and regulations

• Ability and willingness to administer and implement all program requirements, including to partner with RAP trainees in community outreach intervention sessions

• Expectations about the potential of clinic patients to be peer interventionists

• Potential for allocation of resources (time, expertise, appropriate space, materials) to the RAP intervention effort

• Expectations of RAP-Clinic success or failure

• Community characteristics that might affect where PHA-trainees can practice outreach intervention
Findings from the RAP Clinic Implementation Pilot

- It is critical to identify places where clients can reach drug users in safer contexts.
- Attention is needed to assure sufficient staff capacity to implement the program with fidelity, get buy-in, and mitigate concerns about harm reduction principles.
- Input of non-RAP clinic staff increases the likelihood of successful RAP implementation and ongoing clinic-wide support for PHAs’ peer intervention efforts.
- Patients trained as PHAs need multiple supports to continue peer intervention after the training.
- RAP must be integrated with other therapeutic and support activities in the clinic to be effective.
PHA-Train Clinic Patient Interview
Findings: Positive Impacts*

“You know, it’s given me a purpose in my life, now. It’s, you know, I really didn’t never have a purpose to do anything. And this, you know, has given me a purpose to do something and the something is, you know, is to help, you know, people to live better.” -- PHA

“It helps me with my sobriety... It just keeps, you know, it helps me to feel good about my sobriety... and it gives me another reason to stay on track.” -- PHA

“I learned so much from it, you know. It just helped me even more staying clean. You know with all the information that you learn... and not only about what I learned but I get to pass it on to others.” -- PHA

* Kristin M. Kostick, PhD, RETI Presentation, July 15, 2012
Findings: Suggestions for Improvement

- Need for more extensive PHA training & preparation
- Casual “debriefings” with PHAs are needed before and after outreach
- Informal meetings among patients are beneficial
- Post-training transition needs to be carefully considered
Future of RAP Implementation in Drug Treatment Clinics

• A larger clinical trial is needed to test RAP reach, efficacy, and sustainability when implemented in drug treatment clinics.

• Sustainability of RAP requires sufficient funding to support clinic staff facilitators, patient incentives, and prevention supplies.

• Beyond grants, sources of ongoing funding for prevention efforts like RAP are thin. Options must be identified that allow long-term RAP implementation in clinics.
Thank You!

Institute for Community Research: RAP research staff (alphabetical):

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Maria Martinez  Outreach/Intervention Coordinator
Katie E. Mosack  Statistical Data Analyst
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Greg Palmer  Outreach/Interviewer
Juan Restrepo  Data Manager
Eduardo Robles  Outreach/Interviewer
Kim Radda  Project Director
Jean J. Schensul  Co-Investigator
Margaret R. Weeks  Principal Investigator
Oscar Woods  Outreach/Intervention Facilitator

FUNDER: National Institute on Drug Abuse

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The Institute for Community Research

Affiliated study of the Center for Interdisciplinary Research on AIDS (CIRA), Yale University, ICR, HHC


High Risk Sites Publications


Latkin CA. Shield Study: Community Outreach Worker Training. Baltimore: Johns Hopkins University (unpublished manuscript), September 24, 1998b.

References (cont.)


