PILOT

National Institute on Drug Abuse (NIDA)
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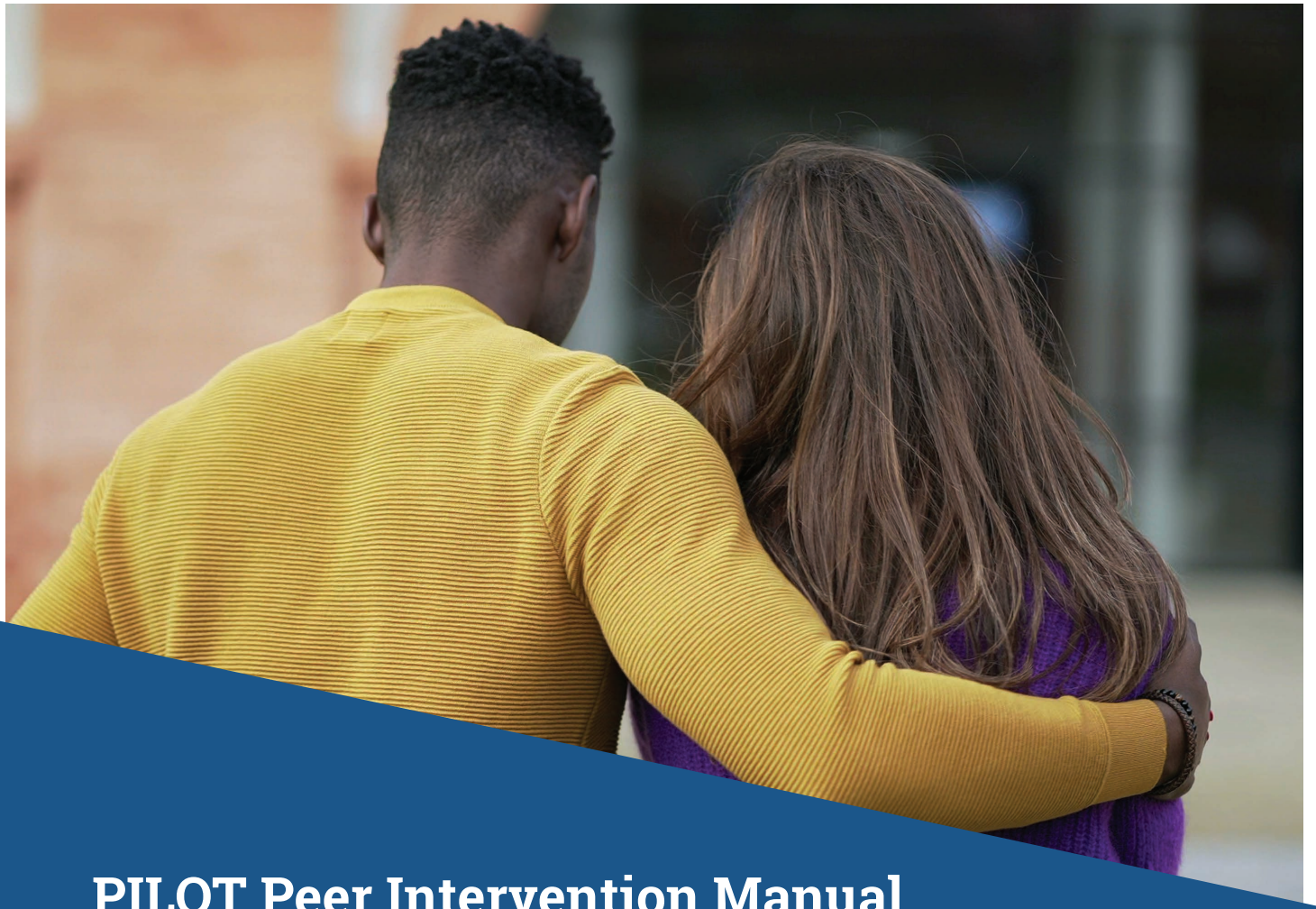

PILOT Peer Intervention Manual

Peer Intervention to Link Overdose Survivors to Treatment (PILOT)

NIDA CTN Protocol 0107

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Version 1.0

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Author List

Author	Affiliation	Organization
Kelly Barth, DO	CTN-0107 Principal Investigator	Medical University of South Carolina
Tim Matheson, PhD	CTN-0107 Project Training Director	San Francisco Department of Public Health
Louise Haynes, MSW	CTN-0107 Co-Investigator	Medical University of South Carolina
Erin McClure, PhD	CTN-0107 National Project Director	Medical University of South Carolina
Carrie Papa, MBA	CTN-0107 Project Coordinator	Medical University of South Carolina
Rich Jones, MBA, LCAS, CCS, CCDP, CAI	CTN-0107 Consultant	YouTurn Health, Heritage Cares
Tricia Lawdahl, CPSS, NCPRSS, NBC-HWC, BSN	CTN-0107 Peer Consultant	FAVOR Greenville

Acronym List

Abbreviation	Definition
CPSS	Certified Peer Support Specialist
CTN	Clinical Trials Network
DSC	Data and Statistics Center
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
ED	Emergency Department
FAVOR	Faces and Voices of Recovery
FORCE	FAVOR Overdose Recovery Coaching Evaluation
EHR	Electronic Health Record
HIPAA	Health Insurance Portability & Accountability Act
ICF	Informed Consent form
IRB	Institutional Review Board
LI	Lead Investigator
MOP	Manual of Procedures
MOUD	Medication for Opioid Use Disorder
MUSC	Medical University of South Carolina
NIDA	National Institute on Drug Abuse
NFOO	Non-fatal Overdose Involving Opioids
OUD	Opioid Use Disorder
PILOT	Peer Intervention to Link Overdose survivors to Treatment
RA	Research Assistant
SBIRT	Screening, Brief Intervention and Referral to Treatment
SUD	Substance Use Disorder
TAU	Treatment As Usual

Chapter 1: What Peers Should Understand: The Background of the PILOT Study and the Intervention Manual

1.0 Use of the PILOT Peer Intervention Manual

This PILOT Intervention Manual is prepared for use by peers working on CTN-0107. The intent of the manual is to provide:

- materials to be used during Peer training
- reference materials to be used during the implementation of the clinical trial
- reference material for supervision

Each peer should maintain a personal copy of the manual, either electronic or hard copy, with their own notes and questions.

At the end of our pilot study, the manual will be revised based on input from Pilot Peers, and a revised manual will be developed for use in any follow-up studies. Your input is valued!

1.1 Overview of PILOT Study: Study Design and Outcomes

The PILOT study will be conducted with participants who have survived a non-fatal opioid overdose (NFOO) and present in one of the 3 emergency departments (EDs) conducting the study. Participants will be randomly assigned to one of two groups: the PILOT peer intervention or Treatment as Usual (TAU). Our primary goal is to see if participants who receive peer support over a six-month period will have differences in overdose risk behaviors than participants who receive TAU.

1.1.1 Study Objectives

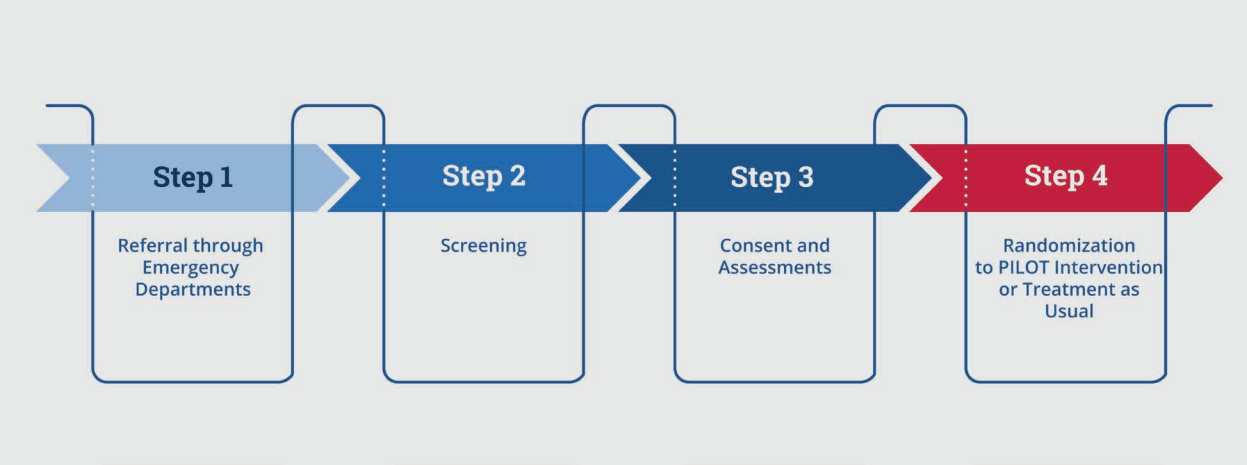
The primary aim of this study is to test the hypothesis that the PILOT intervention will lead to a reduced frequency of self-reported overdose risk behaviors among NFOO survivors at 180 days (end of treatment) compared to TAU.

The secondary aims of the study are to:

1. Evaluate the number of steps achieved along a substance use disorder (SUD) Cascade of Care among individuals with a recent NFOO; and,
2. Assess whether NFOO survivors approached within an ED setting are willing to engage in study procedures and with peer support specialists, measured by number of patients approached compared with number willing to be enrolled, and length of engagement and enrollment in PILOT among those willing to be enrolled and randomized to PILOT.

1.1.2 Treatment, Assessment, Intervention and Duration

Figure 1: Process for Patients Admitted to the Emergency Room to Join the PILOT Study



Study staff, including the Research Assistant (RA) and/or Peers, will identify eligible patients in the ED by reviewing ED track boards, screening, and/or through ED staff identification and referral. All participants will be consented and will complete screening study procedures to determine eligibility. For those participants who have screened eligible and provide consent, screening assessments will be conducted by the RA (or possibly a peer), and then participants will be randomized to the PILOT intervention or TAU.

1.1.3 Treatment as Usual (TAU) Group

Participants randomized to TAU will continue with routine clinical treatment in the ED. All EDs in this study will have peer support specialists in the ED for Screening, Brief Intervention, and Referral to Treatment (SBIRT-like interventions for patients presenting with substance-use disorders). Peer support specialists are referred to as Certified Peer Support Specialist [CPSS] in South Carolina (lead site) but may have other official titles in other states. Thus, aside from standard ED medical treatment, TAU participants may also interact with TAU peer specialists while they are in the ED for an SBIRT-like intervention (depending on staffing and availability).

All TAU participants will be provided with referral and community resource information, consisting of:

1. A handout providing names, locations, and telephone numbers of addiction treatment services in the area.
2. When possible, telephone access to call a clinician or facility of their choice, which will be informed by their method of coverage (insured or not); and
3. Information about receiving naloxone per state regulations and community resources.

TAU participants will also meet separately with the study RA to complete study assessments, including a follow-up visit after the intervention has been terminated (210-day follow-up study visit). To maintain the differences between the PILOT arm of the study and TAU, PILOT Intervention Peers will not interact with TAU study participants.

1.1.4 PILOT Intervention Group

Those randomized to the PILOT intervention will continue with routine clinical treatment as provided in that ED (including the TAU peer as available) and also meet with a PILOT peer – a peer with specialized training in overdose survivor engagement. The PILOT intervention will begin in the ED per the PILOT intervention manual. PILOT contact/ sessions will continue over the next 180 days (6 months) and can be delivered in-person, virtually, or a combination of both approaches. PILOT Peers will use a model based on Assertive Community Engagement (ACE), using Motivational Interviewing (MI) methods (see Appendix IV) and a Strengths-Based Case Management approach (see Appendix VII) to engage participants in care and develop a participant-centered wellness/recovery plan. For some participants this plan may include accessing substance use treatment. For other participants this plan may not focus on stopping use or accessing treatment, but rather reducing

Over the course of the 180-day (6 months) intervention period, PILOT intervention Peers will work with each participant to tailor a plan to meet the specific needs and personal goals of that participant.

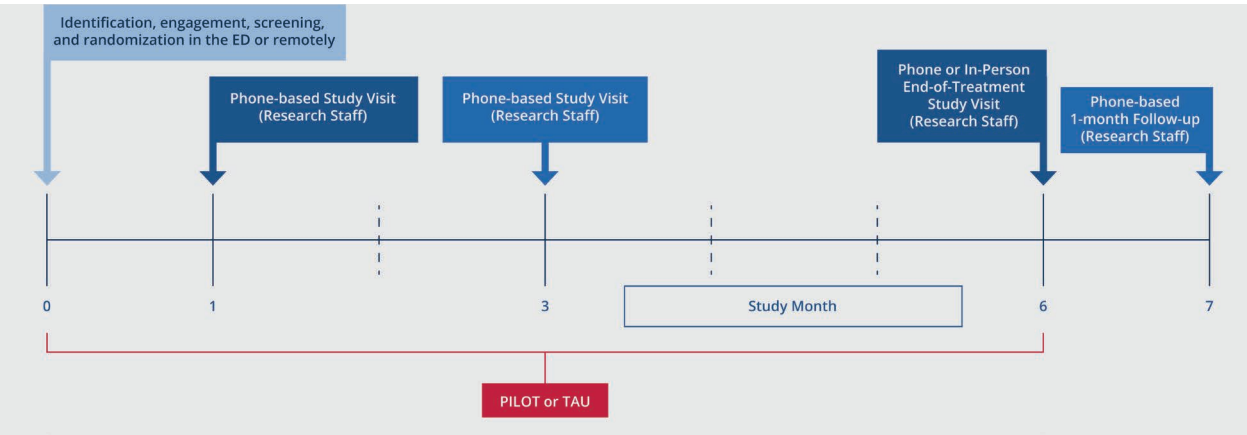
harm around their use, including reducing their risk for overdose (See Appendix X for Harm Reduction Principles and examples). The intervention participant, not the Peer, decides what personal goals to work on, and the Peer will offer support to help the participant reach those personal goals.

All participants, including those randomized to PILOT will meet separately with the study RA for study assessments, including a follow-up visit after the intervention has been completed (210-day follow-up study visit).

1.1.5 Research Follow-Up Visits (All Participants)

Research follow-up visits will occur at 30-, 90-, 180-, and 210-days after randomization to PILOT or TAU (see Figure 2, Study Timeline, below) and will be conducted by the RA via telephone and/or videoconference or in a community setting if the participant does not have a reliable telephone or if technology barriers exist. There will also be weekly mobile surveys sent to participants in both study arms to complete on their mobile device. Participants without mobile devices will be provided one for the duration of the study and follow-up period to complete surveys and provide a means of communication with research staff.

Figure 2: Study Timeline



1.1.6 People Who Choose Not to Participate in the PILOT Study

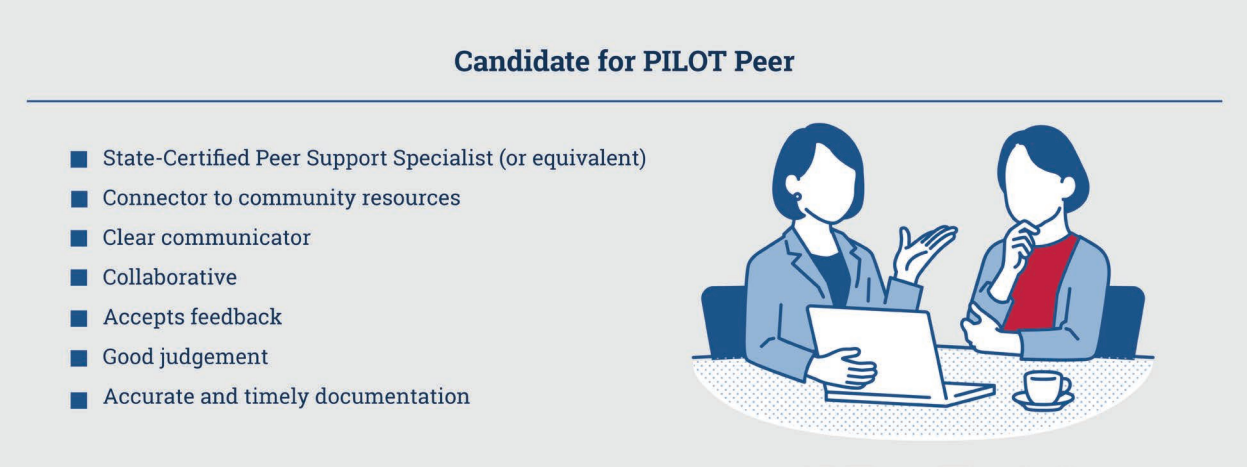
Those who decline to participate in the study will receive treatment as usual as provided in that ED setting and will have the option to fill out a brief de-identified survey to help the study team determine characteristics of suspected overdose and reasons for study decline.

1.1.7 COVID Restrictions

Given recent access restrictions to EDs due to the COVID-19 pandemic, back up plans are in place should access to the ED be restricted for peers and research staff. At any time during study enrollment research staff will be able to engage participants remotely and conduct consent and all study procedures.

1.2 PILOT Peer Qualifications, Knowledge, Training, Experience and Expectations

Figure 3: Qualifications Needed to be a PILOT Peer



Individuals conducting PILOT Peer duties will have lived experience in recovery and, whenever possible, have a certification as a Certified Peer Support Specialist (or equivalent) in their state. PILOT Peers will work as an integral part of the research team. PILOT Peers will be expected to be very familiar with resources in their community and, along with the other members of their research team, will develop a community resource guide. The ability to communicate clearly and to work collaboratively as a team member are essential to a PILOT Peer's success. PILOT Peers will need to be open to supervisory feedback and specific requirements involved in conducting research. PILOT Peers will be expected to use good judgement during Peer/participant interactions balanced with the guidance provided in the national training, this intervention manual, and through regularly scheduled supervision. Accurate, timely (i.e., daily) and thorough documentation of all Peer/participant intervention activities is required and essential to the project's success.

In addition to the training received in their CPSS training, PILOT Peers will receive training specific to CTN-0107, including:

- Good Clinical Practice
- Responsible Conduct of Research
- Human Subjects Protection
- Motivational Interviewing
- Strength Based Case Management
- Harm Reduction
- Participant Tracking
- Self-Care
- Safety Issues
- Suicide Risk Reduction
- Documentation
- The Research Team: Roles and Responsibilities

1.3 Background of the PILOT Intervention

The PILOT Intervention is based on a program developed in 2016 by the Greenville, SC Chapter of Faces and Voices of Recovery (FAVOR) which utilized a technique called Assertive Community Engagement (ACE). Rather than waiting for individuals with SUD to come to treatment, the original ACE, as well as the PILOT Peer intervention, focuses on engaging and retaining individuals in recovery who are ambivalent about getting help and/or otherwise disengaged from help. FAVOR Greenville believed this group could be helped through creative engagement methods such as conducting visits in the home and out in the community, engaging family members, using technology, and employing evidenced based coaching techniques which promote therapeutic rapport.

ACE was deployed in a strategic and targeted manner, since not every person needed this intense level of services, such as those who can/do engage in recovery via traditional channels. More recently, ACE was modified for delivery in the Greenville Health System Emergency Department targeting opioid overdose survivors. This adaptation of the ACE program was called FAVOR Overdose Recovery Coaching Evaluation (FORCE). Under the FORCE program, Peer Recovery Coaches were called into the ED to meet with opioid overdose survivors and start the ACE intervention. The FORCE program showed excellent engagement and retention outcomes and serves as the foundation for the current manualized PILOT Intervention.

ACE is a philosophy and approach used in working with individuals with substance use disorder whose needs have not been met via traditional services.

1.3.1 What is ACE?

Progressive health systems have a long tradition of delivering services in the home and/or community. These programs have been effective at engaging participants, reducing healthcare costs, and supporting improved quality of life among participants. ACE borrows from these models and provides direct services in the home and community.

ACE was originally designed for participants with the most challenging and persistent problems. ACE capitalizes on the fact that 85% of successful change comes from:

The participant's own experience

The participant's hope for change

–

Peers can provide this through their own lived experience

Relationship with their provider

–

We believe peers are uniquely positioned to support these relationships

1.3.2 ACE practices encompass:

- Peer coaching as the primary vehicle for engagement.
- The use of Motivational Interviewing as the foundation for all coaching activities (See Appendix IV)
- Strength-Based case management efforts: Helping clients identify their own strengths and goals is much more powerful than simply telling them what to do
- Peers assume as much responsibility as the participant for successful engagement.
- Integration of family and other social supports
- Regularly scheduled face-to-face visits and phone calls/texts to support connection between visits.
- Small caseloads to ensure appropriate staff response.
- Staying attuned to participant needs:
    - Trauma-informed
    - Awareness of social determinants of health/hierarchy of needs
    - Culturally specific
    - Harm reduction
    - Navigate power dynamics
- Providing navigation and service coordination as needed/appropriate.
- Implementing practical, strengths-based and solution-focused interventions
- Using the community as a support.

1.4 The PILOT Intervention

1.4.1 Introduction

The PILOT intervention is a manualized version of the interventions (ACE and Force) developed by FAVOR Greenville. FAVOR staff participated in the development of manual and will continue to work on the Lead Intervention Team to supervise implementation of the intervention throughout the study. Key components of the intervention are described in this manual along with specific examples to assist PILOT peers in implementing the intervention with fidelity to the model.

1.4.2 PILOT: Three Guiding Principles

Borrowing from Assertive Community Engagement (ACE), there are three guiding principles that serve as the foundation of all PILOT activities.

Assertive Engagement

Participant Directed

Effective Supervision

Principle 1: Assertive Engagement

Assertive Engagement refers to both the relationship between the peer and the participant as well as the expectation of active engagement with community partners and resources. Characteristics of the peer/participant Assertive Engagement include:

- Peer support based on Peer's lived experience
- PILOT peers assume as much responsibility as the participant for successful engagement
- Peer-based recovery coaching as the primary vehicle for engagement
- Multiple communication modalities: face-to-face visits, phone calls, texts (and emails) to support and maintain connection with participants
- Multiple paths exist to recovery which includes harm reduction. Some participants will pursue traditional path to recovery, others may not. Participants decide and Peers provide support regardless of the goal and plan
- Routine assessment of participants' Level of Engagement – 1. active/engaged, 2. ambivalent or 3. unengaged – with a strategy to match each level. One size does not fit all.

Characteristics of the Assertive Engagement with community partners and resources include:

- PILOT Peers will develop comprehensive knowledge of community resources and will develop a local resource guide
- Active linkage to services, including accompanying participant to appointments as appropriate
- Integration of family and other social supports into the recovery planning process
- Preparation for termination begins early – discussion of plans for referral to community resources following the participant's study participation

Principle 2: Participant Driven

Participant Driven characteristics include:

- Goals are defined by participant
- Autonomy: Peers honor participants as the experts in their own lives
- Peers accept that there exist "many paths to recovery"
- Peers embrace the "spirit" of Motivational Interviewing which includes empathy and unconditional positive regard
- Peers use MI methods which informs all peer coaching activities
- Peers help participants identify their own strengths and goals which more powerful than Peers simply telling participants what to do

Principle 3: Effective Supervision

Effective supervision in the PILOT study begins with in-depth training of peers followed by weekly supervision meetings of the local peer team conducted by the Lead Peer who is the on-site supervisor and weekly virtual national supervision calls with the intervention lead team and peers from all sites. The Lead Peer at each site and the national intervention lead team will monitor each peer's documentation of peer activities with each participant on their case load. The Lead Peer will also document supervisory sessions in the Supervisor (see Documentation). Effective PILOT supervision will include:

- A three-day, face to face intervention training (will be recorded) for peers which will include didactic training, group discussions and role-plays
- Small caseloads to ensure consistent PILOT peer contact with participants
- Promotion of peer self-care
- Supervision that supports peers in staying attuned to participant needs including:
    - Trauma-informed
    - Awareness of social determinants of health/hierarchy of needs
    - Harm reduction
    - Providing case-management and service coordination as needed/appropriate
- Implementing practical, strengths-based and solution-focused interventions
- Multiple levels of supervision: local and national

Chapter 2: What PILOT Peers Do: Peer Activities in PILOT

2.0 Focus of Intervention Activities

Within the framework of the PILOT intervention there are the three Guiding Principles as described above in Chapter 1. The three Guiding Principles are Assertive Engagement, Participant Directed and Effective Supervision, and the three principles are integrated into all PILOT Peer intervention activities. In addition to the three Guiding Principles, this manual describes three main types of PILOT Peer Activities, each with a particular focus:

Engagement and Re-Engagement

-

Activities designed to build trust and rapport

Peer Coaching

-

Activities designed to assist the participant in reaching their goals

Transition/Termination of Peer Coaching

-

Activities designed to assist the participant in transitioning out of the relationship with the peer and into reliance on other resources

These three types of activities can be viewed as happening sequentially, but in the real world they will often overlap. There will be times when some participants will be out of contact for a while and once those participants are located Peers will need to begin all over with engagement activities before moving to coaching activities. The following sections will describe in some detail the focus of these Peer Intervention Activities.

2.1 Focus of Peer Activity 1: Engagement (and Re-engagement)

One of the most important initial requirements for participant engagement is the ability to locate that individual. The first interaction the PILOT Peer will have with the participant may be in the Emergency Department (ED), clinic or in the community.

Wherever that first contact is made, after establishing early rapport, it is important to collect sufficient location information to find/call/text that individual after they leave the ED/initial encounter.

The Research Assistant (RA) for the study will be initially collecting this information using the Locator Information Form (LIF). The PILOT Peer will coordinate with the RA to ensure the necessary locating information is collected to find/contact that individual after ED discharge. The Locator Information Form includes sections for securing consent from the participant for communicating with family members, friends, care providers, and concerned others who may be able to help with re-engagement. The RA and or Peer should explain to the participant that RA and PILOT Peers will make every effort to maintain consistent contact with the participant, and to do so, study staff have a few additional questions to ask, such as the following:

- *Who can we reach out to if we lose contact with you?*
- *Who is supportive?*
- *Who do you hang out with?*
- *Are there other people who are important in your life that we may add to the LIF?*
- *How would you like PILOT study staff to identify themselves to your contacts?*

Approaches

- Face-to-face, video-chat, phone, text, written note/mail, message through others (i.e., family, friends, service agency staff, etc.).
- Family/support system engagement, as family recovery is a core value for the PILOT program.
- Collect and update reliable Locator Information.

Availability

- Availability is a key aspect of the PILOT model. At the same time, healthy boundaries must be maintained.
- Discuss with participant the hours of Peer availability. PILOT Peers should establish their availability in consultation with site supervisors and communicate that clearly to the participant and with study staff.
- PILOT Peers should maintain availability boundaries over the course of the program.

2.1.1 Techniques for successful initial engagement

a. PILOT Peer's initial engagement with a participant:
    - In ED (best if done face-to-face):
        - Establish rapport (friendly, casual, "real," rapport-building).
            - There often exist challenges to establishing rapport in the ED including the very busy nature of the ED, a lack of privacy for speaking with the participant, pressure to discharge the participant resulting in insufficient time
        - Demonstrate Peer's usefulness and be an advocate by focusing on immediate physical and or emotional needs in the ED (i.e., if the participant is thirsty or hungry, give snack/drink); advocate for the participant's needs
    - Follow-up with the new intervention participant (after the in-hospital visit) with an immediate text, followed by phone call, followed by face to face) to stay in communication and to build rapport and trust
    - Respect informed consent. Participants will have an opportunity to opt out of all service options, including: follow-up calls (outreach) or peer coaching (engaged). If participant opts out, peer should request to continue checking in with participant over time.

b. Early engagement with a participant:
    - Front-load Peer/participant visits/contact in-person whenever possible, and take advantage of in-person opportunities when available (i.e. when the participant is in hospital, see as often as possible); spend time when you can ("act like you have all day")
    - Remember to be useful whenever the opportunity presents itself (i.e. meet someone at a meeting, help solve problems, help resolve case management needs)

2.1.2 The Initial PILOT Peer and Participant Contact

PILOT Peers may work on an on-call basis. The Study Coordinator/RA will call the PILOT Peer when a patient is identified in the ER who may be eligible for the PILOT Study and will also provide the PILOT Peer with updates so the PILOT Peer can be ready to arrive to the hospital in a timely manner. Once the participant has been randomized, the RA can inform the PILOT peer of the participant's randomization arm (TAU or PILOT Peer). With this clear communication,

The peer is expected to meet the participant within 1 hour of receiving the call from study staff, meaning the Peer should arrive to the ED (already parked their car and in the ED) within 1 hour after the initial call to allow for the RA to PILOT Peer hand-off.

Upon arrival at the ED, the PILOT Peer should first check in with the study staff (RA) to see if the newly randomized intervention participant is ready to have contact with the PILOT Peer. The preferred warm handoff should be with the RA and the PILOT Peer at hospital bedside with the RA introducing the patient to the PILOT Peer and the RA asking (preferably ahead of time) what brief information the RA may share about the participant to the RA. If for some reason, a warm handoff cannot logistically occur the RA is expected to ask the participant permission to share some specific participant information with the PILOT Peer and ask what information is to remain private

between RA and participant. Respecting the participant's privacy and boundaries, the RA will then communicate in person or over a telephone call some basic information about the participant.

Again, with the participant's consent, that information may include substance use of choice, readiness or not for substance use treatment, housing status, employment, transportation options, family/social support, etc.) The Peer is expected to meet the study participant as soon as is possible Although a face-to-face meeting is much preferred, a video call or a phone conversation with the participant may take place if a face-to-face meeting is not at all possible. If needed, the content contained in the outline of the Initial Peer/Participant Session can be covered over two or more meetings/phone calls/text conversations.

Having some basic information about the participant ahead of time (shared by the RA) might inform how the PILOT Peer may want to approach the topic of the participant's substance use during the initial meeting. For instance, If the participant had indicated to the RA that the participant is not at all ready or has no intention of stopping use, the PILOT Peer may decide not to mention immediately that the PILOT Peer is in recovery or use the term "Recovery Coach" in describing the PILOT Peer's role. On the other hand, a participant who has stated clearly that they are 100% committed to stopping use right now may benefit from knowing that the PILOT Peer is in recovery, as well as how long the PILOT Peer has been in recovery.

Given that some participants may not be feeling physically well and/or may be ambivalent about having a PILOT Peer, the PILOT Peer should be sensitive to the participant's current physical and emotional state and be responsive to any immediate needs while in the ED (such as helping the participant get food if hungry, beverages if thirsty, medications needed from the nurse (if available to the participant). The participant may not be interested in a lengthy Peer/participant conversation; therefore, PILOT Peers should be mindful about keeping the following talking points brief.

The initial meeting in the ED may also offer an opportunity to establish communication and a therapeutic relationship with the participant's family or supportive friend who might be present in the ED with the participant.

The PILOT Peer, however, must first receive permission from the participant for the PILOT Peer to engage with the participant's family or friends.

If the participant provides permission and if family and/or friends are present in the participant's room when the PILOT Peer arrives, the PILOT Peer should respectfully ask family/caregivers to give the Peer a few minutes for a confidential conversation with the participant. The PILOT Peer could tell the family member that, with the participant's permission, they would like to speak with them briefly after completing the initial visit with the participant. The subsequent discussion with the family/ friend should include discussion of narcan and other resources (i.e., ALAnon), as appropriate.

2.1.3 Checklist for Initial Session (in hospital ED)

To assist the peer in covering as many as possible of the planned topics for discussion during the first visit with the participant, a checklist has been developed. The checklist includes suggested language in italics. With practice, peers will learn to cover all of the topics in a conversational way. The peer should have the checklist available during the first couple meetings/conversations so that the peer can review

the list during the peer/participant meetings to ensure the peer covers the content that is expected. Following the session, the peer will use the checklist to indicate which of the items were discussed and which were, due to necessity, postponed for a future interaction with the participant.

The completed checklists (including participant ID #, date(s) of meeting(s), and peer initials (on top of checklist and for each discussion point covered) will be stored locally as per local SOP and will be used for supervisory purposes. Additionally, there is guidance in the manual around intervening (between the initial and the final session) and final PILOT Peer/participant sessions.

2.1.4 Outline of Initial Peer/Participant Session

What follows is an outline of the initial conversation between the PILOT Peer and the participant that a Peer is expected to deliver at hospital bedside (or in the community if a visit in the ED is not possible). If a Peer is unable to cover all the content listed in this outline during the initial session, the Peer should cover the remaining content areas at the next meeting.

Provide Brief Introduction of self (Peer) to the Participant
The PILOT Peer will warmly greet the participant, briefly stating the PILOT Peer's name and association with the PILOT study. The PILOT Peer should acknowledge that the participant has already spent time talking with the RA and briefly explain the difference between the RA and PILOT Peer (RA will conduct all study visits asking participants similar questions again in 1, 3, 6, and 7 months and providing a stipend for completing each research study visit's activities). The PILOT Peer will work with the participant for 6 months focused on what participant wants to work on: housing, food, employment, mental and physical health, substance use treatment, harm reduction, etc.)

Clarify time frame of today's meeting
The PILOT Peer is to ask permission from the participant to spend a few minutes talking.

- *May we meet for about 10-15 minutes to get to know each other a bit?*

Identify and address pressing needs (food, water, other)
The Pilot Peer should demonstrate the peer's usefulness and support by asking if the participant needs anything.

- *Before we discuss anything, may I get you anything: a beverage, a snack, a blanket?*
- *If NO: Please let me know if that changes and you want something.*

Briefly Share PILOT Peer's Role in the PILOT Study
The PILOT Peer should briefly share Peer's own experience with substances and current recovery. The PILOT Peer may briefly emphasize the following additional points and offer a hard copy or an electronic version of the document, "What is a PILOT Peer Coach?" (See Appendix I).

- PILOT Peer's Interest and experience in supporting individuals who use substances
- PILOT Peer's knowledge and experience with local health care services and understanding of the barriers to accessing those services
- PILOT Peer availability for six months to support the participant's priorities
- Contact can occur through phone calls, texting, email, and face to face meetings

- PILOT Peer can provide practical assistance, help with securing identification, insurance, referrals for housing, medical care, emotional support, etc.
- The participant always determines what, if anything, to work on and how the PILOT Peer may assist
- Possible language to use:

  - *As a Peer, I can be someone that you can talk to about stuff that is going on with you.*
  - *I can support you in setting personal goals, gaining access to resources such as food, clothing, housing, job, school training (if you wish).*
  - *You decide on what we work on together*

Ask participant to share information about themselves: what happened that they ended up in ED. Peer provides active listening. Share life experience as appropriate.

- *I know (RA name) shared some information with me. I'm so glad you survived the overdose. Very scary. What all do you remember that led up to your overdose?*

Determine immediate plan for discharge from ED (who is picking participant up, where spending the night, etc.)

Inquire about Participant's Immediate Needs (post hospitalization)
The PILOT Peer should be direct in asking how they can be of help. The PILOT Peer can ask something like:

- *What is your plan when you leave the hospital? Where will you go?*
- *What plans, if any, do you have once discharged from the hospital?*
- *What do you want me to help you with?"*

Based on the participant's priorities at this time, the PILOT Peer should provide appropriate referrals, offer to have the participant call the referral now and/or discuss the needed steps to satisfy the participant's priority and who (participant/PILOT Peer) will be responsible for which steps.

Discuss participant preferences for best way to contact

- *In general, what is the best way to reach you: phone call, text, email?*
- *How often do you access email?*

Review locator form – if possible add other contacts or information
The PILOT Peer should secure from the RA the participant's completed locator form and review it. The PILOT Peer should then explore with the participant any additional other possible ways to locate participant that have not yet been shared (service organizations participant currently accesses; if marginally housed, where participant typically sleeps at night and hangs out during the day; other community members that the participant sees). If not already listed on locator form, ask participant about social media accounts (i.e. Facebook, Instagram, Twitter, Snapchat, etc.) and inquire if research team can "Friend/follow" the participant.

- *Other than people you have already listed on the locating information form, is there anyone else who I may contact to pass on a message to you?*
- *Of everyone who knows you who is the one person who will know how to get ahold of you the best?*

Provide Peer's contact information and guidelines for contacting peer; ask participant to put peer's phone number in ppt's phone. Peer to do the same.
If participant does not have a phone, Peer and RA should arrange to provide a loaner phone. Whether it is a loaner phone or the participant's own phone, Peer should request that participant enter the Peer's phone number and name into the phone's list of contacts. Peer should also ask permission to put the participant's contact information in the peer's phone.

- *May I put your name and phone number in my phone now?*
- *May we put my name and phone number in your phone now so you know it is me contacting you?*

Discuss access to and use of naloxone (Narcan) and other Harm Reduction Practices
The PILOT Peer should briefly ask: (1) If participant is familiar with Narcan; (2) If the participant has ever used Narcan on anyone; (3) If participant currently has any Narcan; and, (4) If the participant uses with others (and if so, do the other users know where the participant keeps their Narcan. The PILOT Peer should provide any education or instruction that may be needed and provide naloxone kit as needed and share where participant may secure Narcan in the future. (Appendix VI is a 3-step guide to responding to an overdose – if appropriate, provide handout and briefly outline the 3 steps). If appropriate and if available in the community, discreetly mention how to access clean needles. If the participant mentions a desire to reduce use or stop use, the PILOT Peer should use MI methods such as reflections, open-ended questions, and summaries to explore further the participant's readiness to make what changes around their use. If appropriate, the PILOT Peer should provide requested referrals.

- *What all do you know about Narcan (naloxone)?*
- *If appropriate: May I share some additional information about Narcan?*
- *May I provide you with some Narcan before you leave the hospital just in case for you or friends you use with?*

Set goal for next session
The Pilot Peer should make an attempt to have the participant to agree to one possible goal, even if that one goal is to meet with you the next day. Other possible short term goals may be to make a call to a service agency, reach out to a friend or family member for support, or make an appt to see a care provider. The PILOT peer should also specify what the PILOT Peer will do between this meeting and the next. Again, the PILOT Peer should be clear on how the peer will help or be of service.

- *So, based on our conversation what I will do between now and (tomorrow/tonight) is _____ and you will _____ (one or at most 2 things: meet with me tomorrow, make a call to ____, take and keep narcan near/on you, etc.)*

Express desire to work w/participant and hope that they can accomplish ppt's goals
The PILOT peer should convey genuine willingness to work with the participant on things the participant on the participant's priorities.

- *I really look forward to getting to know you better and working with you on the things that are a priority for you.*

Schedule next contact meeting
If possible, schedule another contact (a phone call or a text exchange if a face-to-face meeting is not possible) as soon as possible (i.e., the very next day, even if the patient is still in the hospital) to continue building rapport and providing any possible PILOT Peer services. If appropriate, the PILOT Peer should provide a verbal overview of tasks for both participant and the PILOT Peer to accomplish prior to the next contact

- *So, as we agreed, I will (call, text, meet) you ____ (tomorrow at ___, etc.)*
- *Between now and then, I will do _____. And you will do _____. Do I have that right?*

Documentation Post Participant/Peer Meeting
After meeting with the participant, the peer should complete the Checklist for the First Peer meeting and provide the finished document to the Lead Peer for storage. Additionally, the peer will need to promptly complete the Peer Intervention Log (PIL) and the Running Progress Note (RPN). More information on documentation can be found in section 3.1 of the intervention manual.

2.1.5 Alternate Scenario During Initial Contact with PILOT Participant

It is highly preferable for the Pilot Peer to have an initial face to face meeting with the participant in the ED. However, The PILOT Peer's first meeting with an intervention participant might be cut short, scheduled for another day or not be face to face for a multitude of reasons (e.g., participant asks you to leave, the participant is leaving the hospital, the participant becomes sick, etc.). If another face-to-face meeting with the participant in the hospital is not possible, then in the limited time available, the PILOT Peer should demonstrate through communication and action that the PILOT Peer is interested and available to assist and support the participant for the next six months. In the time available, the following activities (conversation) are critical and should be the priority:

1. Secure the participant's telephone number if RA was unable to do so and try to secure any other locating information (family members' phone numbers, hangouts, FB, etc.) and offer the PILOT Peer's contact information
2. Following the site's policy on availability of Narcan, the peer should offer to assist the participant in obtaining Narcan and clearly communicate that participant can always call (contact) the PILOT Peer for help obtaining additional Narcan (as available at site)
3. When appropriate, inquire if the participant needs transportation upon discharge and if so, the PILOT Peer should do what is possible to help secure transportation

2.1.6 Ongoing engagement with a participant

Assuming that the first one or two Peer/participant meetings have occurred, below are suggestions for the Peer around communication efforts with participants:

- Mix participant contact methods (texting, email, telephone calls, and in-person visits) whenever possible. The level of on-going engagement with each participant is individualized based on the needs of the participant, however, PILOT Peers are expected to make contact at least once a week.
- If you are unable to establish contact (i.e., the participant does not respond), engagement should be attempted, via text or telephone, phone at least two times per week.
- In consultation with your supervisor (Lead Peer), additional re-engagement strategies should be used including home visits, family and/or community outreach, etc.
- If rapport and communication between the PILOT Peer and participant is waning, attempt an in-person visit to re-establish rapport.

2.1.7 Outreach, Re-Engagement and Delayed Engagement Efforts for Out-of-Touch Participants

As with all study activities SAFETY IS OF UPMOST IMPORTANCE in all outreach efforts.

Re-engagement is defined in the following manner: the participant was engaged at some point during the intervention period for any length of time. The engaged participant was taking phone calls, accepting of Peer coaching services, and connecting with the Peer and then stops responding or "goes off the grid."

Delayed engagement refers to situations where the peer was unable to engage the participant during the initial enrollment of the participant in the study. As an example – a participant left the ED prior to the Peer's arrival and subsequently does not respond to text messages or calls from the Peer.

Re-engagement is a normal and predictable part of the process.

This is the rule, not the exception and PILOT Peer staff should expect phases of "disengagement" with study participants. Thus, Peers will be continuously reaching out and bringing participants back onto the wellness/recovery pathway.

The goal of an outreach contact is to build rapport and connect or re-connect with the participant. Outreach can involve all methods of contact: texting, phone calls, email, direct messaging, and face to face outreach. Outreach contact should be done in consultation with your supervisor and the study team so that safety protocols and creative re-engagement strategies are utilized. Examples of creative re-engagement strategies include home visits, stopping by participant workplaces, visiting common places where a participant hangs out, reaching out to family or friends.

Re-engagement and delayed engagement strategies are founded on MI principles. Regardless of the method of re-engagement (phone, face to face, text, email, social media messaging) the content of the communication should be consistent with motivational interviewing principles.

Peers should review the Safety section of intervention manual for safety protocols in making visits out in the field. Additionally, the research team for each site will develop a local SOP that provides guidelines and expectations for finding out of touch participants while minimizing risk to PILOT

peers while working in the community. The SOP will include a system for checking in before and after face-to-face visits with participants in the community. If higher-risk visits are planned, two staff members should make the visit together. Another PILOT Peer may be called upon to accompany on such visits.

2.1.8 Guidelines for Re-Engagement Text Messaging, Phone calls, and Emails

1. Most delayed engagement and re-engagement is done via texting; however, the PILOT Peer can use these same principles when making phone calls. PILOT does not recommend repeated phone calls. The Peer should leave a voice mail and then use a text message to enhance the outreach. Email and private messaging on social media are also options. The Peer can always call back, but the recommendation is that the calls be spaced apart, with at least one week between calls.
2. If the participant has gone off the grid, the PILOT Peer should start the delayed engagement or re-engagement process with a more intentional and focused approach to texting. The tone of the texting should be individualized. For example, a long-term relationship and consistent interaction may have a different tone versus the tone used with a relatively new participant with a history of inconsistent contact.
3. If texting has been met with no response, the PILOT Peer then shifts to a more specific re-engagement effort. Specifically, the PILOT Peer states concern for the participant's wellbeing and expresses a desire/hope to hear from the participant. The PILOT Peer is to convey concern in a genuine manner and inform the participant that the PILOT Peer will be reaching out to others and/or coming by for a face-to-face visit. An example text may look like this:

> *"Hey Tim, it's Rich. Getting a little worried about you. If I don't hear anything in a day or two, I'm going to reach out to your mom."*

Let this text sit there for a day or two. Many times, a text like the one above will prompt a response. If there is still no response, the Peer should reach out to family members or friends and/or initiate outreach to the appropriate locations (based on the participant's signed LIF).

4. The goal of outreach is simply to establish or re-establish contact. If the PILOT Peer is able to get in touch with the participant, then the focus should be on securing a re-commitment for ongoing contact. The PILOT Peer should strive to make the process of "getting back on the path" as seamless and non-intrusive as possible.

2.1.9 Examples of texting/re-engagement strategies

The emphasis of delayed engagement or re-engagement strategies should be: **"Concern with a focus on safety."** It is very important that PILOT Peers convey this. The Peer is not reaching out just for the sake of reaching out. The Peer is ensuring the participant is safe and takes steps to support risk reduction. The PILOT Peer should always identify her/himself at the front end of the text. Do not assume that the participant has the Peer's number in their phone. The Peer should not assume the participant "remembers" the Peer. Depending on individual circumstances, the Peer should remind the participant of the relationship. The Peer should not go into detail with the introductory text message. For example, the Peer should NOT say something like this:

> *"Hi. it's Rich Jones from FAVOR Greenville.*
> *We met when you overdosed and wound up in the hospital."*

Instead, the Peer should consider texting something like the following text messages:

> *"Hey Bill, Rich Jones here. Just checking in. Please get back to me. Let me know you are okay."*
>
> *"Hey Bill, Rich Jones here. How you are doing? Please get back to me when you can."*

The Peer may include an agency name but should not provide more revealing information. Some examples are below:

> *"Hey Bill, Rich Jones from FAVOR Greenville here. Thinking about you. Hoping all is well. Please give me a shout out when you can."*
>
> *"Hey Bill, Rich Jones from FAVOR Greenville it's been a minute. Just want to make sure you are okay. I'm going to give your mom a call if I don't hear from you."*

Persistence is important. However, the Peer is NOT to STALK the participant or HAMMER TEXT the participant over and over. There is a fine line between assertiveness and being a nuisance. Pilot Peers should send no more than about 2-3 texts per week, followed by a planned outreach visit.

2.1.10 Guidelines for Delayed Engagement and Re-Engagement Visits in the Community

1. All delayed engagement and re-engagement visits must be approved and scheduled through the supervisor. These visits are different than routine face-to-face visits, which do not have to be scheduled through the supervisor. A delayed engagement or re-engagement visit means the PILOT Peer is showing up uninvited therefore, the PILOT Peer must get support and supervisory approval. The PILOT Peer should inform the participant of the visit ahead of time via voice mail or text message. The recommended message to the participant should be something like, "I am coming by on [day] at this [time] to say hi and see how you are doing." Unless the participant expressly communicates to not show up, the PILOT Peer should proceed as planned.
2. As much as possible delayed engagement and re-engagement visits should be done during daylight hours.
3. The goal of a delayed engagement or re-engagement visit is to establish contact. The visits should be short in duration, high in compassion and with further follow-up to be determined. The primary goal of a delayed engagement or re-engagement visit is finding, locating, and trying to establish or re-establish the routine with the participant.
4. Use CLEAR COMMUNICATION UP FRONT on the reason for visit. The PILOT Peer should emphasize Pilot Study's harm-reduction orientation and should focus on the Peer's desire to provide ongoing unconditional support. The PILOT Peer should be direct and tell the participant something like the following:

> *"When I lose contact with you, I will work hard to re-engage and find you. We want to help you stay alive. We will not pursue you in order to talk you into treatment. We just want to stay connected because we care and want to support you in ways that you want."*

The PILOT Peer should use their own language. This interaction needs to be sincere. Use the examples provided as a framework.

5. "Team" visits are more common with delayed engagement and re-engagement. Home visits, community outreach, family visits, etc. via team is prudent. If you haven't seen or heard from the participant in several weeks, discuss the situation with your supervisor and pair up with another PILOT staff member to make visits out in the community. In some cases, a solo re-engagement visit may be permissible but only with supervisory approval

2.1.11 Other Re-engagement Strategies: Family, friends, and Others

Family, friends, and significant others should be the first point of contact when someone is categorized as unengaged. Strategic integration of the family starts with ensuring all appropriate releases of information are complete and permission is given up front to contact the family. Assuming this has been completed, the following steps are recommended:

1. Semi-regular (possibly ~1/month) check ins with the family during stable periods of time in order to establish familiarity and rapport.

> *"Hi Mrs/Mr XX, this is YY calling to check in. This is my contact information. If you have anything you think is important for me to know, please contact me. Also, I want you to know that the participant has given me permission to check in with you on occasion. Do you have any questions?"*

2. If the participant has fallen into the unengaged category, The PILOT Peer should conduct phone outreach to family, friends, and/or significant others to a) gather any pertinent information and b) ask them to let the participant know we are trying to get in touch with them.
3. The purpose of this call is not family therapy. Do not share confidential information about the participant. The purpose is to explore ways to re-engage the participant. And sometimes family members, friends or significant others will have good suggestions.
4. Be aware that sometimes family members will test The PILOT Peer's boundaries and have unrealistic expectations of the PILOT Peer's role (For example, they may want to treat the Peer like a therapist). PILOT Peers are encouraged to seek supervision around boundary issues and practice healthy boundaries with these relationships.

2.1.12 Engaging with a Participants Who Deny Substance Use Problems

The foundational elements of the PILOT intervention — Motivational interviewing, harm-reduction, and ACE — are designed to work with individuals across all stages of change. In theory, "recognition of a substance use disorder" is NOT necessary for effective execution of these evidence-based strategies. PILOT Peers are NOT concerned about "recognition of the problem." Instead, Peers are interested in connection, unconditional positive regard, and value-added interactions with participants. In the PILOT Study, Peers are expected to "meet their participants where they're at". PILOT Peers should take pride in their ability to connect with and engage people regardless of the participant's stage of change or problem recognition.

Working with people who deny substance use will be common with participants. The problem recognition issue is taken off the table by maintaining a value-added perspective. In working with each PILOT study participant, the Peer should be answering the following questions:

- How can I add value to this participant's life?
- How can I be useful to this participant?
- What practical issues can I help this participant address?

As the health priorities of a participant are addressed, the therapeutic relationship is strengthened. Many times, action-oriented sessions may yield positive results. Action-oriented sessions are coaching sessions which occur in the context of another task. Examples include:

- Meeting a participant at the doctor's office to support intake.
- Helping a participant get to the social security office to secure benefits.
- Helping a participant complete paperwork for admission into a program.

As the task unfolds, the participant will frequently open up. The PILOT Peer will move the needle on recovery through this practical interaction. Furthermore, as these practical issues are resolved, the participant's recovery capital increases and his/her quality of life improves.

2.2 Focus of Peer Activity 2: Peer Coaching

For the purposes of this Manual, Peer Coaching is described as separate from engagement techniques, acknowledging that establishing and maintaining engagement is critical for effective Peer Coaching. This section will focus on the activities that can be encompassed within Peer Coaching. We will focus on several important components of Peer Coaching in the PILOT Intervention, and then describe how to determine the type and frequency of contact that best supports each.

Based on the shared lived experience, the primary method of supporting positive change for PILOT participants is Peer Coaching. The coaching includes setting short and long term goals as well as action-oriented steps to achieve the goals. In PILOT, goal setting is conceptualized as an interactive and ongoing process involving developing understanding of the participant's Values, Importance, Priorities and Strengths (VIPS). Identifying Values, Importance, Priorities and Strengths is based on the PILOT Principle of **PARTICIPANT DIRECTED** and is facilitated by peer coaching using the spirit of motivational interviewing.

Peers are not expected to develop a formal treatment plan with participants. Instead, the Peer will use Motivational Interviewing methods such as open-ended questions, affirmations, reflections and summaries to help the participant identify long and short term goals and action steps based on the participant's values and strengths.

To facilitate continuity between interactions the Peer will document the short and long term goals in a Rolling Progress Note (RPN) in each participant's research record.

2.2.1 Domains

> Each participant's story will guide the Peer in understanding that participant's individual **values, importance, priorities and strengths.**

The participant may talk directly or indirectly about what they value most in life, what's important to them, and their priorities (both immediate and longer range priorities).

For PILOT, participant priorities have been conceptualized as falling into one of thirteen possible Domains:

Figure 4: Potential Life Domains for Discussion between Participants and PILOT Peer

(These Domains are listed on the Peer Intervention Log described in the Documentation section of this manual, and peers will be asked to identify and record the Domains each participant is working on.)

2.2.2 Values, Importance, Priorities, Strengths (VIPS)

In the process of supporting the participant during the 6-month intervention period, Peers are expected to explore with the participant their **V**alues, discovering what is **I**mportant to the participant, establishing the participant's own **P**riorities and identifying the participant's **S**trengths to focus on their priorities and accomplish the tasks necessary to successfully meet their prioritized goals. In PILOT this is referred to as VIPS.

Figure 5: Exploring Participant Values, Levels of Importance, Priorities, and Strengths

2.2.3 Long Term vs. Short Term Goals

During the first few encounters with the participant, the Peer will likely focus on short term goals related to food, housing and safety. The early stages of the interaction between peer and participant will be very important for building trust and rapport. Only after this initial rapport building will the peer move to an exploration of long term goals. The timing of this will be different for each participant and could be an important topic to explore in supervision. Once the participant identifies his long term goals, then the short term goals can become stepping stones toward the participant's "ultimate" goals.

2.2.4 Setting Short-term Priorities/Goals

Setting and monitoring progress on short term goals is a key component of peer coaching. At hospital bedside and after discharge, the participant will likely have immediate or pressing needs to be addressed. The PILOT Peer should assist the participant in describing current goals by asking an open-ended question like: *"What can I help you with today?*" or *"What are your priorities today (this week)?* A study participant with housing insecurity may not want or need a check-in about any other areas of their life, and some participants may only engage on immediate or pressing needs.

2.2.5 Summarizing and agreeing on action-oriented steps

The PILOT Peer should close each session by summarizing and clarifying agreed upon goals that will be in place until at least the next interaction/session. The PILOT Peer will then encourage the participant to agree to one action-oriented step. Some examples include "*Participant will complete the application for the supported living program*" Or "*We will meet at the Wednesday night Narcotics Anonymous meeting*".

The next contact (or session) with a participant should start with a review of the previous session's agreed upon action steps and any progress made on that step or a discussion on the barriers to completing the step and a reassessment of the participant's more immediate needs.

Short term goals should be documented in the Rolling Progress Note (RPN). The peer may want to write a paragraph or two about the participant/peer meeting or conversation (text exchange, phone call, email, face to face). However, at a minimum, the Peer is expected to clearly and simply list the short term goal by typing in **BOLD Short Term Goal or the abbreviation "STG":** then typing the specific goal. Below, are a few examples of documenting the short term goal in the Rolling Progress Note:

Short Term Goal: Keep Voc. Rehab appt that is scheduled for this week.
STG: Meet with Peer at Weds. night NA meeting on Valencia Ave.

Short Term Goal: Participant will complete the application for supported living
STG: Set up an appt for Medicare (to get a replacement card)

Timing is an important component of goal setting. During the Emergency Room visit and immediately after hospital discharge the participant may be in crisis mode and only want to focus on immediate needs, such as finding temporary housing, food, or even substances, etc. In such a state, the participant may not say anything about their overall values or future priorities. During this time of crisis would **not** be the time for the Peer to initiate a conversation about the participant's values. Instead, the Peer should try to be as helpful and useful as possible in addressing the participant's immediate needs. On the other hand, a participant may make a comment in passing that may provide a hint of a Domain that is important to them. For example, the participant may say something like *"I really need to get clean **someday** but right now I just need get my stuff back*

and find a place to sleep." Or *"I really want to reconnect with my adult children but not in this state,* ***not now****."* In the first example, the participant is expressing a desire to become substance free sometime in the future; in the second example the participant is acknowledging that they value their family relationships. Both of these examples fall under the above mentioned "domains." In both of these situations the Peer should make note of the domain of interest, and simply provide a reflection such as:

> *"Your main focus at the moment is finding all your stuff (clothes, backpack etc.), eventually you want to put substance use behind you."* Or *"Right now you need to just focus on finding a bed for the night. Down the road you want to reconnect with your children as you value family".*

Other than making an appropriate reflection, the Peer should not attempt any deeper conversation about the participant's values. The Peer's focus should remain on the participant's immediate needs/goals and try to be as useful as possible to demonstrate the Peer's interest in meeting the participant "where they are" and prove helpful. After a few weeks (or more in some cases), once the more immediate crisis (crises) is/are addressed, the Peer is expected to explore the participant's values, the importance of those values, and the readiness level to take steps to address their priorities.

2.2.6 Setting Long-Term Priorities and Goals

Clarification of Values and Importance: During coaching activities, Peers will use Motivational Interviewing methods such asking open-ended questions, offering reflections, providing affirmations and using summaries, to initiate a conversation with the participant and assist them in clarifying their values and what is important to them. Using the participant examples from above, the Peer may say something like:

> *"When we first met in the ER, I remember that you mentioned you eventually want to put substance use "behind you." Please share with me the most important 1 or 2 reasons why you want to leave substance use behind someday."*
>
> *or*
>
> *"During one of our first meetings, you mentioned that you eventually want to re-establish contact and maintain a connection with your adult children. It seems you value family. Please tell me more about this desire to reconnect with family members."*

If during the initial one or two meetings a participant has not provided any indications of what they value or see as important in their life, then the Peer should initiate a conversation about what the participant values or the priorities they have. For example, the Peer may say something like:

> *"Since we have 6 months to work together, for me to support you on what you want to focus on, it would help me to know what one or two things you value most in life. What do you value most?"*
>
> *or*
>
> *"Since we have the opportunity to work together for a good stretch of time, it would help me to know you better. What do you want your life to look like in one year? In 3 years?"*

The intent behind the above questions, statements and requests for the participant to elaborate is for the Peer to provide an opportunity for the participant to think about what they value most and where their priorities lay. During such conversations, the Peer should provide reflections, ask open-ended questions and provide appropriate summaries and affirmations. During future conversation/ meetings the Peer is then expected to follow-up on this initial conversation. Once a participant has clarified for themself their values and priorities, the Peer can then explore with the participant about steps the participant is willing to take/accomplish to reach those priorities. For the participant who wants to reconnect with their family explore what would have to happen for the participant to be ready to reach out (it may mean stable housing, it may mean reducing substance use, it may mean securing different clothing, etc).

A participant having clearly stated values or priorities does NOT necessarily translate to readiness to take action. Ambivalence is a normal state for anyone contemplating change and ambivalence may prevent movement towards goals. Critical to Peer work is assisting the participant to resolve their ambivalence. The Peer can ask open-ended questions about the disadvantages of status quo *(What would your life be like in 3 years or 5 if you make no changes to your substance use? What are the biggest disadvantages for you around your substance use?); ask questions about the advantages of change (How would your life be different/better if not using? What would be the main advantages to you if you stopped use [or reduced use]?)*, and providing hope by exploring other times when the participant made changes, the strengths they demonstrated, and affirming those strengths *(When before have you made a change in your life and how did you go about it? What strengths did you demonstrate back then that you can use for this change when you are ready?)*. The "readiness ruler" is an easy and quick way to assess a participant's readiness level to take steps in making change. Below is an example of using the "readiness ruler:"

Peer:
Sammy, on a number of occasions you have talked about your interest in stopping use (or reconnecting with family, or getting a job). On a scale of 1 to 10, where 1 is "not at all ready" and 10 is extremely ready (to take action), how ready are you to take steps to stop your use?

Sammy:
Well, honestly, I'm at about a "5" right now.

Peer:
So you are at a "5". Thank you for your honesty. Please tell me why you are at a "5" and not at a "2"?

Sammy:
Well…with fentanyl is in everything these days and so overdose is more likely and I have been lucky so far, lucky to survive my overdoses. But my luck may run out. A cat may have 9 lives but I'm not so sure I have that many. Basically, really, I really don't want to die, I want to live.

Peer:
Thank you for sharing that. So you feel lucky to have survived your overdoses and you don't want your luck to run out. You want to live. Please tell me what would have to happen for you to be and "8" or "9" instead of a "5."

Sammy:
I'm not sure..maybe another overdose haha..no I might not survive it. Um if I end up in the hospital again with another abcess…I'm not sure. But I'd also want to get my things in order, like getting a new ID, reconnecting with my family so I have support when I would be ready to go into treatment, have a place lined up to live when I get out of treatment. I dunno..stuff like that.

Peer:
So, although you are not ready now to sign up for treatment, you have considered what things in your life need to happen before getting treatment. Will it be okay if I check in with you in a couple weeks about this topic and see where you are around treatment?

In the above exchange, the Peer recognizes that the participant is not ready to sign up for treatment today or this week, but the Peer has created a safe non-pressured opportunity for the participant to think about treatment and what might help the participant move further along the readiness scale. Importantly, the peer has left the door open, so to speak, for additional conversations around the participant's substance use and seeking treatment. In the above example, if the Peer were to push for the participant to call a treatment agency this week to set up an intake appointment this participant would have pushed back and the Peer may have lost the participant's trust and hurt their rapport as the participant may see the Peer as having only one agenda, treatment, which is not the participant's current agenda.

2.2.7 Documentation of Long Term Goals

Peers will use the Rolling Progress Note to document the participant's long term goals. The goals statement for the Long Term Goal(s) is likely to change during the course of the intervention and should be updated at least monthly in the PIL, even just to state, "Long Term Goals remain the same: Get sober sometime in the future, after finding stable housing."

Here is an example of documentation of a Long Term Goal in the Rolling Progress note that includes both the goal and a brief statement to support or expand on the interaction that led to the goal.

7-10-21 Participant's Long Term Goal: "Get sober, so I can return to college":
In phone conversation today the Participant described his desire to re-enroll in college. He also described conflict with parents about continued financial dependence on them. Verbalized anger and frustration. Continues to resist participation in support group. Plan for getting sober still needs to be developed but participant not ready to discuss or commit"

The Long Term Goal should be revised and documented if the participant indicates a change in their priorities and plans. This revised Long Term Goal should be documented in the Rolling Progress Note at the time the participant discusses the change with the peer.

Here is an example of a participant might say to indicate a change in their long term goal:

"I know I said I wanted to get sober so I could go back to school, but I now realize I'm just not ready. I really need to work on finding a place to live that is not with my parents, and I need to work on getting a job. I need a couple of years before I think about re-enrolling in college. Maybe I should be going in another direction. I have no idea what I would want to study. My parents are on me about making decisions and how much money I have borrowed from them. I really want my own place. I think my family will help me, but I've got to get a job. The Voc Rehab counselor seems like he can help me sort it out – that is if I can stay clean and pass the drug tests.".

After the Peer makes an appropriate reflection to the participant and receives confirmation from the participant that a change in the participant's long term goals, the peer would enter a note in the Rolling Progress Note similar to this:

7-25-21 Revised Long Term Goals: Get sober. Find stable housing. Find a job. Participant had productive conversation with parents. Has completed assessment process with Voc Rehab. Is hopeful they will arrange a supported employment placement for him. Hopes to save enough money for deposit on apt by end of summer. Seems a bit more open to discussion of plans for "getting sober". Plans for return to college are on hold.

2.2.8 Guidance around Intervening Sessions

Intervening sessions are Peer/participant meetings (face to face or a series of text messages or emails that occur between the Initial and Final Peer/participant Sessions). Below is guidance for conducting intervening sessions. The guidance is intended to be used throughout the participant's 6 month intervention period and thus is content that will be repeated during multiple sessions.

a. Check in with participant about any progress made on goals (action items) from last contact

The PILOT Peer should acknowledge and support any progress the participant made and/or explore the challenges the participant faced and attempts the participant made to overcome challenges. The PILOT Peer should explore what ways the participant may be able to overcome the challenges in the near future.

b. Explore with participant what they currently value most and their priorities

After clarifying the participant's current priorities, the PILOT Peer should explore the participant's readiness to work towards any goals between now and the next PILOT Peer/participant session. The PILOT Peer should clarify what, if any, specific steps the participant is willing to take. If the participant does not bring up any thoughts or changes around substance use, the PILOT Peer should gently broach the topic by asking an open-ended question or two about participant's substance use, such as asking:

"What, if anything, might you consider changing about your substance use?" or
"What thoughts do you have about your current substance use?" or
"If you were to change something about your substance use in the future, what changes would you want to make?

As appropriate, the PILOT Peer should review and/or provide to the participant the handout titled "Frequently Asked Questions about Medications for Opioid Use Disorder (MOUD)" (Appendix III) as a way to further explore the participant's thoughts around possible medication support.

c. Discuss access to and use of Narcan and other Harm Reduction Practices (See Overdose Harm Reduction Activities)

The PILOT Peer should quickly check in with participant regarding their supply of Narcan, where they keep (or will keep) it, and the possibility of having Narcan in multiple places (backpack/purse) including their home, their car, and with family and/or friends. The PILOT Peer should briefly explore any harm reduction measure participant is taking to reduce chance of overdose and other harms. Handouts A and B (see Appendix XI) that list activities that increase risk of an overdose and activities that reduce risk can be reviewed with the participant and/or hardcopies or electronic copies may be provided.

d. Update Locating Information

The PILOT Peer should quickly ask about any changes or additions to locating information which should include changes to telephone numbers, social media accounts, hangouts, agency services, and friends and family contacts.

e. **Schedule the next contact**

   A phone call or a text exchange if a face-to-face meeting is not possible

f. **Provide a verbal overview of tasks** for both participant and Peer to accomplish prior to the next meeting/contact

2.2.9 Peer Coaching and Patient Navigation, Linkage to Care/Services, and Advocacy

Care of the PILOT participant often involves more intensive efforts such as patient navigation and linkage to various services. Below is guidance for Peers around navigation, linkage and advocacy.

2.2.10 Develop in-depth familiarity with local resources

Prior to study start up, PILOT Peers are expected to learn extensively about local resources and begin establishing a network of contacts. Peers are to start with any resource lists currently available and add any relevant new resources. Peers should call current and new contacts and if possible, meet in person at their facility. Peers should be on a friendly first name basis with front desk, intake, and case managers. Establishing and maintaining these relationships ahead of time will facilitate participant utilization of services in a timely manner when the need arises. Peers are expected to update the resource list at least quarterly (every 3 months).

2.2.11 Identify and Prioritize Navigation and Linkage Needs

Below are two examples of navigation/linkage needs that may arise with an intervention participant:

Scenario #1
Brittany, A 27-year-old woman, has been hospitalized for withdrawal from opioids. Brittany wants to stop using for her family and be the mother and wife that she knows she can be. Since Brittany is the primary caretaker for her 2-year-old daughter, Brittany does not want to enroll in inpatient services, but is interested in outpatient treatment. Brittany would also like to talk with a provider who could offer her opioid cravings. Brittany has good family support and has insurance.

Navigation and linkage needs for Brittany include helping Brittany:

- Locate an outpatient program that takes her insurance and fits her schedule
- Connect with a practitioner who offers Vivitrol and takes her insurance
- Adjust to all the changes of recovery during the next 6-month intervention period, which may include reestablishing contact with friends from whom Brittany isolated during her opioid use and establishing new or renewed activities that promote mental and physical health such as exercise

Scenario # 2
John, a 41-year-old man, arrived in the hospital emergency department due to an opioid overdose. John is homeless and reports being ready to seek treatment for his opioid use. John needs to find housing in a recovery house where he's expected to locate a job and begin employment within 2 weeks. He has no identification or social security card, both of which are required to apply for most jobs. John also wants to connect with a mental health agency to access both medication for depression and a therapist. A recovery house may have restrictions on what medications are and are not allowed. John has high blood pressure and has insulin dependent diabetes (Type I) thus has immediate medical care needs. John has no money and has food insecurities.

The numerous navigation and linkage need for this participant include helping John to:

- Find a recovery house that allows medications and is comfortable with medical issues
- Access the DMV for an identification card
- Access the Social Security office to apply for his Social Security card
- Secure appointments for a local mental health clinic and medical clinic that have sliding scale fees (or his insurance, when he secures some).
- Locate a local food bank and identify hours of operation
- Access transportation assistance to help him navigate to these resources (This could be someone driving John or assisting him in getting a bus pass)

In this example, the Peer will work with John to prioritize his navigation/linkage needs and define what steps the participant will complete, what steps the Peer will accomplish, and in what order.

2.2.12 Linkage to "formal" SUD treatment and MOUD

Participants who are seeking treatment will be familiar with and seeking traditional SUD treatment (inpatient or "detox," rehab or outpatient care). For participants with opioid use disorder, one important component of decreasing risk for overdose death is utilizing a medication for opioid use disorder (MOUD). Oftentimes, Peers are in the position of discussing the risks/benefits as well as misunderstandings or fears about the use of MOUD. For this reason, PILOT Peers will be expected to have a sound basic understanding of the 3 FDA-approved medications for OUD and how to connect participants desiring treatment with MOUD with those treatments. Please see Appendix V for clear information about MOUD.

2.2.13 Advocacy and Acknowledging When Needs that Cannot Be Met

There may be scenarios where an individual has a navigation or linkage need that cannot be met (or multiple). For example, in the case of John above, it may be that there is no available recovery house able or willing to care for his medical conditions and/or no recovery houses available willing to take someone on Suboxone, despite your advocacy for this individual. This can be an extremely upsetting position to be in for any helping professional, and it is important in these scenarios to realize some barriers are outside of our immediate influence, and we have to make the best plan with the resources available at that time. It is important to discuss these areas in supervision for your own support, but also to gather momentum from other peers to advocate for change on a larger level (e.g., make a concerted effort to educate hospital administrators regarding the unnecessary barriers that may exist within the ED). It is important to remember advocacy can exist at the individual participant level, but also at higher policy levels, so reminding yourself and the participant "this Is what we can do tonight, but we can both work over the long-term on making treatment easier to access."

2.2.14 Coaching Around Harm Reduction

Harm Reduction incorporates a spectrum of strategies that includes safer use, managed use, abstinence, meeting people who use drugs "where they're at" and addressing conditions of use along with use itself. For example, Harm Reduction for people who inject opiates or other drugs reducing risk of ongoing includes using clean syringes and works to reduce the risk of HIV and HEP C as well as using strategies such as not mixing substances, using a test shot first, or having Narcan around to reduce overdose (see Appendix V for Principles of Harm Reduction). The PILOT Peer is expected to discuss harm reduction throughout the six-month intervention period and re-review harm reduction options with participants to reinforce the idea that harm reduction is important and possible and to assess whether or not the participant has changed their motivational level in implementing some

harm reduction strategies. The Peer should frequently inquire about the participant's ease of access to Narcan and encourage the participant to take steps to assure availability.

2.2.15 Overdose Harm Reduction

A number of PILOT intervention participants will continue to use substances throughout the 6-month intervention period. Other participants may stop for a while and then re-initiate use. PILOT Peers should review with participants the activities (or behaviors) that increase the risk for an overdose and engage the participant in addressing the specific behaviors that put the participant at increased risk for having an overdose.

Behaviors That Increase Overdose Risk

- **Using more or stronger opioids**
- ***Using fentanyl (whether by choice, or unintentionally)**
  Fentanyl is about 4 times riskier for overdose than heroin, and fentanyl overdose happens much more quickly. It's important to act especially fast in the event of a fentanyl overdose.
- **Mixing opioids with other drugs like benzos, alcohol, or cocaine**
  Opioids, alcohol, and benzos all can slow or stop a person's breathing. A person may already have other drugs and/or medications in their system, prior to using, that can increase their risk for overdose.
- **Injecting (compared to snorting or smoking)**
- **Using after a break (for example: using after a hospital stay)**
  If someone hasn't used, or drastically reduces their use, even for a couple of days, their tolerance may decrease.
- **Using alone**
  An overdose fatality is much more likely if someone uses opioids in a space where no one is aware that they're there, a space no one can access, and/or if no one knows to check on them.
- **Not having naloxone nearby**
  If an overdose does occur, not having naloxone close at hand (and someone there to administer it) decreases a person's chance of surviving an overdose.

After quickly reviewing behaviors that increase risk the Peer should also have a conversation around ways a person can reduce their risk for an overdose and discuss what the participant may already do to reduce overdose risk and anything additional the participant might want to do or will consider doing to further reduce risk. A handout (Appendix XI) is available if the Peer thinks it would be helpful to either have the participant read or to have the participant and Peer to take turns reading. If a participant declines reading or partaking in this review, at a minimum the Peer should offer a copy to the participant to take or to pass on to any friends who use.

Ways to Reduce Overdose Risk

- **Test drugs with fentanyl test strips (if available)**
- **Do a tester shot/go slow (you can always do more but you can't do less)**
- **Change route of administration (from injecting to snorting or smoking)**
- **Use with others and take turns**
- **Use in a safer place** (better lit space that is secure, so you don't have to rush. Leave the door unlocked or use multiple-stall bathrooms where you could be found if you overdose)
- **Carry Narcan and/or use with someone who has Narcan**
- **Start methadone or buprenorphine medications** (people who engage in methadone or buprenorphine treatment have a much lower risk for overdose (50% less risk!)

Medications for Opioid Use Disorder as Harm Reduction:

The Peer should use MI methods such as asking open-ended questions, offering reflections, providing affirmations, and use of scaling questions to:

a. Evaluate each participant's knowledge of the 3 FDA-approved medications for OUD;
b. Provide additional information as needed; and,
c. Assess the participant's readiness to discuss medications with an appropriate provider.

Again, throughout the participant's six-month intervention period, the Peer is expected to keep the conversational door open to revisit the participant's readiness for MOUD. Appendix II provides an FAQ regarding MOUD. Whenever appropriate, the Pilot Peer should offer a paper or electronic copy of this MOUD FAQ to participants.

2.3 Focus of Peer Activity 3: Transition and Termination of Intervention

As PILOT is an intensive and time-limited intervention, attention will be dedicated at the outset to

Preparation for the final visit should begin at least a month prior to the scheduled last visit.

transition and termination of care. Early steps should be taken for participants who engage and respond to services to continue those services with another provider/facility after the PILOT study intervention period ends.

Attention will be given to the following areas as termination approaches: Review progress to date and next steps, process end of relationship, devise concrete plans for transition to or continuation with non-research provider or service, who to contact after research intervention ends, access to Narcan and other harm reduction services, and study visits still remaining.

The peer should remind the participant of the approaching end of the peer-participant relationship and help the participant develop a plan for securing appropriate community services to minimize

the participant's possible sense of loss or abandonment by the peer. The final contact or meeting between the Peer and the participant would be best conducted face to face. If that is not possible, then a telephone call will suffice. Only as a last resort should the content of the final contact between Peer and participant be conducted via text messaging or email. The Final Session outline contains all of the items that the peer should try to cover during this session, which may extend beyond a single encounter. However, once the participant's intervention end date has been reached no other session content can be discussed. Accompanying the Final Session is a Final Session Checklist that the Peer will fill out and upload. Instructions for the checklist are in Section 3.1.3 of the manual. The Final Peer/Participant session outline of activities is below.

2.3.1 Outline of Final Pilot Peer/Participant Session

a. Review Self-care Progress Made Since Initial PILOT Peer/ppt Meeting

Review self-care progress made since initial PILOT Peer/participant meeting. The PILOT Peer will invite the participant to talk about ways the participant demonstrated self-care efforts in the past 6 months: reduced risk for overdose, reduced substance use, became abstinent, attended AA or other support meetings, got on medication assisted treatment (MAT), sought out support of religious/spiritual services, reconnected with family or friends, became stably housed, found and kept employment, started exercising, became mindful of diet, etc. Progress discussed will include anything directly related to substance use as well as progress in other areas of the participant's life such as finding more stable housing, accessing other services, efforts at securing employment, making appropriate relationship decisions, and engaging in other health promoting activities (exercise, social life). Although some participants may not have made much progress in self-care during their study participation, any attempts and any small steps completed need to be acknowledged and supported (e.g., got an ID, visited the clinic or SA treatment site).

b. Discuss Continued Challenges to Self-care Efforts and Goals

Examine continued challenges to self-care efforts/goals. Using active listening techniques such as open-ended questions, reflections, and summaries, the PILOT Peer should invite the participant to discuss the current challenges the participant faces in meeting self-care tasks, any ways the participant has overcome similar barriers in the past and reinforce the strengths participant has demonstrated previously that could be used.

c. Discuss Ways to Continue Self-care Efforts Post Study Participation

Explore support options for maintaining self-care goals. The Peer should encourage the participant to identify individuals and organizations who can support the participant to maintain or complete self-care steps and discuss when the participant might reach out to those individuals or organizations.

"Who in your life might assist you in your continued self-care?"
"How might you go about requesting their support?"
"When would be a good time for you to seek out their support?"
"What agencies or organizations might be able to support your efforts?"

d. Discuss possible next steps in self-care activities

Recognizing the participant's accomplishments in the past six months and their continued challenges, the PILOT PEER should assist the participant, if the participant is interested, in generating new realistic self-care goals post study and how the participant may want to achieve them.

e. Explore the Experience of Working Together for the Past 6 Months

Invite the participant to share about their experience of working together during the past six months. The PILOT Peer should encourage the participant to share the benefits of working together as well as the challenges. After the participant responds, the PILOT Peer should also share about their experience of working with the participant. The PILOT Peer should make every effort to focus on the positive aspects of the participant or the participant/Peer relationship. The PILOT Peer should acknowledge challenges and their successful resolution (if any).

f. Discuss Final Upcoming PILOT Study Follow-up Visit (non-PEER Visit)

Review the date of and the activities for the 7-month follow-up study visit. The PILOT Peer should ensure that the participant has a 7-month appointment scheduled and is provided with an appointment card listing the date, time and location of the appointment and a contact name and phone number. The PILOT Peer should remind the participant of the reimbursement available for completing 7 the month study activities and express appreciation for the participant's study involvement. The PILOT Peer should review the participant's contact information and make any needed updates.

g. Discuss Limitations of Contact between Participant and Peer Post Study

Based on guidance by the local study team and the intervention lead team, the PILOT Peer should have a brief conversation with the participant about possible limitations of contact between the Pilot Peer and the participant. The PILOT Peer may wish to discourage face to face sessions and active case management and as an alternative, may encourage the participant to reach out to local support and referrals for case management needs the PILOT Peer provides to the participant. The PILOT Peer and participant may agree to contact through email, text, and phone calls as long as the PILOT Peer has the time to engage in this manner. If the PILOT Peer is hired by a local hospital or agency to deliver Peer coaching services, the PILOT Peer should discuss with their employer the possibility of resuming Peer services for specific former PILOT study participants.

Chapter 3: Other Things Peers Know and Do in PILOT

3.1 Study Documentation by PILOT Peers

Pilot Peers are expected to document their intervention work with participants in several different documents:

- Participant Locater Form
- Peer Intervention Log
- Rolling Progress Note
- Checklists for the initial and final sessions

3.1.1 Documentation of Participant Locater Information

Research staff, including PILOT Peers, have access in EMMES eClinical platform to the PILOT participant Locater Information Form (LIF). The LIF includes the many ways study staff can contact or reach the participant and is a dynamic form meaning that updates in participant locating information can and should be updated in the LIF in real time. If a participant changes addresses or secures a new telephone number or is assigned a new case manager or hangs out in a new area, then updates should be entered in to the PIL as soon as possible. No contact information is ever deleted; new information is merely added to the form. The reason for never deleting is that old information may be current information at a later date: an old phone number may work again, a previous hangout location may be used again, and a previous case manager who had worked with the participant a while ago may be in recent contact with the participant.

Throughout the six-month intervention period with each participant the PILOT peer is expected to continually ask the participant what updates, if any, there are to the participant's locating information.

Anytime there is an update to make the peer is expected to enter that new contacting information that same day whenever possible and by the next morning at the latest. The research coordinator will depend on the peer to update the locator form so that the RC can reliably locate and contact participants and provide reminders of upcoming study visit appointments (non-intervention visits). The data manager from EMMES will be providing a training via webinar on using the PIL which will be recorded and will be accessible to research coordinators and peers.

3.1.2 Documentation in the Peer Intervention Log

PILOT Peers will use the Peer Intervention Log (PIL) to document all attempted and completed interaction with participants. The documentation will occur electronically in EMMES's eClinical platform.

Peers are expected to complete data entry on a daily basis with each participant in their caseload, even if no intervention work was completed with a participant.

The electronic form will include drop down menus for faster data entry, the Peer will be entering data that includes: date and type of contact (face-to-face or text etc.) the domains discussed (housing, legal, financial, family, etc.), the referrals provided (substance use treatment, housing, medical services, etc.) and the harm reduction content covered (access to narcan, ways to reduce an overdose, etc.). The local Lead Peer and the intervention lead team will have access to the PIL for supervision purposes to ensure that peers are entering intervention data in a timely and complete manner. The Peer Intervention Log also will be analyzed to provide detailed information in order to describe the actual work accomplished by peers during the study. The data manager from EMMES will be providing a training via webinar on using the PIL which will be recorded and will be accessible to all peers for review.

3.1.2 Documentation in the Rolling Progress Note

After contact attempts, successful contact efforts, and any Peer/participant coaching sessions, the peer should write a brief paragraph or two about the participant/peer meeting or conversation (text exchange, phone call, email, face to face) in the Rolling Progress Note (RPN) in the eClinical platform.

Peers should document in the Rolling Progress Note (RPN) at least every third day.

The Rolling Progress Note is particularly important for recording the initial engagement with the participant, whether this occurs face to face or on the phone. The RPN for the initial Peer/participant sessions should include the following information:

1. Type and location of first interaction: phone call, in person, at hospital, in community. If not in hospital setting why not?
2. Handoff from RA
3. Drug of choice and pertinent information
4. Circumstances of overdose
5. Other major medical condition if reported
6. Living situation – homeless, lives with family
7. Employment status
8. Availability of transportation
9. Participant's primary concern voiced during session
10. Shared contact information (between Pilot peer and ppt)
11. Narcan (Discussed? Accepted? Provided?)
12. Any other important information, especially regarding safety
13. Discharge plan (if appropriate)
14. Short term goal

The Rolling Progress Notes for the initial engagement session for each new study participant will be reviewed for content and completeness by the Lead Peer and discussed either individually with the peer or on the site's weekly supervision meeting.

Rolling Progress Note (RPN) Example: 50 year old unemployed carpenter seen in internal medicine after accidental 3/23/22 overdose on fentanyl. Handoff from RA – brought to ED by EMS, found unresponsive in his home. Typically uses cocaine (2-3 x per week). No previous OD reported. Lives w/ long term gf in subsidized housing downtown. Has hx of IDU. Reports generally good health. Has desire to find work. Plans to stay with gf tonight. Accepted Narcan. Ppt gave peer permission to speak with gf (on LIF). We shared contact information. No recovery experience. SHORT TERM GOAL: Ppt will tell gf about joining study and that peer can contact gf. PILOT Peer will share overdose risk reduction info at next visit. Agreed to phone call for tomorrow at 10am. Will schedule face to face visit within next few days.

During the early stages of engagement, the SHORT TERM GOAL should be simple and concrete and should be something that the participant agrees to do and can easily succeed in doing, such as "participant agrees to take my call tomorrow at 10AM".

Peers will also use the Rolling Progress Note to document participant long term goals. The goals statement for the Long Term Goal(s) is likely to change during the course of the intervention and should be updated at least monthly in the RPN, even just to state, "*LONG TERM GOALS remain the same: Get sober sometime in the future, after finding stable housing.*" The term "Long Term Goal(s) can be abbreviated by using **"LTG."**

For subsequent interactions between the Pilot Peer and the participant the PILOT Peer should provide in the RPN a summary of any progress made on agreed upon step(s) from the **previous** session or a discussion on the barriers to completing those step(s) and a reassessment of the participant's more immediate needs. Additionally, the Peer should describe or list any new next steps to which participant and Peer agreed during the current session. An example might be "*Participant will complete the application for the supported living program*" Or "*We will meet at the Wednesday night Narcotics Anonymous meeting*". These steps may relate (but not necessarily) to a short or long term goal the participant has discussed or expressed (see VIPS section of manual, section 2.2.2). All short term goals should be documented in the Rolling Progress Note (RPN).

The Peer is expected to clearly and simply list the short term goal by typing in **ALL CAPS SHORT TERM GOAL:** then listing the specific goal.

Some examples of short term goals include something like:

SHORT TERM GOAL: Keep Voc. Rehab appt that is scheduled for this week.
STG: Meet with Peer at Weds. night NA meeting on Valencia Ave.

SHORT TERM GOAL: Participant will complete the application for supported living
STG: Set up an appt for Medicare (to get a replacement card)

Peers will use the Rolling Progress Note to document any and participant long term goals. The goals statement for the Long Term Goal(s) is likely to change during the course of the intervention and should be updated at least monthly in the RPN, even just to state, "Long Term Goals remain the

same: Get sober sometime in the future, after finding stable housing." The term "Long Term Goal(s) can be abbreviated by using **"LTG"** in **bold**.

Below is an example of documentation of a Long Term Goal in the Rolling Progress note that includes both the goal and a brief statement to support or expand on the interaction that led to the goal.

7-10-21 LTG: ***"Get sober, so ppt can return to college":***
In phone conversation today the Participant described his desire to re-enroll in college. Ppt also described conflict with parents about continued financial dependence on them. Ppt verbalized anger and frustration. Continues to resist participation in support group. Plan for getting sober still needs to be developed but participant not ready to discuss or commit."

The data manager from EMMES will be providing a training via webinar on using the RPN which will be recorded and will be accessible to all peers for review.

Site Lead peer and intervention lead members will have access to Rolling Progress Notes to ensure timely completion of notes, to ensure clarity exists about short and long term goals, and in the event that another local Peer needs to help out with this participant (the backup Peer would understand which ways the Peer should follow-up with the participant).

3.1.3 Checklist for Documentation of Peer Intervention Session Activities

Both the Initial meeting between PILOT peer and study participant, may happen at hospital bedside or other location, and the Final Pilot peer and study participant session which will happen sometime towards the end of the participant's 6 month intervention period will be documented by filling out the appropriate Session Checklist.

The checklist is a simple list of expected activities/discussions for each session.

The checklist requires only a date, site ID, Peer ID (or initials?) a check mark "√" next to teach of those intervention activities the peer did complete and a "0" next to those intervention activities/discussions the peer did not complete. The activities/discussions for each session can be covered over more than one "session" or conversation. If the peer completes activities/conversations for the Initial Session over two or three meetings/conversations on different days then the Peer should complete a separate checklist for each day that some content from the Initial session was completed. Peers are expected to be honest in providing checkmarks next to only those activities/conversations actually covered. Examples of the checklists can be found in the appendix of this manual.

3.1.4 Supervisor Log

The Lead Peer completes the Supervisor Log to document Peer supervision and weekly meetings.

Following the weekly supervision meetings, the lead peer will rate each of the participating peers' overall performance on the criteria included on the Log (use of MI, knowledge of community resources, etc). There is a Comments section on the form to allow Lead Peers to add relevant narrative content related to the group or individual session. If a peer attended the session but did not have any open cases to discuss, the lead peer should indicate that in the comments section.

3.2 Supervision

Effective Supervision is the third Guiding Principle of the PILOT Intervention. Every PILOT Peer is expected to participate in regular supervision both on a local level with the Lead Peer (who supervises all other site PILOT Peers) and on a national study level with the intervention lead team.

3.2.1 Peer Supervision at the Local Level

Each study site is expected to have one PILOT Lead Peer who will have a caseload of intervention study participants and who will also support the other site PILOT Peers on a daily basis. Site Peers should reach out to the Lead Peer to discuss any concerns or questions peers have about study implementation, delivery of the Pilot intervention, and study participant concerns. Site Peers will attend weekly group supervision meetings facilitated by the site Lead Peer. During each weekly peer supervision meeting, peers are expected to discuss each participant in their case load at least briefly. The information that each Peer will share and discuss with other Peers and the Lead Peer is the following:

- The participant's substance use
- The participant's level of engagement status
- The most recent PILOT Peer/participant communication (or contacts attempted)
- Any goals the participant is/was working towards
- The PILOT Peer's next step(s) with the participant

The three levels of participant engagement are "unengaged" "partially engaged" and "engaged." The figure below describes each level of engagement and expectation of Peer in discussing engagement level of each participant.

Table 1: Unengaged, Partially Engaged, Engaged

"Unengaged"	"Partially Engaged"	"Engaged"
• Not answering phone calls. No rapport • No contact despite Peer's consistent outreach efforts in 6 weeks • Case must be presented at supervision to problem solve and develop a re-engagement plan	• Randomly answering a phone call or text, but only if a need arises • Limited/no SUD work • Participant is responsive to outreach contact but not engaged with peer support work • Peer should discuss at supervision to generate ways to have participant be more fully engaged	• Attending meetings once/week with peer • Participant regularly participates in peer support work • Peer should update participant progress during supervision meetings

Note: Determining level of engagement is not contingent upon condition of SUD

During the weekly site supervision calls the PILOT Peer also will be expected to solicit support and feedback from Lead peer and other peers in their preparation for the more thorough case presentation each peer is expected to provide at some point during the national supervision calls.

3.2.2 Peer Supervision at the National Level

National study level supervision will take place via regular national supervision calls with the Lead Intervention Team. During these national peer calls, the PILOT Peer is expected to discuss cases that are challenging, cases where not much is happening or which are lost to follow-up, and cases that have had some success. Peers are expected to respect and support other Peers during these calls. On a rotating basis, each peer will be expected to provide a more thorough case presentation on one participant for guidance on the case presentation. Additionally, lead team intervention calls will be used to encourage and support PILOT Peer self-care and cover specific topics or additional training. Outside of the regularly scheduled national supervision calls, Peers, through their Lead peers, will be encouraged to reach out (via email or phone calls) to the lead intervention team members to discuss unusual situations with intervention participants or gain clarification around intervention study procedures, including documentation of PILOT Peer/participant study activities.

3.2.3 Supervision Expectations of The Lead Peer

The Lead peer is expected to:

- Respond to PILOT Peer questions and provide support as needed.
- Review on a regular basis (i.e., weekly) PILOT Peer eCRFs such as the Peer Intervention Log for completeness and timely entry of intervention data
- Formally meet with their site PILOT Peers on a weekly group basis to review each study participant in each PILOT Peer's caseload to:
    - Discuss the participant's substance use,
    - The participant's engagement status
    - The most recent PILOT Peer/participant contact or contacts attempted
    - Any goals the participant is/was working towards
    - The PILOT Peer's next step with the participant
- Support and guide PILOT peers in their preparation for the more thorough case presentation each peer is expected to provide during the national supervision calls.

After each weekly site supervision meeting (and as needed 1:1 supervision meetings), the Lead Peer will complete the Supervisor Log and rate each peer on the following factors:

- Effective use of motivational interviewing
- Effective in addressing harm reduction
- Knowledge of community resources
- Effective linkage to community resources
- Seeking supervisory support
- Responsive to feedback
- Offering support to other peers

3.2.4 Support/Supervision of Lead Peers

The Lead PILOT Peer will be expected to meet with a local study site supervisor or Site PI on a regular basis for support around the Lead PILOT Peer's participant caseload as well as support and guidance in supervising the other site PILOT Peers.

All site Lead PILOT Peers will meet about twice a month with the lead intervention team via a group Zoom or conference call.

(or more often as needed) to receive support and guidance around supervision of their local site PILOT Peers, discuss any Lead peer participant cases as needed, and receive support and guidance for their more thorough case presentations during the national supervision calls.

3.3 PILOT Peer Self-Care and Support During the PILOT Study

Study participants who are actively using substances may be challenging. Participants may push boundaries and request more than a Peer can or should provide. There may be a time(s) when a PILOT Peer might extend themself too much for a particular participant. It is likely that a participant's chaotic life and active substance use will be stressful to witness. Specific participant interactions that may not go as planned or hoped could produce emotions or thoughts in a PILOT Peer that might linger too long and wear down a PILOT Peer.

Due to the nature and challenge of the PILOT Peer's work on this study, the PILOT Peer is expected and will be supported in monitoring the Peer's own self-care around recovery and general well-being. Regular local group supervision and as needed 1:1 supervision will provide opportunities to check-in around the PILOT Peer's self-care. PILOT Peers will be expected to continue with accessing their typical support systems whether that is attending recovery groups, seeing therapists 1:1, engaging in regular exercise, journaling, socializing, etc. PILOT Peers are expected to recognize warning signs of their stress level and reach out to others on the study team, supervisors, and one's typical support system to receive the support needed.

3.4 Safety During Work in Community Settings

SAFETY FIRST! Prior to conducting a visit to a participant in the community, the peer should call or text the participant to let them know that they are planning to visit at a specific time and date. If the peer is unfamiliar with the neighborhood where the visit will occur it is a good idea to gather information prior to the visit. This could include checking out the address on Google or by first conducting a drive (before the day of visit) through the neighborhood to see if there are any concerns visiting the participant in this area. Before leaving for visits with participants in the community (i.e. home visit, out in the community, participant escort, family outreach, etc.) and periodically during the time while in the community, the PILOT Peer should email, text, or call the PILOT Peer supervisor or designated colleague to alert them regarding visit location and estimated time in the community. Consider sharing your location with the PILOT Peer supervisor or another coach. It is impossible to overshare this information. Some text/email/call examples include:

- *Heading to 18th and Valleyview to visit DS. Be back in hour.*
- *Escorting EA to Medi-Cal from 9-10*

While in the community, the PILOT Peer should always have fully charged cell phone on their person to receive texts or calls from their supervisor or other colleagues AND to make text or calls to participants, community people, supervisor or colleagues. If a participant is not at home or at their usual hangout, the PILOT Peer should call the participant while on location in case the participant is nearby.

PILOT Peers are expected to follow safety best practices:

- Always put your safety considerations first and follow your instincts
- Use a Buddy system if you feel that going out on your own might be risky.
    - If you have not been in regular contact, we strongly encourage going with a buddy or team.
- If needed, use GPS Directions
- Be aware of your surroundings by avoiding distracted walking (i.e., limit use of phone while walking)
- Plan visits during daylight hours only
- Wear clothes appropriate to the setting (i.e., don't overdress for the occasion)
- Wear comfortable shoes—no sandals or open-toe shoes
- If possible, avoid bringing personal items (purse, jewelry, etc.)
- Carry the minimum amount of protected health information (PHI) necessary
- NEVER leave PHI in public view or unattended
- Carry backpack with a lock, if appropriate, and bring the following:
    - Notebook and pen
    - Business cards
    - Letter(s) (using blank letterhead) to leave in mailbox or taped to door etc.
    - Follow all COVID-19 precautions. See General COVID-19 Precautions in the next section.
- Provide alternative transportation (e.g., transportation tokens, other PILOT Peers, etc.) to those participants who have been or may be inappropriate with assigned PILOT Peer

If a visit is running over a reasonable amount of time, the PILOT Peer should text or call the supervisor or designated colleague as soon as possible about running late. When visit is complete, text or call supervisor or designated colleague to communicate the next location (office, hospital, another field location and give the location). Examples may include:

- *Done w DS. rth (returning to hospital) or rto (returning to office)*
- *Done w EA. going to c MH since close. Maybe another 30m*
- *Done searching for TW. heading home*

If a PILOT Peer experiences any emotionally charged event while out in the field, the PILOT Peer should do the following:

- First priority is safety. Get to a safe location and call emergency services, if needed.
- Text Supervisor or/and fellow peer and use "*code red*" if emotionally charged situation needs to be interrupted by a call from supervisor or colleague
- Debrief with supervisor by phone or in person as soon as possible
- Take 30- 60 minutes for self-care

- If unable to continue with scheduled appointments, the PILOT Peer is to send a group text to fellow Peers and supervisor to see if someone can cover other appointments. The PILOT Peer can use "*code yellow*" to inform navigators of need for coverage without having to repeat aspects of the emotionally incident.
- After an emotionally charged session or event, the PILOT Peer should change their environment (i.e., leave the field) and use time to complete less emotionally charged duties such as documentation.
- The Peer and/or Lead Peer (supervisor) should contact the Lead Intervention Team and the site PI to report any situation involving a significant concern or a threat to participant or staff safety.

If the PILOT Peer experiences any unsafe incident or loss of property while out in the field, they should contact their supervisor immediately.

If the supervisor does not respond to text or a call, the PILOT Peer should call their supervisor twice in quick succession and hang up both times. This will inform supervisor to contact the PILOT Peer as soon as possible. If unable to reach the supervisor, the peer should contact the site PI and/or the intervention lead team.

3.4.1 General COVID-19 Precautions for all Peers

The CDC recommends the following:

- Wear a mask to protect yourself and others and stop the spread of COVID-19
  - Wash your hands or use hand sanitizer before putting on your mask.
  - Wear your mask over your nose and mouth and secure it under your chin.
  - Fit the mask snugly against the sides of your face, slipping the loops over your ears or tying the strings behind your head.
  - If you have to continually adjust your mask, it doesn't fit properly, and you might need to find a different mask type or brand.
- Stay at least 6 feet away from others who don't live with you.
- Avoid crowds. The more people you are in contact with, the more likely you are to be exposed to COVID-19.
- Avoid poorly ventilated spaces
  - As much as possible, avoid indoor spaces that do not offer fresh air from the outdoors. If indoors, bring in fresh air by opening windows and doors, if possible.
- Wash your hands often
  - Wash your hands with soap and water for at least 20 seconds especially after you have been in a public place, or after blowing your nose, coughing, or sneezing.
  - If soap and water are not readily available, use a hand sanitizer that contains at least 60% alcohol. Cover all surfaces of your hands and rub them together until they feel dry.
- Cover coughs and sneezes
  - Always cover your mouth and nose by using the inside of your elbow or with a tissue do not spit.

    - Throw used tissues in the trash.
    - Immediately wash your hands with soap and water for at least 20 seconds. If soap and water are not available then use hand sanitizer that contains at least 60% alcohol.
- Clean and disinfect frequently touched surfaces daily. This includes tables, doorknobs, light switches, countertops, handles, desks, phones, keyboards, etc.
- Monitor Your Health Daily
    - Be alert for symptoms. Watch for fever, cough, shortness of breath, or other symptoms of COVID-19.
    - Take your temperature if any symptoms develop.
    - Don't take your temperature within 30 minutes of exercising or after taking medications that could lower your temperature, like acetaminophen.
- Get vaccinated

3.4.2 COVID Safety in Preparation for a scheduled face-to-face visit with an intervention participant

If the PILOT Peer and participant have previously agreed to meet on a certain day and time, then the PILOT Peer should provide a reminder call, email or text. During this reminder, the PILOT Peer should ask the participant the following screening questions:

1. In the last 30 days, have you had a positive COVID-19 test?
2. In the last 14 days, have you had sustained close contact (such as household contact) with a person with a positive COVID-19 test?
3. In the last 14 days, have you experienced any of the following **new or worsening** symptoms not explained by an existing condition:

    - Fever
    - Unexplained muscle aches
    - Difficulty breathing
    - Dry cough
    - Sinus congestion
    - Runny nose
    - Sore throat
    - Nausea
    - Vomiting
    - Diarrhea
    - Loss of taste or smell
    - Eye redness or discharge
    - Confusion
    - Dizziness

If a PILOT participant's answers to any of the COVID-19 screening questions is "yes," the visit should be postponed or moved to a phone call. The participant should be referred to their medical provider.

If the participant responds "NO" to all of the above COVID screening questions, the PILOT Peer should ask about the participant's ability to adhere to COVID-19 safety measures during the face-to face visit by asking the last two screening questions:

Are you willing to:

1. Wear a surgical mask or facial covering that covers both the nose and the mouth during the entire in-person visit?
2. Maintain 6 feet physical distancing from each other during the visit?

The participant must agree to the above two COVID safety measures before the PILOT Peer confirms the face-to-face appointment.

At the designated time of the appointment, the PILOT Peer should have extra unused masks. The PILOT Peer is to provide the participant with a new mask if the participant is not wearing one or if the participant's existing mask is fitting poorly or appears dirty. If the participant refuses to wear a mask during the visit, the PILOT Peer may cancel and reschedule the visit.

3.4.3 Safety preparation for trips into the community to search for an intervention participant

A PILOT Peer should prepare themselves for going out into the community by bringing the following:

1. The PILOT Peer's mask and extra masks for participants and/or their family members or friends
2. Hand sanitizer for the PILOT Peer's use and small extra bottles to give to participant and/or others as appropriate
3. Disposable gloves (in case the PILOT Peer wants to wear them in a given situation)

Upon finding any participant, the PILOT Peer should follow the screening guidelines above including providing an unused mask and asking about symptoms.

Appendices

Appendix I: PILOT Peer Coach FAQ

Welcome to the PILOT Peer Study!
Questions & Answers about Your PILOT Peer Coach _____

What is a PILOT Peer Coach?

- A PILOT Peer Coach is someone who:
    - Has lived experience with substances, similar to you
    - Supports you in choosing your own personal goals and priorities
    - Provides case-management and service coordination when you want it

How often will I meet with my PILOT Peer Coach?

- You will most likely meet face to face with your PILOT Peer Coach more frequently at first and then probably less frequently towards the end of the 6 months
- You will also have regular contact with your PILOT Peer via telephone calls, text messaging, and email.

How long will our meetings last?

- Much of the contact will be through text messaging, phone calls or email
- Contact time will vary depending on your needs

In what ways will my PILOT Peer Coach help me?

- Work with you to identify your needs, which may be completing paper work for insurance, housing, transportation, care clinics, and substance use treatment
- Partner with you to prioritize and help you address your needs
- Provide referrals, help you make appointments, and help set up reminders for upcoming appointments
- Accompany you to any important appointments/meetings (if you want)

How else can my PILOT Peer Coach help me?

- Answer basic questions you might have about reducing harm around your use or about treatment services
- Remind you of your strengths and abilities in reaching your goals
- Listen and support you when discussing what gets in the way of your priorities
- Cheer you on when you are taking charge of goal setting and making accomplishments
- Support you when you are struggling with self-care

Appendix II: Medications for Opioid Use Disorder

Why do we use medications for the treatment of Opioid Use Disorder?

1. Use of medication significantly decreases the risk of dying of an overdose
2. Use of medication decreases symptoms and suffering from Opioid Use Disorder

Currently there are 3 medications approved for the treatment of Opioid Use Disorder:

	Naltrexone	Buprenorphine or Buprenorphine/Naloxone	Methadone
Other Names	Vivitrol, ReVia	Suboxone, Subutex, Sublocade	
How It Works	Blocks the opiate receptors in the brain from being acted on by opiates like heroin or fentanyl	Mildly turns on the opiate receptor and blocks the opiate receptor from being acted on by opiates like heroin or fentanyl	Turns on the opiate receptor and blocks the opiate receptor at higher doses from being acted on by opiates like heroin or fentanyl
How/how often it is taken	Monthly shot (Vivitrol)	Under the tongue daily or shot (weekly/monthly)	Oral dose (liquid or tablet) daily, from a methadone clinic
When to start	Must be off opiates for 7-10 days	Must be in mild opiate withdrawal	Must be given in methadone clinic; cannot be high when starting
Abuse potential	No abuse potential	In Suboxone, buprenorphine is coupled with naloxone (Narcan) to prevent injection of the medication; when injected, it will cause withdrawal (but not when taken under the tongue)	To decrease diversion, administered in methadone clinic daily at first, then with take-homes once stable
Other notes	• Naltrexone is not an opiate or controlled substance • Difficult to be opiate-free for 7-10 days – high relapse rates when trying to start • May consider for those leaving jail, detox, rehab, or those who don't want to be on opiate replacement with Suboxone or methadone • Need to come off for surgeries, etc., but no withdrawal when coming off	• Buprenorphine is a long-acting opiate with proven safety for treating OUD • Naloxone is in Suboxone only to prevent injection; naloxone is not in the Sublocade shot • Pregnant women take buprenorphine without naloxone (Subutex) • Can be provided in outpatient setting from a qualified medical provider (e.g., do not need daily dosing in a clinic) • Can/should continue when hospitalized or getting surgery • Withdrawal if/when coming off	• Methadone is a long-acting opiate with proven safety for treating OUD • For treating OUD, must be given through a methadone clinic • Considered the "highest level" treatment, especially for those who may have failed other treatments • Can/should continue when hospitalized or getting surgery • Withdrawal if/when coming off

Appendix III Frequently Asked Questions about Medications for Opioid Use Disorder (MOUD):

Q: What's the difference between methadone, Suboxone and extended-release (XR) naltrexone?

A: **Methadone** is a "full" opioid (completely activates the opioid receptor in the brain) and is given through a methadone clinic in liquid or pill form. It is usually dosed every day at first, then with "take-homes." It has the most research for OUD and decreases risk of death from overdose.

Buprenorphine/naloxone (Suboxone) is a "partial" opioid (turns the opioid receptor partially on) and is given through a prescription from a provider in an office setting, with weekly-to-monthly appointments. It is generally as effective as methadone and also decreases risk of death from overdose. It is taken as a pill or film under the tongue, and there are newer forms of buprenorphine that can be given as a weekly or monthly shot.

Extended-release (XR) naltrexone is an opioid blocker (blocks the opioid receptor), and is given as a monthly shot. Generally, you have to be off opioids for 7 days to start naltrexone. When addiction is active, it can be difficult to be opioid-free for 7 days, so any time you might find yourself off opioids for a period of time, such as coming out of detox, hospitalization, or jail, is a good time to think about this medication. If started after detox, XR naltrexone is as effective as methadone or buprenorphine for OUD.

Q: Is the use of medications like methadone and buprenorphine simply replacing one addiction with another?

A: No. Opioid addiction is a life-threatening disease with cycles of euphoria (high), crash, and craving—sometimes repeated several times a day— which causes suffering and puts one at high risk for overdose and death. The medications buprenorphine and methadone not cut the risk of death in half, but they also help stabilize individuals and end the cycle of suffering and addiction. Because methadone and buprenorphine are opioids, they can result in withdrawal if not taken, but that is different than addiction. Your prescriber can help treat your withdrawal symptoms if and when you're ready to come off.

Q: How long will I stay on treatment with methadone, buprenorphine, or XR naltrexone?

A: It is generally recommended that you stay on medication until the OUD is stable for at least one year. Studies show that the longer someone with OUD remains on medication, the better they do. However, some individuals decide to come off medications sooner, and some will remain on medication life-long. It is important to talk with your prescriber about how long you want to stay on medication.

Q: If I want to come off medication – will I experience withdrawal? Will I be "stuck" on medication?

A: If you're on methadone or buprenorphine and decide you want to come off, it is important to discuss with your prescriber so they can help you consider the risks and benefits of coming off, transition off safely, and taper to decrease withdrawal symptoms. After coming off buprenorphine or methadone, it is recommended to transition to XR naltrexone (non-opioid) to ensure stability.

Q: I want to be opioid-free/abstinent - is there an option?

A: Yes. XR naltrexone is a non-opioid option for treatment of OUD. Using this medication generally requires being off opioids for at least 7 days. This may be an option if you're going immediately to an inpatient detox setting or other structured setting (e.g., jail, rehab, hospital). If that is not an option at this time, it is better in the short-term to be on buprenorphine or methadone than to undergo an outpatient detox to no medications. The most important outcome is survival, and

both methadone and buprenorphine prevent overdose and death. Detoxing to no medication can actually increase your chance of overdose and death.

Q: I have chronic pain – will these medications help my pain?

A: Yes. Both buprenorphine and methadone are also approved as pain medications and are usually very effective for chronic pain.

Appendix IV: Motivational Interviewing

Motivational Interviewing (MI) was originally developed from William R. Miller's experience working with problem drinkers *(Miller WR, Rollnick S. Motivational Interviewing: Helping People Change (Third Edition).* New York: The Guilford Press, 2013). Motivational interviewing *"is a collaborative, conversation style for strengthening a person's own motivation and commitment to change."* MI has been applied, tested, and researched in various settings and efficacy of MI has been established. MI is an evidence-based practice for the treatment of individuals with substance use disorders.

According to Miller and Rollnick, ambivalence (feeling two opposing or conflicting ways about something) about making a change is typical. Though ambivalence is a normal part of preparing for change, it is often where a person can remain stuck for some time. MI concentrates on exploring and resolving an individual's ambivalence. In the use of MI, the PILOT Peer focuses on the motivational processes within the individual which enable change.

Spirit of Motivational Interviewing
MI is characterized by a certain clinical "way of being" with a client or study participant within which to apply specific MI methods. Four key elements make up the MI spirit: collaboration, acceptance, evocation, and compassion.

Partnership (versus directing) is the process where the PILOT Peer and participant work together in a partnership. The PILOT Peer is not the "expert" who confronts, directs, or warns. Rather, the participant is the "expert" on themselves. PILOT Peers do not have all the answers to participant dilemmas or problems. The teamwork approach facilitates trust and builds rapport and is critical for possible change.

Evocation (versus imposing ideas/reasons) is drawing out of the participant their own thoughts or ideas around the reasons and motivations for change. The PILOT Peer does not tell the participant why the participant should change or how to change. Change is more likely to occur and more likely to last when the PILOT Peer encourages the participant to uncover his/her own motivations and skills for change.

Acceptance does not mean the PILOT Peer necessarily approves of the study participant's actions. Acceptance involves seeing and prizing the inherent worth and potential of every participant. By being freely accepted, the participant may be equipped with the empowerment and the responsibility to decide to change, as well as determine how that change will occur. The PILOT Peer encourages empowerment and responsibility and does not decide when and how the participant is to make change.

Compassion (versus sympathy or identification) is to actively promote the participant's welfare, to give priority to the participant's needs. Compassion is a deliberate commitment to pursue the welfare and best interests of the other.

Four Principles of Motivational Interviewing
The four principles of MI guide the PILOT Peer in the practice of MI and the Peer should maintain these principles throughout the intervention. The four principles are: express empathy, support self-efficacy, roll with resistance, and develop discrepancy.

1. Express Empathy
   Empathy is the process of understanding the participant's perspective, putting oneself in the participant's world. Whereas sympathy is often defined as feeling sorry for or having pity for a participant, empathy is appreciating and conveying understanding of the individual's experiences.
2. Support Self-Efficacy

To make a change, a participant needs to believe that they are capable of implementing change. MI is a strengths-based counseling approach, in which the PILOT Peer encourages participant self-efficacy through an exploration of the participant's past successes and current strengths, with the hope that the client may utilize these strengths to make changes.

3. Roll with Resistance
   A participant may not be ready to make a change as quickly as a PILOT Peer would like. Or a participant may not be ready to make the type of change that a PILOT Peer thinks is best for the participant. If the PILOT Peer argues for change the participant will resist. PILOT Peers using MI may avoid resistance by not confronting participants. If a participant becomes resistant to change, the PILOT Peer may decrease participant resistance by "rolling with resistance," accepting the participant's current stance.
4. Develop Discrepancy
   Motivation for change is more likely when a participant sees a mismatch between their current situation and where they would like to be. The PILOT Peer facilitates participant motivation by assisting the participant with examining their discrepancy between current behaviors and overall values and goals.

Motivational Interviewing Methods

Implementing the MI "spirit" and demonstrating the four principles of MI is orchestrated through the skillful use of the four core MI methods: **O**pen-ended questions, **A**ffirmations, **R**eflections, and **S**ummaries, or as they are often called, **OARS**. By using OARS, the PILOT Peer moves the change process along by building a therapeutic alliance and prompting conversation about change.

1. Open-ended questions are questions that tend to start with "How", "What", "In what way." These questions require more than a "yes" or "no" response and invite more thinking on the participant's part. Open-ended questions more easily guide the participant conversation towards reasons for and the possibility for change. Closed-ended questions typically begin with a "Did", "Do," "Don't", "Could" or "Would" and truncate a conversation by allowing the participant to answer "yes" or "no" without any thoughtful consideration and further elaboration. Although closed ended questions may be appropriate from time to time, open-ended questions generate more thoughtful responses.
2. Affirmations are comments that acknowledge client strengths. A critical element in promoting the MI principle of Supporting Self-Efficacy, affirmations help a participant recognize his/her own capabilities and can provide hope that change is possible. For example, a participant may minimize a "clean" period as "just another month." The PILOT Peer should reframe the "just another month" by pointing out that the participant did not use for an entire 30 days and inquire how the participant was successful for those 30 days. The PILOT Peer can encourage the participant to view the 30 day "clean" period as an accomplishment to build on.
3. Reflections are statements that "reflect" back or mirror back what the participant shares with the PILOT Peer. Reflecting statements demonstrate PILOT Peer interest, understanding and empathy. Reflections can encourage further exploration and shift away from problematic statements. Reflections may start with "So, you feel..", "It sounds like.." or "You are.." If a participant states to the PILOT Peer that "Doctors think they can boss you around. Well, no one tells me what to do." The counselor may reflect the following: "You want your care providers to respect you and listen to what is important to you." or "You want to decide when it is time to make some changes."
4. Summaries or summary statements link together and reinforce material being discussed. Summaries also show that the PILOT Peer has been carefully listening, and may prepare a participant to elaborate further. The best and most effective summaries are succinct. A participant may share with a PILOT Peer about a trip to the emergency room due to an abscess and, in the process, relate the chain of events. One summary that could be made is something like: "So, this infection got really bad and worried you enough to get treated at the

hospital. You don't like being in the hospital, but you care enough about your health to get better. Good for you. In what other ways are you taking care of your health?"

PILOT Peers are expected to become adept in the use of OARS (open-ended questions, affirmations, reflections, and summaries) and scaling questions should practice if needed with coworkers, friends, and/or family members so that the use of OARS is a natural part of a Peer's communication repertoire with study participants.

Change Talk

Change talk is a communication style that encourages a participant's own reasons for change and the advantages of change. If the Peer were to present the reasons or arguments to support why the participant should enter a substance abuse treatment facility or look for employment, the participant's response typically may be to argue against change or present the reasons for the status quo. If the Peer were to invite the participant to share about why the participant might want to make changes the participant then, is in a position to present his/her own reasons for change.

There are four forms of change talk. Questions about the "Disadvantages of the Status Quo" promote a discussion around negative consequences of a participant's current behavior or state. "Advantages of Change" questions pull from the participant any benefits the participant sees to making some changes. The participant expressing confidence around making change is a third kind of talk called "Optimism for Change." The fourth type of change talk is where the participant is expressing an intention or desire or commitment to change and is call "Intention to Change."

The PILOT Peer is expected to be continually aware of any type of change talk the participant may spontaneously share and encourage change talk with the strategic use of change talk questions like the ones that follow.

Disadvantages of the Status Quo

1. What worries you about your current situation?
2. What makes you think that you need to do something about your substance use?
3. What difficulties have you had in relation to your substance use?
4. What do you think will happen if you don't change anything?

Advantages of Change

1. How would you like things to be different?
2. What would be the good things about reducing your use (seeking substance use treatment)?
3. In what ways would you like your life to be different a year from now?
4. If you could make this change immediately, by magic, how might things be better for you?
5. What are the main reasons you see for making a change?
6. What would be the advantages of making this change (seeking substance abuse treatment, reducing use)?

Optimism about Change

1. If and when you did decide to seek substance use treatment, what makes you think that you could do it?
2. How confident are you that you can change if you want to?

3. If you decided to make a change what do you think would work for you?
4. When else in your life have you made a significant change like this? How did you do it?
5. What personal strengths do you have that will help you succeed?
6. Who could offer you helpful support in making this change?
7. How confident are you that you can make this change?

Intention to Change

1. What are you thinking about your substance use at this point?
2. What do you think you might do?
3. How much do you want to do this?
4. What would you be willing to try?
5. What do you want to have happen?
6. What do you intend to do?

Readiness or Importance Questions

1. On a scale of 0-10, where "0" is "Not at all important" and "10" is "extremely important", how important is it for you to find employment? Please tell me why you are at a "6" and not a "2"? What would have to happen for you to move from a "6" to a "9"?
2. On a scale of 0-10, where "0" is "Not at all" and "10 "is "extremely ready", how ready are you to seek medication assisted treatment (or substance use treatment, or go into detox)? Please tell me why you ae at a 4 and not a zero? What would have to happen for you to move from a 4 to 7?

Appendix V: Principles of Harm Reduction

Some participants enrolled in the PILOT intervention arm may choose to go into detox or rehab and/or start medication for opioid use disorder (MOUD) such as methadone, buprenorphine, or naltrexone. Other intervention participants may decide they do not want to stop their use but want to reduce their use. Other participants may want neither to stop nor reduce their use but continue using as they have been using. Whichever choice the participant makes is up to the participant, and the PILOT Peer accepts the participant's choice while also recognizing that individual participants may change their decision or vacillate between options. Using Motivational Interviewing (MI) methods such as open-ended questions and reflections, PILOT Peers are also expected to find opportunities to engage with participants about their use by exploring the downsides the participant experiences with their current use, the advantages to reducing or stopping use or how their life would be different with no use or greatly reduced use.

As long as a participant is using, no matter at what frequency or quantity, or even if the participant is recently abstinent there is always the potential for the participant to reduce the potential harm with their use. The PILOT Peer is to have a good understanding of Harm Reduction principles and strategies that can reduce harm and to explore with the participant ways the participant may want embrace or reduce potential harm around their use. For example, a participant can carry naloxone (Narcan) and let his friends know where he keeps Narcan so that it is accessible during an overdose, thus preventing a death from overdose. Another harm reduction example is when a participant uses a clean needle (and not sharing needles or "works") to avoid contracting HIV and/or HCV. Other harm reduction methods are presented in Section 2.2.15 of the manual, starting on page 35. Below, is a definition of Harm Reduction and the principles of Harm Reduction provided by the National Harm Reduction Coalition.

Harm Reduction incorporates a spectrum of strategies that includes safer use, managed use, abstinence, meeting people who use drugs "where they're at" and addressing conditions of use along with use itself. Because harm reduction demands that interventions and policies designed to serve people who use drugs reflect specific individual and community needs, there is no universal definition of or formula for implementing harm reduction.

However, the National Harm Reduction Coalition *(harmreduction.org; National Harm Reduction Coalition; #529; 243 5th Ave; New York, NY 10001)* considers the following principles (revised in 2020) central to harm reduction practice:

1. Accepts, for better or worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.
2. Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe use to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others.
3. Establishes quality of individual and community life and wellbeing – not necessarily the cessation of all drug use – as the criteria for successful interventions and policies
4. Calls for the non-judgmental non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm
5. Ensures that people who use drugs and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them
6. Affirms people who use drugs themselves as the primary agents of their drug use and seeks to empower people who use drugs to share information and support each other in strategies which meet their actual conditions of use
7. Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based

discrimination, and other social inequalities affect both people's vulnerability to and capacity for effectively dealing with drug-related harm

8. Does not attempt to minimize or ignore the real and tragic harm that can be associated with illicit drug use

Appendix VI: Responding to an Overdose

Responding to an Overdose

Many participants will have experience in using Narcan to reverse someone's overdose. It may still be useful to review the steps in managing an overdose. At a minimum, the review will reinforce what the participant knows. It is not unusual, however, for someone who was provided Narcan to still learn something new from this review. A handout (Appendix XI) is available if the Peer thinks it would be helpful to either have the participant read or the participant and Peer to take turns reading. If a participant declines reading or partaking in this review, at a minimum the Peer should offer a copy of this handout to the participant to take or to pass on to any friends who use. A handout (Appendix XI) is available that demonstrates the overdose recovery position. Many participants may not be aware of this recovery position so even quickly showing the handout may be useful.

3 Steps in the Management of Witnessed Overdose

- Step 1: Recognize an overdose
    - *As we've discussed, someone might be having an overdose if they lose consciousness after using drugs, if their skin color looks bluish or grey, or they are not breathing normally.*
    - *Use a sternal rub (vigorously rubbing knuckles of closed fist to the center of the chest) to attempt to wake the individual.*
    - *(Optional) Provide a loud verbal warning "If you don't wake up, I will use Narcan on you!"*

- Step 2: Respond to the overdose
    - *Administer naloxone as soon as possible.*
    - *Call 911. Tell the dispatcher that the person is unresponsive (or not breathing).*
    - *Provide rescue breathing and/or chest compressions. If you are unfamiliar with these techniques, 911 dispatchers can walk you through these procedures.*

- *Here are a few things to keep in mind about narcan:*
    - *Always carry naloxone with you or know where it is so you can act quickly!*
    - *Narcan can be used on anyone, so if you suspect an overdose, use it.*
    - *If they don't respond after about 3 minutes, give another dose.*
    - *Narcan expires. Be sure to replace your kit every 2 years if you have not used it. But if expired naloxone is all you have in an emergency, use it!*
    - *Narcan lasts for a shorter time than the majority of opioids, meaning that the narcan can wear off before the opioid and the patient can "re-overdose". For this reason, it is very important that 911 is called as the patient may require repeated doses of narcan and monitoring by medical professionals*
    - *Fentanyl may cause a faster overdose – where the person stops breathing or their heart stops right away, so:*
        - *You may need to do rescue breathing and/or chest compressions right away.*
        - *An ambulance may be needed sooner.*
        - *Narcan might need to be given several times.*

- Step 3: Provide after-care
- *Place person in the recovery position.*

- *Stay with the person until help arrives or they are awake for at least 2-3 hours (longer if using prescription opioids). Naloxone only lasts about an hour, so the effects of the opioid may come back and they may overdose again.*

If you are not comfortable staying with them, make sure that someone (either a friend of theirs or a medical professional) is available to help.

Appendix VII: Strengths Based Case Management

Strengths based case management is a model of case management that focuses on a participant's own abilities or strengths for making changes in their life. Strengths based case management was developed in the 1980's by the School of Social Welfare at the University of Kansas as a way to assist people with persistent mental illness in their transition from long term institutionalization to more independent community living. Strengths based case management has been used effectively to assist individuals linking into as well as maintaining substance use treatment (Saleeby, 2009- *Saleebey D. (Ed). The Strengths Perspective in Social Work Practice (5th Edition). Boston, Massachusetts: Pearson Education, Inc., 2009.).* Additionally, strengths based case management has shown effectiveness in linking newly HIV positive individuals to their initial HIV care visit (Craw et al, 2008; Gardner et al, 2005).

In strengths-based case management, the case management activities of assessment, linkage, coordination, advocacy and monitoring is guided by five principles:

1. Encourage the individual to identify and to use his/her strengths, abilities and assets
2. Recognize and support the individual's control over goal setting and the search for needed resources
3. Establish an effective working relationship with the individual
4. View the community as a resource and identify informal sources of support
5. Conduct case management as an active community-based activity

Encourage the Individual to Identify and to Use Their Strengths, Abilities, and Assets
Inherent in strength based cased management is the viewpoint that individuals are most successful at accomplishing goals when they are able to identify their own strengths, abilities and assets, and intentionally use them in reaching their goals. The PILOT Peer, in helping study participants recognize their own strengths, will assist participants in appreciating their previous successes, increasing their motivation to make changes, and identifying and accomplishing goals. Some PILOT study participants may have previously entered substance use treatment, or maintained employment or stable housing. The PILOT Peer will explore with participants what abilities/strengths were used in these previous successes and help participants recognize that those personal abilities and strengths remain and can be used to make and accomplish new self-care goals, such as secure stable housing, find employment, reduce use or seek substance use treatment, or increase food security.

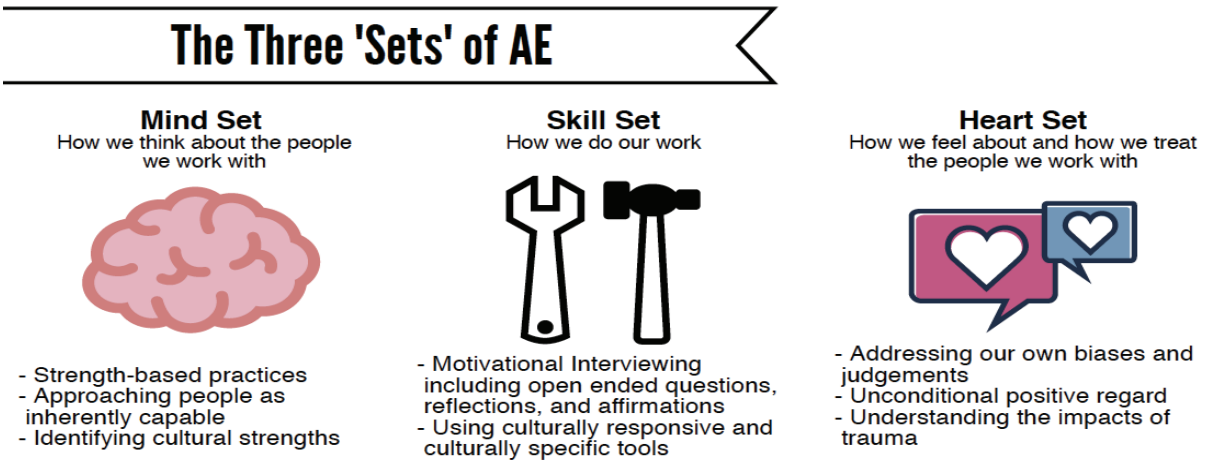
Recognize and Support the Individual's Control over Goal Setting and the Search for Needed Resources
Pilot intervention participants are likely to engage more readily in treatment if the goals they work on are goals they set for themselves not goals imposed on them by others. Based on the individuals' perception of needs, PILOT Peers will assist participants in formulating goals, establishing realistic steps for those goals, and identifying available resources. As previously mentioned, the PILOT Peers are to assist study participants in reducing their risk of overdose which may include safer use practices including carrying Narcan, reducing their use or stopping use. PILOT study participants may have other competing goals that may need to be addressed simultaneously or before participants are ready to recognize the importance of reducing substance use and/or entering substance use treatment. For example, some study participants may see stable housing as top priority or finding steady employment for themselves over managing or securing help for their substance use. PILOT peers, therefore, will assist study participants to secure more stable housing and/or employment while also working with these participants around reducing overdose risks, reducing substance use or entering substance use treatment.

Establish an Effective Working Relationship with the Individual
PILOT Peers, acting somewhat as case managers, will be the consistent person with whom study participants will maintain contact and are the people who work to coordinate the community resources available for participants. PILOT Peers will, whenever necessary, involve other people in the search for appropriate resources. PILOT Peers should have contact (phone calls, texting, face to face meetings) with study participants on a regular basis such as 1-2 times a week and will be responsible for knowing available community resources as well as work towards personally establishing relationships with the staff at these agencies (primary care, substance use treatment, housing, transportation) and will enlist agency support on behalf of their PILOT study participants.

View the Community as a Resource and Identify Informal Sources of Support
PILOT Peers should view the community as an overall asset, one that holds important and needed resources. PILOT Peers will establish working relationships with agency staff and by engaging with agency staff, PILOT Peers are role modeling successful contact with agencies. PILOT Peers will also urge individuals to seek out more informal sources of support such as family members, neighbors, friends, self-help groups. PILOT Peers will have good working relationships with community agencies and will use those relationships as a bridge to assist their participants in also making connections to agency staff. PILOT Peers will additionally encourage study participants to seek out and maintain additional support from their personal community around.

Conduct Case Management as an Active Community-based Activity
PILOT Peers will meet participants "out in the field" for example, at the individual's house, a coffeehouse or at a support agency. By conducting case management like activities out in the field PILOT Peers have a better understanding of the participant's possible barriers in reaching goals. The participants, with support from the PILOT Peers, have the opportunity to develop and maintain skills in the community where they reside. PILOT Peers will be expected to meet, when appropriate, study participants out in the field and if appropriate, offer to provide or find transportation for study participants on key appointments (medical, housing, employment, etc.) and as indicated, accompany participants to key appointments.

Appendix VIII: Additional Resources on Engagement



Source: Department of County Human Services, Multnomah County, OR: https://multco.us/info/three-sets-assertive-engagement

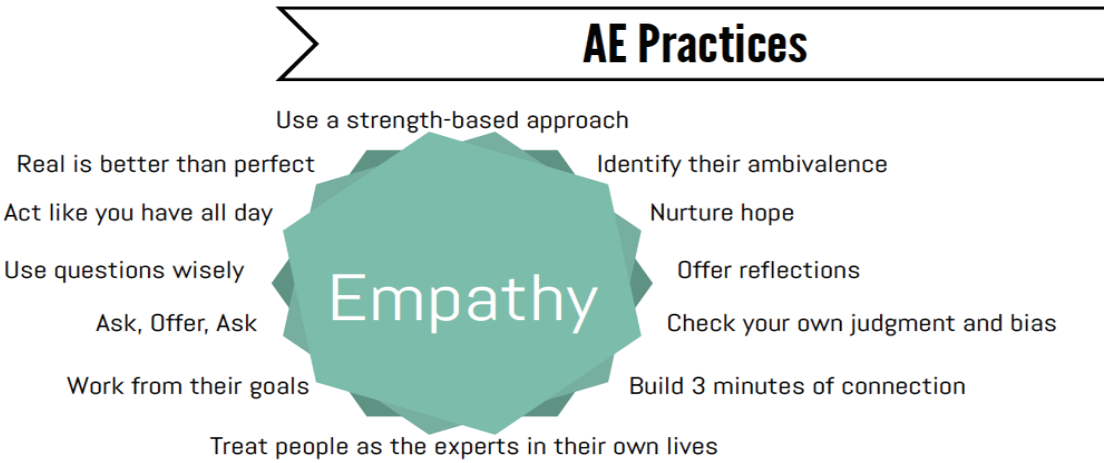
Five Tips for Making Meaningful Connections
https://www.lsfhealthsystems.org/wp-content/uploads/2023/11/ROSC_Toolkit_FINAL_July-2022-1.pdf

These tips on effective outreach and engagement are drawn from practitioners, peer supporters, law enforcement officials, housing experts, people who have been homeless and chose to disengage from behavioral health services, and their families. Outreach and engagement are about cultivating relationships:

1. Meet people where they are: Seek them out and find out what is most important to them. This is more likely to be a pair of warm, sturdy boots than it is an appointment with a psychiatrist. Ask "How can I make your life a little better today?"
2. Engender hope and respect and identify a particular strength that the person has during each interaction. Find out what the person thinks is most important to their well-being and give it priority. Many pathways lead to engagement and recovery. Resistance and reluctance may be acts of honor, courage, and a desire for independence. Recognize that strength.
3. Be persistent: Show everyone—respectfully and without intruding on their privacy— your sincere concern for them. Return and suggest more options for support when they are ready to choose them. Sometimes peoples' lives seem defined by chaos as they find themselves in and out of public service systems: a homeless shelter, an emergency room, the corrections and judicial system. Here, persistence, walking with them on their journey, and reaching out to help is essential. "If someone is not at the prison door when the person is released, we have lost that person."
4. Respect worldviews: People have many reasons why they have not engaged in, or have dropped out of, behavioral health services. Some found that treatment did not help; others gave up when they did not see immediate change. They may have had a poor therapeutic relationship or another negative experience. They may have wanted greater involvement in the decisions affecting them or felt dehumanized and disrespected by language used. For example, "I don't want to get near a case manager: I don't want to be managed!"
5. Be genuine: While the system is largely oriented towards eligibility, capacity, data, and scarce resources, never overlook the human factor in outreach and engagement.

Figure 3: Assertive Engagement (AE) Practices – Multnomah Co Handout

Re-engagement



Appendix IX Types and Frequency of Engagement

Determining Type and Frequency of Peer/Participant Contact

The PILOT intervention requires Peers to assertively reach out to participants. The following describes the type of "sessions" a Peer might have with a participant and give guidance to Peers and Lead Peers on the optimal frequency of these types of contacts. In order to determine the contact frequency, we first need to establish "contact types".

TYPE 1: Meaningful "Recovery/Harm Reduction Focused Session" with an engaged participant

This contact is delivered via all available methods: face to face, phone calls, texting, email. The manner of connection, and the length of the communication is less important than the "content" of the communication. The following characteristics represent a "Recovery/**Harm Reduction** Focused Session" with an active-status engaged participant:

- Contacts tend to be regularly scheduled (i.e., every Friday at 1 pm for a phone check in).
- Contacts tend to be longer in duration because the content requires more intensive focus (15 minutes to 30 minutes).
- The Recovery/Harm Reduction Focused Session should touch on one of the VIP domains (See page 26) and go beyond simple "check ins". (i.e. the PILOT Peer reviews with the participant the agreed upon goals or focus areas: "How are the recovery meetings going?" or "Please tell me about your progress on finding a suitable living arrangement", etc.)
- Each Recovery/Harm Reduction Focused Session should open with a check-in on the "agreed upon goal" from previous session AND should close with an "agreed upon goal" for the upcoming week.

TYPE 2: Check-In and/or Supportive Engaged Contact

These are reminders, check ins, or follow-ups with an engaged and active status participant, a participant actively working to meet their recovery or harm reduction goals. The contact method includes phone calls, texting, social media direct messaging, email. [Note: if the interaction is face to face it is nearly always a Type 1 interaction or Type 3 effort at re-engagement].

The goal of the Type 2 contact is to encourage the participant to continue on a positive pathway, encourage the participant to "get back on track" OR simply maintain connection and therapeutic rapport. Examples include:

> *"Did you get to the appointment at Greenville Mental Health?"*
>
> *"Hey Rich, Didn't hear from you last week. Hope all is well"*
>
> *"Good morning Tricia, Have a great day. Looking forward to talking with you on Friday."*

TYPE 3: Outreach and Re-Engagement Contact

As stated previously, at any point in time a participant may go "off the grid" and become disengaged from services. This is the rule, not the exception, and PILOT Peers should expect phases of "disengagement" with study participants. A Type 3 contact involves all methods of contact: texting, phone calls, email, direct messaging, face to face outreach.

The goal of a Type 3 contact is to re-connect with the participant. Type 3 contact should be done

in consultation with your supervisor and the study team so that safety protocols and creative re-engagement strategies are utilized. Examples of creative re-engagement strategies include unannounced home visits, stopping by participant workplaces, visiting common places where a participant hangs out (this information can be found on the Locator Information Form). Please see Safety section of intervention manual (page 47) for more on safety protocols.

Standards of Frequency of Contact

Type 1 = at least 1 time per week.
Type 2 = at least 2 time per week.
Type 3 = As necessary, dependent upon participant status.

Appendix X Checklist for First (or First/Second) Peer/Participant Meeting

Checklist for First (or First/Second) Peer/Participant Meeting
Meeting date _____ Ppt ID____ Peer Initials ____

Instructions: Peer is to place Peer's initials on each content item that was addressed in the first meeting with the participant. Peer is to place an X on each item not covered.

___ Prior to starting the initial session, consult with RA and or TAU Peer & discuss/review

- Main circumstances of participant's hospitalization (drugs, housing, employment, transportation, family/social support, etc.)
- Locator form

___TAU peer or RA will provide warm hand off, RA or TAU peer will ask participant's permission to share a little information about participant

___Introduction of PILOT Peer

- *Hello my name is _____ and I am the PILOT Peer in the study*
- *As a Pilot study Peer, I have personal lived experience with substance use, overdose…..etc.*

___ Clarify time frame of today's meeting

- *May we meet for about 10-15 minutes to get to know each other a bit?*

___ Identify and address pressing needs (food, water, other)

- *Before we discuss anything, may I get you anything: a beverage, a snack, a blanket?*
- If NO: *Please let me know if that changes and you want something.*

___ Briefly explain role as peer (and all the ways Peer can be of help)

- *As a Peer, I can be someone that you can talk to about stuff that is going on with you.*
- *I can support you in setting personal goals, gaining access to resources such as food, clothing, housing, job, school training (if you wish).*
- *You decide on what we work on together*

___ (If info not shared by RA) **Ask participant to share information about themselves: what happened that they ended up in ED. Peer provides active listening. Share life experience as appropriate.**

- *I know (RA name) shared some information with me. I'm so glad you survived the overdose. Very scary. What all do you remember that led up to your overdose?*

___ Determine immediate plan for discharge from ED (who is picking participant up, where spending the night, etc.)

- *What is your plan when you leave the hospital? Where will you go?*

___ Discuss participant preferences for best way to contact

- *In general, what is the best way to reach you: phone call, text, email?*
    - How often do you access email?

___ Ask about other contacts or contact information (if available/appropriate)

Other than people you have already listed on the locating information form, is there anyone else

who I may contact to pass on a message to you? OR OF *everyone who knows you who is the one person who will know how to get ahold of you the best?*

___ Provide Peer's contact information and guidelines for contacting peer; ask participant to put peer's phone number in ppt's phone. Peer to do the same.

- *May I put <u>your</u> name and phone number in my phone now?*
- *May we put <u>my</u> name and phone number in your phone now so you know it is me contacting you?*

___ Ok to speak with family or friend? (Circle one: not available, yes, no, participant refused)

- *If I lose contact with you may I reach out to (family/friend) just to pass on a message for you to contact me?*
- *If yes: How do you prefer I identify myself to people I reach out to: just my name, my name and the study name, name and a friend, etc.)?*

___ Discuss access to naloxone

- *What all do you know about narcan (naloxone)?*
- *If appropriate: May I share some additional information about narcan?*
- *May I provide you with some narcan before you leave the hospital just in case for you or friends you use with?*

Narcan Provided: Yes____ No ____ Ppt Declined ____

___ Set goal for next session

- *So, based on our conversation what I will do between now and (tomorrow/tonight) is ____ and you will _____ (one or at most 2 things: meet with me tomorrow, make a call to ___, take and keep narcan near/on you, etc.)*

___ Express desire to work w/participant and hope that they can accomplish ppt's goals

- *I really look forward to getting to know you better and working with you on the things that are a priority for you.*

___ Set next meeting time

- *So, as we agreed, I will (call, text, meet) you ___ (tomorrow at ___, etc.)*

After meeting with the participant:

___ Complete Peer Intervention Log (PIL) in eClinical

___ Complete Rolling Progress Note (RPN) in eClinical. Include the following info if known:

- Type and location of first interaction: phone call, in person, at hospital, in community. If not in hospital setting why not?
- Handoff from RA (Did it happen? In person?)
- Circumstances of overdose
- Drug of choice (route of administration, other substances used)
- Other major medical condition if reported
- Living situation – homeless, lives with family, etc.
- Transportation

- Employment status
- Participant's primary concern voiced during session
- Shared contact information (between Pilot peer and ppt)
- Narcan (Discussed? Accepted? Provided?)
- Any other important information, especially regarding safety
- Discharge plan (if appropriate)
- Include short term goal in all caps: SHORT TERM GOAL or STG
- IF participant discussed clear long term goal list it in all caps: LONG TERM GOAL or LTG

Example of a Rolling Progress Note (RPN):

50 yr old unemployed carpenter seen in internal medicine after accidental 3/23/22 overdose. Handoff from RA – brought to ED by EMS, found unresponsive in his home. Typically uses cocaine (2-3 x per week). No previous OD reported. Lives w/ long term gf in subsidized housing downtown. Has hx of IDU. Reports generally good health. Has desire to find work. Plans to stay with gf tonight. Will take bus, ppt/gf have no car. Accepted Narcan. Ppt gave peer permission to speak with gf (listed on LIF). We shared contact information. No recovery exp. SHORT TERM GOAL: Ppt will tell gf about joining study and that peer can contact gf. PILOT Peer will share overdose risk reduction info at next visit. Ppt agreed to phone call for 3/24 at 10am. Will schedule f-t-f visit w/in next few days.

Handout **A**

Behaviors That Increase Overdose Risk

* **Using more or stronger opioids**

* **Using fentanyl** (whether by choice, or unintentionally)
  Fentanyl is about 4 times riskier for overdose than heroin, and fentanyl overdose happens much more quickly. It's important to act especially fast in the event of a fentanyl overdose.

* **Mixing opioids with other drugs like benzos, alcohol, or cocaine**
  Opioids, alcohol, and benzos all can slow or stop a person's breathing. A person may already have other drugs and/or medications in their system, prior to using, that can increase their risk for overdose.

* **Injecting** (compared to snorting or smoking)

* **Using after a break** (for example: using after a hospital stay)
  If someone hasn't used, or drastically reduces their use, even for a couple of days, their tolerance may decrease.

* **Using alone**
  An overdose *fatality* is much more likely if someone uses opioids in a space where no one is aware that they're there, a space no one can access, and/or if no one knows to check on them.

* **Not having naloxone nearby**
  If an overdose does occur, not having naloxone close at hand (and someone there to administer it) decreases a person's chance of survival.

Handout **B**

Ways to Reduce Overdose Risk

* **Test drugs with fentanyl test strips**

* **Do a tester shot/go slow** (you can always do more, but you can't do less)

* **Change route of administration** (from injecting, to snorting or smoking)

* **Use with others and take turns** (to ensure that someone is awake and able to respond to an overdose, and to avoid multiple people overdosing at the same time, if the drugs are stronger than expected)

* **Make injection spaces safer**
  If it's possible, find a cleaner, better-lit space that is secure so you don't have to rush. Leave the door unlocked or use multiple-stall restrooms.

* **Carry naloxone and/or use with someone who has naloxone**
  Let others know where you have your naloxone, and know where they keep theirs. Make sure everyone knows how to use it.

* **Start methadone or buprenorphine medications**
  People who engage in methadone or buprenorphine treatment have a much lower overdose risk (at least half the risk)

Handout **C**

Responding to an Overdose in 3 Steps

* Step 1: Recognize an overdose

- Someone has lost consciousness after using drugs, their skin looks bluish or grey, or they are not breathing normally.
- Use a sternal rub to attempt to wake the person up.

* Step 2: Respond to the overdose

- Administer naloxone as soon as possible.
- Call 911. Tell the dispatcher that the person is unresponsive (or not breathing).
- Provide rescue breathing and/or chest compressions. 911 dispatchers can also walk you through these procedures.
- A few things to remember about naloxone:
    - ◊ It isn't useful if you don't have it with you, or can't get to it quickly. Keep it on you and make sure you always know where it is—let others know where it is too.
    - ◊ It's safe to use on anyone, so if you suspect an overdose, use it.
    - ◊ If someone doesn't respond to a dose of naloxone after 2-3 minutes, give them another dose.
    - ◊ Naloxone only lasts about an hour, so the effects of the opioid may come back and the person could fall back into an overdose, needing another dose.
    - ◊ Naloxone expires every 2 years, BUT if all you have on you is expired naloxone, use it!

* Step 3: Provide after-care

- Place the person in the recovery position (See Handout D).
- Stay with the person until help arrives or until they are awake for at least 2-3 hours (longer if they were using prescription opioids).
- Remember: it is possible that someone can fall back into an overdose once the naloxone wears off (in about an hour).
- If you are not able to stay with the person, make sure someone else is available to stay with them.

Appendix XII: National Training Slides: Research 101

CTN-107 Study National Training was held for all study staff members, including PILOT peers. The training was virtual and many of the training topics are noted in Section 1.2 of this manual. This Appendix is a sample of one of the training modules titled, Research 101. This module, developed with the training needs of Peer Support Specialists in mind, served to introduce research-naïve staff to basic research terminology and processes.

Anatomy of a Randomized Clinical Trial (Research 101)

NIDA CTN 107
Peer Intervention to Link Overdose Survivors to Treatment (PILOT)

PEER TRAINING

PREFACE TO FACE-TO-FACE WEBINAR 1

PILOT

Overview of the Training

- Issues and questions about research: Please ask!!!
- The language of research (vocabulary)
- Ongoing learning and supervision
- Learning from each other (bi-directional) – bridging the gap between research and community practice
- Webinars and face-to-face meeting

Anatomy of a Randomized Clinical Trial aka Research 101

Builds on your prior training – training that may have raised questions for you

- Certified Peer Support Specialist (CPSS)
- Good research practice – CITI online
- Human subject protection – CITI online
- Protocol overview
- Overview of the National Institute on Drug Abuse (NIDA) and the Clinical Trials Network (CTN)

PILOT

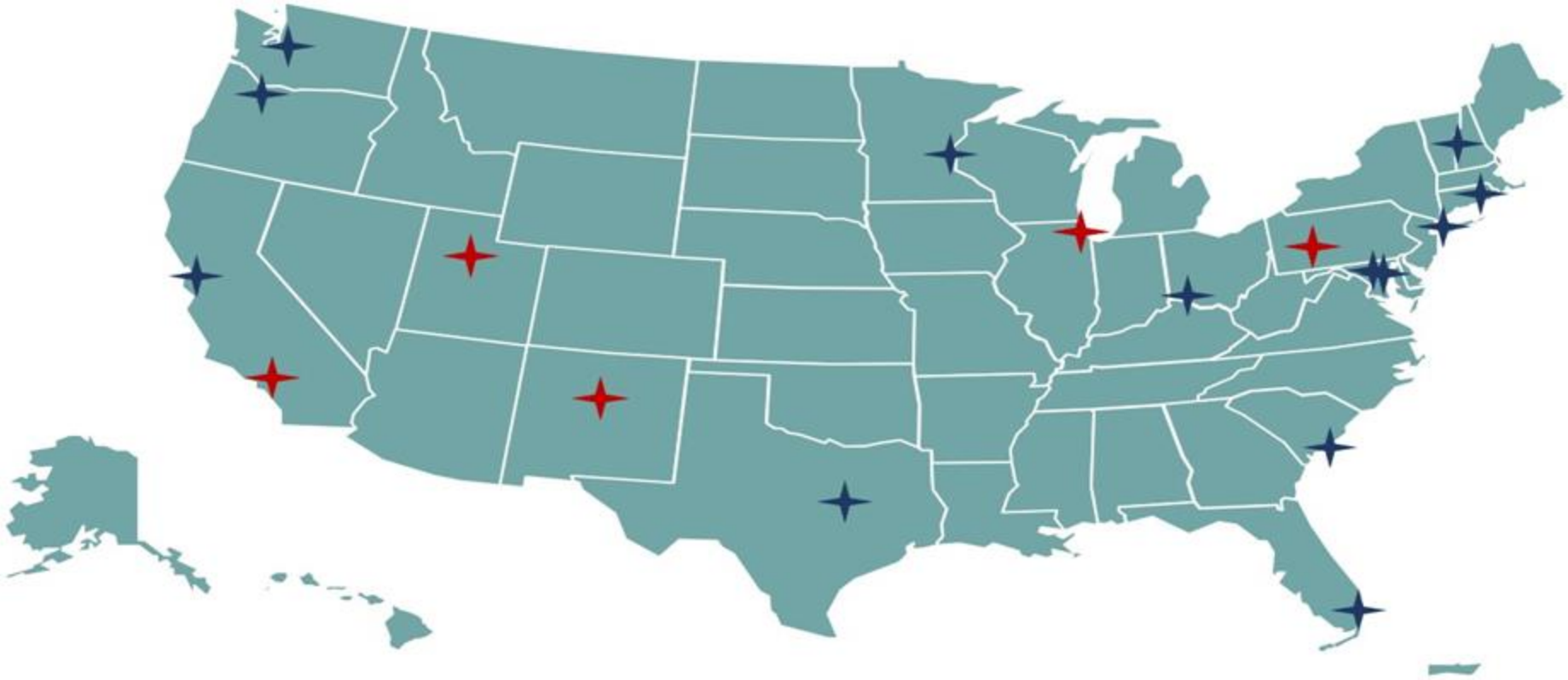
PILOT as an Opportunity to Provide a Community Service

- This is your chance to “scientifically” describe and define what peers do.
- It is our chance, as a team, to rigorously test this intervention's effectiveness and/or learn how it might be effective.
- We all have hypotheses (and maybe different hypotheses) as to why/how peers might be effective, but we really don't know the answer and that's why we're doing this study.
- We have decided to use/model Faces and Voices of Recovery (FAVOR) Greenville peer intervention model by Rich Jones. This may be similar or different than what you practice, but there are specific components of the intervention that we believe are integral and we will discuss this in detail with you during training.
- The challenge will be how do we do this naturally *and* “scientifically”?

Scientific Objectivity: What Is It?

- Peers have a tough task:
  - Interact with a patient/client as you normally and naturally would as a peer.
  - After that interaction, put on your scientific objectivity hat and reflect/record exactly what happened in that interaction.
- With the scientific objectivity hat on, there are no expectations as to what "should" have been done. From a scientific standpoint, it is extremely important to record exactly what "was" done (without expectations of right, wrong, or should).
- Peer hat and then scientist hat.
- **Scientific objectivity** is a property of various aspects of **science**. It expresses the idea that **scientific** claims, methods, results—and **scientists** themselves—are not, or should not be, influenced by particular perspectives, value judgments, community bias or personal interests, to name a few relevant factors.

Vocabulary Word #1 - Node



PILOT

Your Team: Study Roles

Sites

- PI - principal investigator
- Sub-I
- Champion, not a formal role, who?
- Study Coordinator (SC)/Research Assistant (RA)
- Peer
- Lead peer

- Nodes for each site
  - Project Manager/QA Monitor

Lead Team

- Study Lead Investigator – Kelly Barth, DO
- National Project Manager – Erin McClure, PhD
- Project Coordinator – Carrie Papa
- Intervention Director and team – Tim Matheson, Louise Haynes, Rich Jones, Tricia Lawdahl

Emmes Data and Statistical Center (DSC2)

Emmes Clinical Coordinating Center (CCC)

NIDA/CTN (sponsor $$)

PILOT

Vocabulary Word #2 - Protocol

What is the "protocol"?

- The formal, approved document that describes the study

- To develop the "protocol" we took the community-based peer intervention and described how we will study it.

Collaboration/Protocol Development:

- Lead team, including FAVOR
- Protocol Review Board
- CCTN –Center for Clinical Trials Network; part of NIDA – National Institute on Drug Abuse (sponsor)
- EMMES – Clinical Coordinating Center and Data and Statistical Center

PILOT

Vocabulary Word #3: Randomized Clinical Trial

- Based on a hypothesis
- Randomized
- Clinical
- Will be discussed in more detail when we cover study implementation

What Are the Stages in Research? How Do These Stages Apply to PILOT?

Stage 1: Design and Preparation

Stage 2: Implementation

Stage 3: Analysis

Stage 4: Publication and Dissemination

Steps in Stage 1: Design and Preparation

1. Defining an important question
2. Applying for grant money for a study
3. Creating a study protocol
4. Developing manual of procedures (MOP)
5. Choosing sites
6. **Training**
7. **Site initiation**

Steps in Stage 2: Implementation (Conducting the Study) Described in Protocol and MOP

1. Recruitment
2. Screening
3. Enrollment
4. Randomization
5. Baseline data collection
6. Delivery of intervention
7. Study follow-up data collection

Stage 3: Data Analysis

- Done by Emmes: Data and Statistical Center (DSC2)

Stage 4: Publication and Dissemination

- Primary paper: answers the main research questions
- Publication plan: papers to answer many other research questions
- Publications of interest to peers
- Dissemination

What is the Research Question for PILOT? What Other Questions Do We Want to Answer?

- Hypothesis: PILOT will lead to a reduced frequency of self-reported overdose risk behaviors compared to treatment as usual (TAU).
- Secondary questions: Feasibility? What do peers do? What are the active ingredients?

Other Things You Might Want to Know

How Does the Money Flow?

- NIDA CTN
- National Institutes of Health Helping to End Addiction Long-term (HEAL) Initiative
- Southern Consortium Node
- Local Nodes

What Is the IRB?

- Institutional Review Board
- IRB of record – Medical University of South Carolina (MUSC)
- Local IRBs
- Safety and adverse events – module taught by Emmes
- Primarily concern of site PI, SC

What Is a DSMB?
PRB?

- Data Safety Monitoring Board
- Protocol Review Board
- Reviews protocol for scientific integrity and safety
- Prior to start and at intervals during implementation

Summary of Part 1 Webinar

- Some vocabulary: node, protocol, PI, randomized clinical trial, IRB, etc.
- Protocol development
- Introduced steps of implementation
- Part 2 Webinar will cover more specifics of study implementation

Anatomy of a Randomized Clinical Trial

NIDA CTN 107
Peer Intervention to Link Overdose Survivors to Treatment (PILOT)

PEER TRAINING

PREFACE TO FACE-TO-FACE WEBINAR 2

PILOT

Review: What Are the Stages?

Webinar 1

Stage 1: Design and Preparation

1. Defining an important question
2. Applying for grant money for a study
3. Creating a study protocol
4. Developing procedures/manual
5. Choosing sites
6. **Training**
7. **Site initiation**

Webinar 2

Stage 2: Implementation

1. Recruitment
2. Screening
3. Enrollment
4. Randomization
5. Data Collection
6. Delivery of intervention vs TAU
7. Study follow-up data collection (& compensation)

Stage 3: Data Analysis

Stage 4: Dissemination and Publication

What is “Implementation” – a Deeper Dive

Study Implementation Steps:

- Recruitment
- Screening
- Enrollment
- Randomization
- Baseline data collection
- Delivery of intervention vs TAU
- Study follow-up data collection

Study Implementation: Recruitment, Screening and Enrollment

- Primarily the job of the SC
- Each site will write a local standard operating procedure (SOP) to describe in detail how this will work at their site

Recruitment

- Identify potential study participants
- Occurs in the emergency department (ED)
- Requires coordination and collaboration with ED medical staff – nursing, physicians, TAU peers

Screening

- Overdose as presenting problem or overdose in last 30 days
- Research Assistant (RA)/SC approach – verbal consent to tell the patient about the study

Who Can Be In the Study?

- Inclusion and exclusion criteria
- Consent

Consent

- Research staff will meet with each participant prior to any research activity to explain the study, including all the study activities and potential risks and benefits of participation.
- The research staff will assure that the participant understands the study and willingly agrees to participate.
- During the consent process, participants will be told that they have a 50/50 chance of being assigned to the peer intervention.
- In the consent the participant will agree to being contacted by the peer if they are randomized to the peer intervention.
- Participants are told that they have the right to stop interacting with the peer if they choose. They can choose to stop peer interactions but stay in the study. They also have the right to stop all study activities.

Randomization

- What is a randomized clinical trial?
- How is randomization done? In PILOT?
- Does the participant have a choice about which condition they are in? Does the research staff have a choice?
- Participants get randomized to one of two levels of peer interaction and this assignment is made without consideration of which level would be best for an individual participant. There is a 50/50 chance of one or the other. PILOT peers will only interact with those participants randomized to the PILOT Intervention (more intense level of peer involvement).

What Is an "Intervention"? What Is the Intervention in PILOT?

Term often used to describe a behavioral approach. It is what is being tested/studied/evaluated.

- In general: an intervention used in research is described in detail (manualized/has SOPs) and has a specific dose or period of exposure. At a minimum, the dose is measured.
- What is the intervention in PILOT?
- What is the dose in PILOT? It is individualized, *but* we want to make sure that every participant randomized to a PILOT peer has an opportunity to receive an effective dose – regardless of their "motivation" or "likeability". At the completion of the study, we will want to see what factors are associated with outcomes. Was a larger dose associated with a more positive outcome?

How Is the *Implementation* of an *Intervention* Different in Research than Community Practice?

- A research intervention is manualized, SOPs
- Consistent (as possible) across interventionists (peers) and sites
- How does this apply to PILOT?
  - Peer interaction with participant is individualized
  - Guidelines are described in the Intervention Manual
  - All peer activities are documented
    - Documentation: Peer Intervention Log (PIL) and Rolling Progress Note (RPN)
  - Supervision
  - Checklist for first and last sessions

Compensation

- Study participation is compensated for research activities: assessment and follow-up research visits
- Participation in peer activities is not compensated
- How much is enough, too much?
  - What is meant by vulnerable population?
  - Who decides what is enough or too much?

Examples of Research as Somewhat Different Than Community Practice

- In PILOT, the interaction between the peer and the participant is six months in duration. Even when the peer and participant have a successful therapeutic/helping relationship, it ends at six months and the participant will be offered other community options for continued service.
- What are the implications of this?
- Can anyone think of a time when you needed to end your peer relationship with a client and how you handled it?

What About Dose?

- Example: One participant interacts with peer 40 times, another participant interacts four times
- What might be reasons why this would happen? How do you minimize the variability in dose?
- What is meant by “we measure it” – importance of documentation

What Do We Need to Answer the Study Question?

- Adequate enrollment – tracking reports to each team
- Fidelity – conduct the intervention as described, importance of supervision
- Adequate follow-up rates – Locator Information Form (LIF)
  - If you won $1000 and we needed to find you, where would we look?
  - Research visits vs. peer interactions

Measures of Success of Implementation of the Study

- Trial Progress Reports: Generated by DSC2 (Emmes)
- Reports available online
- Tracks
  - Enrollment by site
  - Quality of data
  - Follow-up rate
- Reports on data entered by peers (Rolling Progress Note [RPN])
- Data on outcomes of study not available until end of study and after data is analyzed
- We will not know the results of the test of the hypothesis until the study is over

How Does the Study End?

- End of intervention
- End of study
- Data lock
- Data analysis

Dissemination and Publication – Telling the story; potential role of peers

- Peer reviewed journals
- Professional magazines
- Approval process for publications
- Conference presentations and posters

Anatomy of a Randomized Clinical Trial

NIDA CTN 107
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FACE-TO-FACE TRAINING

Privacy and Confidentiality

- What do these terms mean?
- Participant trust and rapport
- “De-identified information”
- Protected health information (PHI)
- Sharing information among study staff, hospital staff
- Documentation – Intervention manual
- Release of information:
  - Talking to family and friends of participant – receiving vs. giving information
  - Talking with community providers

Why Is PILOT a Pilot Study?

- What is a pilot study? A smaller study conducted to inform a possible larger study in the future. Is the study feasible – is it possible to gather the data to answer the study objectives?
- What will we learn and how might a future study be designed to better answer the questions?
- What is power? Why three sites? How many participants per site?
- Importance of adequate enrollment and follow-up rates

Assuring the Validity of the Research

- Does the study measure what it plans to measure?
- What does PILOT plan to measure? The efficacy of a peer intervention to improve outcomes for people experiencing an overdose.
- So, what is efficacy? What is effectiveness?

Assuring the Validity of the Research

Is PILOT efficacious? Compared to what?

- Why do you need a control group and what is our control group?
- Our question: at the end of 6 months do participants who receive the PILOT intervention have better outcomes than the participants who receive treatment as usual?
- What is treatment as usual? What if it changes over the course of the study?
- What is contamination?
- What is drift?
- How do you minimize contamination and drift?

How Do You Minimize Contamination and Drift?

- Clear separation between PILOT and TAU
  - Staff
  - Intervention manual
- Fidelity – What is it? How do we measure it?
- Supervision
- Training

Coordination of Roles

- PILOT peers and PI
- PILOT peers and SC/RA
- PILOT peers and Lead Team
- PILOT peers and TAU peers

Retention

- Under what conditions can a participant exit the study?
  - Completion
  - Participant request
  - PI request
- What is the peer's role in retention?
  - Assisting participant in successfully completing study
  - Negotiating and understand participant's desire to withdraw from intervention or study
  - Providing information to PI about safety concerns regarding participant's continuation in study
- Role play: a participant is frustrated and wants to withdraw from study

What Is Meant by "Intent to Treat"

- The outcome of the study will be based on *every* randomized participant
- Implications: even if a participant is "lost to follow-up," their data gets counted

Case Study: Participant Wants to Drop Out

You have been providing peer coaching to Carolyn for 3 months. She is living with her boyfriend and two small children. During the first month she was engaged and attending support groups. For the last three weeks she has stopped responding to your efforts to contact her. Today she took your phone call but said she wanted to drop out of the study. Her boyfriend says it is a waste of time, and she is feeling pressured and overwhelmed. What should you do?

- *Talk with RA. Has she been completing assessment visits? Brief phone surveys? Can the RA help? Compensation?*
- *Talk with PI? Supervisor?*
- *Options: negotiate another month? Motivational interviewing (MI)? Stay in study but D/C peer coaching? Leave study?*

What Do We Need to Answer the Study Question? Review

- Adequate enrollment – tracking reports to each team
- Fidelity – conduct the intervention as described, importance of documentation, supervision
- Adequate follow-up rates – Locator Information Form (LIF)