Lissette Saavedra:

Hi everyone. Welcome to the HEAL Prevention Cooperative Webinar series, and today we're going to be talking about recruiting for youth substance misuse prevention. I'll be moderating today. My name is Lissette Saavedra, I'm a senior research psychologist at RTI International. I'm representing the HEAL Prevention Coordinating Center, and I was previously a liaison to many of the research projects you'll hear about today as part of the initiative.

I lead my own research in mental health and substance community-based settings, particularly with underserved populations, developing and tailoring interventions to improve research and access. And I'll be moderating this webinar.

As just mentioned we'll be answering questions on a flow basis, and please include questions in a box we really want to hear. We'll take the questions at the end and we'll also be linking to a feedback form at the end of the webinar, and we'll appreciate getting your thoughts.

Audience feedback is always so important. It helps us with future webinars. And we'll also send you an attendance certificate and a link to the materials. So the work you hear about today was funded by HEAL Initiative as part of the HEAL Prevention Initiative, and hear the different awards that we're very thankful for.

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And here's the agenda for today. We'll be hearing from Dr. Barbara Oudekerk from the National Institute of Drug Use. And then I'll be talking about issues in recruitment and in the prevention of substance misuse broadly, along with other considerations as a backdrop.

And then we'll hear about some of the research projects, specifically in four different settings. We're going to be hearing about school based settings, emergency departments, community partnerships in child welfare, and finally in the juvenile legal system. And then we'll open up the floor to questions and discussion.

Now I want to turn it to Dr. Oudekerk to talk to a little.

Dr. Barbara Oudekerk:

Thank you, Lissette, and thank you all for joining us today. I am a program officer in the prevention research branch here at NIDA. And the lead project scientist for the HEAL Preventing Opioid Use Disorder research program, which is what the HEAL Prevention Cooperative is funded under.

So I'm going to give just a brief introduction to the HEAL Prevention Cooperative, and then you'll hear as Lissette said from for the research teams that are part of that cooperative.

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So first I just wanted to share some statistics that highlight how essential prevention is to addressing the opioid crisis. In 2020, about 9.5 million people ages 12 or older had misused opioids in the past year, and about 2.7 million people had an opioid use disorder. In other words, there are millions of people each year who we've missed in being able to prevent the onset of opioid use disorder or opioid misuse.

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So when thinking about prevention, the transition from adolescents into young adulthood is a key developmental time period. Among adolescents ages 12 to 17, about two out of every 100 misused opioids. In comparison that doubled to about four out of every 100 young adults ages 18 to 25.

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To help address the opioid crisis, NIH funded the HEAL Preventing Opioid Use Disorder in older adolescents and young adults cooperative, which is a mouthful. So we use HPC for short, or Heal Prevention Cooperative. The HPC aims to develop and test 10 strategies to prevent opioid misuse and opioid use disorder among young people ages 15 to 30.

So really focused on that key developmental time period.

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The HEAL Prevention Cooperative includes 10 research projects supported by a coordinating center at RTI and working through a cooperative agreement award with NIDA. So we also have ongoing advice and input from NIDA leadership as part of those cooperative agreements, and we work with a community engagement board that provides a lot of input and helpful advice along the way as well.

The work and the priorities of the HPC are governed by a steering committee that's comprised of one member from each of the research projects, NIDA, and the coordinating center.

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Together these projects are testing and developing prevention strategies for diverse populations that are often underserved in prevention services. So this includes young people involved in the legal system, experiencing homelessness, referred to child welfare or self-sufficiency systems, those in community based services in rural areas, served in the emergency department, those receiving services in behavioral health treatment systems, those receiving school-based health services, and youth in tribal and indigenous communities.

So as you can see, a very diverse set of studies.

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And today we're going to hear from four of the research projects serving populations highlighted here in yellow. So that's youth in the legal system, those referred to child welfare or self-sufficiency services, served in the ER, and those receiving school-based health services.

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For more information about the HEAL Prevention Cooperative, you can visit our website, which I'll post in the chat after I'm finished seeking. Or sign up for our Listserv if you haven't already. We send out quarterly updates, and that includes publications and all kinds of really fun dissemination products. So before I turn this over to Lissette, I just wanted to acknowledge all of our team members.

So next slide, Lori.

This is just a list of the PIs on each of the research projects and the NIDA staff working on each of the projects. So as you can see, this looks like a large list, but there's actually many, many people involved that aren't listed here as well.

So just a big thank you to all of the HPC teams that make this work possible. And with that, I will turn it back over to Lissette.

Lissette Saavedra:

Thank you, Barbara. As a backdrop to what we'll hear about and learn about today, it's important to initially orient ourselves to why recruitment is important. Beyond hitting our targets required for reporting and understanding and reorientation to what recruitment challenges mean to our research, and the intervention we're developing is critical to prevention work in general. And it's the key to understanding equity and gaps.

And also limited attention to recruitment can limit our progress. And so when thinking about recruitment, is it representing the target population is an important question. We often end up with samples of convenience, and although they are important contributions, these limited snapshots do not give us information about who we're not seeing. And recruitment is meant to ensure that the sample representing our population of interest is actually included in the study. And the participants included should resemble the individuals for which the intervention is intended as much as possible.

And so if sampling is biased due to poor recruiting, there we have a threat to external validity or the generalizability of our study. And also challenges with recruitment might result in a study sample which contains a self-selected group of individuals who are maybe more motivated or eager to change, or have different levels of access compared to the study sample of interest that we're originally interested in.

So ultimately examining the effectiveness of an intervention such as selected group will likely influence the external validity of the intervention. And that is why it's important to also explore, study, and very important to report the patterns of nonparticipation.

This can have implications for subsequent uptake in sustainability. If we're only recruiting individuals who are highly motivated, compliant, or again have access, how were these approaches generalized? Conversely, successful recruitment of participants who represent our population of interest with an equity list can also signal feasibility and implementation of the intervention or the approach in these different settings.

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Increasing attention to recruitment is important. And as researchers and preventionists, one of the challenges we have has to do with the culture and the reporting norms around recruitment. And this is broad, but with what we present in our papers or what we report to federal agencies, unfortunately, insufficient research attention has been given to recruitment challenges and potential solutions.

The prevention field just generally and many fields are relatively silence on this aspect. And this has again, as I mentioned before, has to do with our publication norms, our culture and practices. Usually in our outcome studies, we only report success. And we have limited information about what actually happened. And this is usually not available in the reporting about the challenges experience and how the team ended up working around them to get to their successes. Preventionists and scientists get little to no training on this as well, and so there's little guidance on equitable recruitment.

And because of this we have limited guidance on how to feasibly reach all youth, particularly underserved youth. And so reporting our challenges and how we dealt with these challenges can be invaluable information for end users. And here the end users ultimately of course are the youth we serve. But here I'm talking about practitioners and researchers.

And again, this can be especially useful in context where either there's limited training in recruitment or limited options when resources are tight.

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So today we're doing just that. We're hearing about recruitment experiences in these four different settings, the focus on prevention of substance misuse in youth. And we'll start with Tyre and Lily from Yale University, and they were not able to join us today. So we have prerecorded their presentation. If we have any questions or comments about their presentation, we really encourage you to drop them in the Q and A because we're happy to share the questions with them later and report back to you all.

Tyra Pendergrass Boomer:

Good afternoon everyone. My name is Tyra Pendergrass Boomer and I'm the deputy director for programs and partnerships at the Play2Prevent Lab. And this is...

Lily Hoerner:

Lily Hoerner, and I'm a postgraduate research associate at the Play2Prevent Lab.

Tyra Pendergrass Boomer:

And we'll be talking about our project, a digital intervention to prevent the initiation of opioid misuse among adolescents in school-based health centers. And more specifically for this webinar, our recruitment procedures for this project.

So a little bit of background information about our Play2Prevent Lab. We've been in existence for 12 years, and we develop video games to teach students about making good decisions around health behaviors. So previously we've completed about four different games, and with the HEAL Initiative we've created our newest game PlaySmart that actually is geared towards promoting mental health and preventing opioid misuse.

So our PlaySmart project is very large and multifaceted. Our team likes to call it the octopus because it has so many different tracks to it. So the two that we'll actually concentrate on today for the webinar is our randomized control trial track and then also our implementation evaluation track. So our randomized control trial, we're working with 10 school sites in the state of Connecticut to recruit 532 participants to actually evaluate the PlaySmart game and see it doesn't do what we think it's going to do.

And that again is promote mental health and prevent the initiation of opioid misuse. So Lily will talk about that a little bit later in the presentation. And I'll concentrate on the implementation and evaluation track, which is this national partnership between us and 15... We started off with school-based health centers in the US, but we've expanded over the last year just based on first year recruitment efforts and success in that area, which I'll talk a little bit about later.

We are actually in year two out of three years for both the randomized control trial and the implementation and evaluation arms. And so what we did was at the end of year one, we looked at our recruitment strategies to see if there was anything that could be modified.

So when we first started year one for our implementation evaluation arm, we actually worked with a national partner organization that had access to hundreds of school based health centers around the nation. And they were responsible for reaching out to these sites, introducing them to the project. And basically the goal was to get the game PlaySmart in the hands of as many students as possible. And we would learn from them. We would take notes on how they implemented it, whether it was through a behavioral health specialist, whether their APRN was rolling it out.

And at the end of that first year, what we did end up concluding was even though we were able to establish about five different partnerships with school-based health centers, we only had nine students nationwide that had actually gotten access to the game. So we knew that coming into year two we would have to do something different in our recruitment strategies, not only with the partners that we had, but also as a trickle down effect, our ability to recruit students to actually have access to the game.

So at the beginning of this year, we actually had more targeted outreach that wasn't actually only based upon the site being a school-based health center. We expanded it out to schools that maybe have a health teacher, we expanded it out to schools that may have a behavioral health specialist that's working in the environment, community partners.

And that was really where we started with to modifying our recruitment efforts. So now that we're into a couple of months of year two of this project, we are happy to announce that we actually have six brand new sites that are a different model than only being school-based health centers. But in the first two months that they've been up and running, we've had one site that has recruited 60 students. We've had one site that's recruited 90 students.

So those modifications to our recruitment procedures after year one have actually already started paying dividends. So another thing that we've done in this second year is we've actually modified our letter of agreement with these school sites to make sure that the expectations are known about what the goals of the project are and what we're trying to move forward with.

So going back to year one a little bit, what we did find as far as the recruitment is that all of it was done virtually, which is understandable because we were looking for nationwide samples. But they can basically be summed up in these four different categories of the barriers that we faced in recruitment. School-based health center staff bandwidth, everybody was coming back from COVID, they already have things that they need to do of giving vaccinations, providing physicals, and this was an added project.

Again, COVID barriers affected the entire world, affected this project in year one. Staff turnover and mixed buy-in were also two barriers that hindered our virtual recruitment for nationwide sites in year one.

We would be working with someone, we'd come back a couple of months later, have to re-explain the project because it's a new person. And then we also saw a lot of the people who thought this intervention would be great were the ones that were at the top making the decisions but not actually the ones implementing it. And so there was this mismatch of the decision makers and the ones implementing it, which actually led to mixed buy-in.

So now I'm actually going to turn it over to Lily for her to talk about the randomized control trial and specific recruitment strategies we use there.

Lily Hoerner:

Thanks Tyra. So in a similar way that we have to recruit sites for the implementation arm, we also have to do that for the randomized control arm. So that involves us using our already existing relationships with schools around the state, and then conducting outreach so that we can reach many more school sites around the state.

Then because our goal is to eventually work in parallel with school-based health center staff and other school staff, we have staff trainings where we're really outlining their responsibilities, our responsibilities, and establishing a relationship. Then comes the letters of agreement where we're again just establishing that relationship and outlining our expectations for them, and what we're going to contribute.

After that, in the same way that we have to train the staff for school-based health centers, we have to make sure all of our research team is properly trained to conduct a recruitment session. We need to prep all of our materials, schedule with the school to see when we can come on site. For some school sites recruitment sessions might be during a lunch wave, for others we might partner with a coach after school and be with a sports team. Then comes an actual recruitment session, which I'll go into in the next slide.

So there are many steps to this recruitment that I'm speaking of. Because our project requires that students be eligible either by exhibiting symptoms of depression as outlined by the [inaudible 00:18:15], symptoms of anxiety as outlined by the GAD-2 or reporting substance misuse that's non-opioid, we have to screen students on site. So after we have all these materials prepped, after we're scheduled to be at a lunch wave or in a classroom, we actually screen the students.

So what that requires is them answering a short set of questions on our screener, and then we determine if they're eligible. After we determine if they're eligible or not, they're given a parental consent or an adult consent if they're above 18, and we send them home with that. We follow up with them, and eventually the goal is to get them enrolled in the project.

If they return their consent, then [inaudible 00:18:57]. We have them complete baseline on a system called REDCap Pro, which again requires them to set up another account.

So as we're working with adolescents age 16 to 19, all of these steps cause our numbers to trickle down a bit. We screen a lot of students, we have many less eligible, we have many less actually return the consent and enroll. And that's because there are just so many steps in this process, and adolescents don't always have the bandwidth to work and participate in the project.

So with that we've learned that there are a number of broad components as we like to say, to a successful recruitment both for the implementation arm and the randomized control arm down on the ground. So we know that we have to be flexible, not only with our protocols and procedures, for example, what might work at one site, we have very specific outlined protocols, might not work at another site. So we need to really adjust what we're doing to make our protocols work at a particular site.

We also need to be flexible with retention. When we have these windows that assessments can be completed for the follow up three, six, 12 month assessments, we need to work with each student to make sure our retention numbers are high. We also need to make sure that school-based health center staff feel supported by us, and we need to have proactive and realistic expectations of them.

Every nurse practitioner or social worker might not be able to help us in the same way every site. So knowing who can really participate and assist us in our recruitment efforts has been super critical as we're entering this new school year in recruiting students and school sites around the nation.

So as I've said, as we get further and further in this recruitment process our numbers tend to trickle down. So as you can see we've screened almost 400 students, and only 113 of those are enrolled. And that's just because as I outlined before, there are so many steps of them screening, we send them home with forms, they have to get the forms signed, sign up for our system, that the numbers really trickle down.

We do have a high retention assessment rate for our three month time point. So we have a little over 70 students who have reached that time point, and as you can see, 70 of them have completed it. So our team does do a phenomenal job of following up with the students and really being flexible and finding out what works for schools and students so we can get those numbers as high as possible.

And now I'm going to turn the floor back over to Tyra to finish this off with some key takeaways.

Tyra Pendergrass Boomer:

Thanks Lily. So in conclusion, our key takeaways is that both with the randomized control trial arm and the implementation evaluation arm, we face many barriers that are not only school site specific, whether that's in Connecticut or nationwide, but also student specific in our recruitment processes.

And so learning from those from year one has allowed us to modify and adapt for year two, and we feel like we're seeing the dividends of that with both of our arms. Flexibility is key when working towards successful recruitment as Lily gave great examples of how we have to be flexible around not only the school sites but the students. And I think that just builds stronger partnerships but then also it aids us in our recruitment and retention efforts.

And then finally, virtual recruitment procedures are necessary when working with sites nationwide. It is not possible for our team to be down on the ground as we are working on our implementation and evaluation arm. And so we have to have very specific and targeted and effective virtual recruitment procedures because we are working with sites that are not necessarily in our immediate vicinity.

And we thank you so much. I'm going to now turn it over to Erin from Michigan.

Erin E.Bonar:

Okay. Hello everyone, thank you so much for coming to this webinar. My name's Erin Bonar. I am an associate professor in the department of psychiatry at the University of Michigan. And I'm going to start by giving some background on our healthcare related site, the emergency department for our University of Michigan study, which I co-lead with my colleague Maureen Walton.

So to provide some context for our trial, our virtual interventions are delivered to participants ages 16 to 30 who are in the emergency department or who've recently had an emergency department visit.

Those eligible for interventions are at risk for opioid misuse or opioid use disorder, as is the case with all of these studies. And the emergency department really is a setting to reach at risk youth and young people, particularly those who may not be in school, and serves as a setting to initiate behavioral health interventions.

These stats are probably a little dated, but EDs have over 130 million visits annually and over 20 million of them occur for adolescents and emerging adults or young adults. And doing behavioral health interventions for substance use out of the ED is really supported by a very large body of work, both from our team and others that have shown that ED based behavioral health interventions can have an impact on substance use and related injury risk.

However, I will just say that the techniques we're using with ED patients could be used in other settings.

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So our study is testing single and combined approaches for two interventions in a factorial trial. These include a brief motivational interviewing based session delivered by a trained health coach, either bachelor's or master's level.

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And the health coach session is about 45 minutes, and it's structured but it's also highly tailored and personalized to the participant and delivered over video conferencing.

Our health coaches engage the participant in an MI based conversation that involves exploring substance use, and walk you through a number of scenarios related to opioid consumption and addressing risk factors. So as you can see here, we begin with agenda setting, goals and strengths, work through substance use, exploring risks, and providing psycho education about overdose prevention. Benefits of change, problem solving in scenarios where risk factors are present, and then a summary and plan for next steps.

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Our second intervention is a therapy messaging intervention that takes place on a patient portal like system. And you can see here a screenshot from our beta version of our portal, which we had built separately for the purposes of research, but could easily be integrated into any electronic medical records system that includes patient portals, which most health systems use now. And you can see that our portal has messaging back and forth in the green and gray boxes.

We have patient participant demographics across the top. And consistent with measurement-based care approaches we also have assessment data on the left and a place for memos or notes to self in delivering the therapy over the messaging system.

And again, we built this for the purposes of research because in a research study we are sending therapy messages. If we were doing this in a EMR in a health system, those messages get saved in the chart. And so while this could be implemented, we are keeping the research messages separate for the current project.

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In our portal, health coaches send MI tailored messages to participants at least twice a week over four weeks or 30 days. And they cover the topics shown here. So these are tailored based on what we know about the participant from their assessment data as well as from our health coach session for those who are randomized to receive both interventions.

So for example, a participant who doesn't really suffer from pain, they wouldn't get much content focused on pain but they might receive messages more focused on enhancing life goals or health or mental health. And in our portal participant's message back and forth with the coach, they ask for advice, they share their stresses, and they respond to prompts about the topics shown here.

We're also able to send tailored resources that address participant concerns, which can range from things like coping strategies to referral information. So no one participant's portal messaging looks exactly like the others, and instead is highly tailored to their situations and risk factors.

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And just to give some context about the study sample as we go move into talking about the recruitment challenges, we want to think about who are we trying to reach. And in this case we are trying to reach 16 to 30 year olds who report either misusing an opioid in the past year or report opioid use, for example, medical use, but have a risk factor for later misuse.

And particularly our risk factors that we chose to focus on were identified in a review paper that we've published with the Injury Prevention Center at U of M and the National Safety Council. But our risk factors that we focus on are binge drinking, other drug use, depression, or suicidality.

And now I'll tell you a little bit about the recruitment challenges we've experienced and some of the potential solutions that we've come up with to manage them. And of course, I think like many things in daily life we can't not talk about COVID in the sense of doing this research. And we heard a lot already about virtual approaches.

So most of these challenges, including the ones related to COVID again, are in the context of our efficacy trial currently. But some of these really could apply to community delivery as well. So the first challenge is, again, COVID and the ED setting.

So historically our research studies in EDs have involved in-person recruitment of patients while they're waiting for medical procedures or while they're in the waiting room, or roomed and being in between examinations. And we undertook our feasibility pilot for this study starting in February, 2020, and were after about the first 10 participants shut down due to the emergence of COVID and the emergency department. There were not protocols in place for being able to safely approach people right away.

We had PPE shortages. Michigan itself was a very hard hit state in the initial waves and throughout the surges since then. And so we really at some points have not been able to have staff in the ED recruiting because of these protocols. So our solution to this was to develop remote recruitment approaches, where we essentially are cold calling, emailing, or texting people after an ED visit to attempt to screen them and engage them in the study.

We've actually, even after we've been able to have staff back in the ED, we've continued to use this solution and really have a hybrid approach to recruitment which involves both in-person and remote approaches in order to maximize the number of participants we are reaching.

And this is also important, because even though many aspects of day-to-day life might be going back to normal for some folks, COVID is still very real in the emergency department. If anyone comes in with symptoms that are COVID-like, they're put in droplet precautions and we can't approach them.

So having a remote procedure has been very helpful in trying to engage our participants. And to date, after starting our large advocacy trial, we've enrolled over 700, but our goal is around 1200. And so we still have got a ways to go.

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Another thing that's related to this is really the staffing challenges. So thinking about the people who are needed to be engaged in this research to make it happen and to reach these young people. And there's two ways in which we've experienced some challenges with staff. So coming back to COVID, it's getting those recruiters to go into the emergency department during a pandemic or during surges. And so our hybrid approach has been very helpful for that.

We've been able to have folks work from home when numbers are very high or when they are able to, or need to isolate because of a potential exposure. So most of our recruiters work both in-person and remotely approaching participants. And we're able to make that happen and address concerns that people have in their daily life when COVID is surging or other things that might come up.

The other challenge has been recruiting entertaining interventionists to deliver our interventions. Research is not a highly profitable endeavor for the folks that are on the ground doing this work, and during COVID, as telemedicine rapidly expanded, there are a lot more opportunities for licensed master level staff to work in telemedicine and have flexible schedules. And not have to be maybe constrained by some of the things that are part of research procedures.

And so really what we've had to do to keep up with the industry competition is to increase our salaries for our interventionists as well as our other study staff, which is over and above what we were initially able to budget in our research.

And so we've had to make cuts and work on a thinner budget in order to retain staff. And if we can't retain staff, we can't engage participants. And so that's been really highly important, and we're feeling like this is helpful and folks should be compensated well for the hard work they're doing with the challenging clinical population.

So the next slide, another challenge has been subgroup participation in our research. So getting different subgroups to enroll at more balanced rates. And I would really think the key highlight in our study, and some of the other studies have mentioned in our larger collaborative meetings is that young men seem to enroll at a lower rate than young women in our studies.

And we want to represent them however, and they could benefit from prevention as well. And so one of the things that we do in our approaching for enrollment in eligibility screening is to prioritize males.

So for example, if a male and a female in our age group came into the emergency department at the same time and we've got one recruiter there, that recruiter would go to the male first because they don't want to miss the opportunity to deliver their care to get them engaged in the study when they're instead approaching a female.

And so we prioritize subgroups depending on how our enrollment is going while also staying systematic in our approach so that we can try to represent the population, like Lissette mentioned earlier.

And then the last challenge I will touch on before I give a quick sum up is challenges with regard to enrollment and engagement. So we really need to actively engage youth and young adults in these interventions, particularly in our case in our portal it's over 30 days. So that's longitudinal that we are asking people to do something.

And prevention is not necessarily the priority of our population. So young people talking to virtual strangers about substance use and other topics that pose risk is not exactly comfortable or easy for everyone. So we take great care to use MI-based approaches, which we believe help build trust. And in terms of ongoing engagement for our research, we have done things like increasing remuneration in current times. Because let's face it, when we proposed these projects in 2019, $50 went a little further than it does now.

And so we've increased remuneration. And we've also employed a variety of reminder strategies to keep people engaged both in the intervention but also in follow-up assessments. So we send people prompts, text messages, social media messages to let them know that they've got a new message in their study portal or to let them know they're due for follow ups. And we rotate between these formats as a way of increasing novelty and engagement.

And finally, my last point is that although our focus currently is on our RCT, this work really comes from a larger body of community engaged research with partners in our emergency department. And we know that there are several items that are important to consider when we might be delivering these programs in the community outside of an RCT approach and in actual implementation. And one of the key things that I want to stress is that we cannot engage you without partnership from, in our case, our clinical setting.

And so a key recommendation that we really have from our team for recruitment is to also making sure we're addressing partner concerns. And in our case, in our emergency department feedback that we've gotten over many years and also in the current context has been to keep it short, keep our screening short, they want to be able to ask one or two questions maximum to identify whether someone should get an intervention in real life.

And that's important, because emergency department partners are constantly tasked with adding more and more to what they're supposed to do in a clinical screening. And so we hear them loud and clear that we want to be able to identify people at risk. And whether they need the intervention in a short screening, we want to address key priority areas for them. And it happens to be that we have several initiatives in our emergency department focused on opioid prevention, but they're more focused on overdose and treatment linkage and things like that.

And we're able to fill a gap by addressing prevention which upstream of those other areas, and so that's a priority for our emergency department. And the last thing often comes down to money. There's currently not a lot of reimbursement from payers for the types of intervention we are doing, or it's limited in terms of who could deliver the intervention and be reimbursed for it. And how many days after emergency department visit, or is it done in person or telemedicine?

And so we need a lot of support for reimbursement in order to get these things implemented in real life long term. And that again will affect recruitment into these interventions when implemented as well, because if we can't pay for it we're not going to be able to get people engaged and to deliver the services that are needed.

And so with that, I'll be interested to hear questions that come up later, but I will now turn it over to Ryan to tell you more about his project.

Ryan Singh:

Thanks Erin, and thanks everyone else for listening in. My name is Ryan Singh and I am an early career scientist with the Oregon Social Learning Center. Today I am going to discuss how we've addressed challenges around recruitment by relying on our community partners.

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Rates of opioid misuse and methamphetamine use in the state of Oregon are staggering. The burden itself is intensified by the rise in synthetic opioid use and the corresponding increase in opioid related deaths. And because of the COVID-19 pandemic in which an increasing number of people face social isolation and the potential for limited access to resources for prevention in the state of Oregon.

Families are particularly vulnerable, demonstrated by the influx of parents into the child welfare system due to both opioid use and methamphetamine use disorders. Thus, there's a need for prevention among families in the state of Oregon.

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In order to prevent initiation or escalation of parental substance use, the PRE-FAIR intervention is being evaluated both for its effectiveness and implementation. PRE-FAIR was adapted from the evidence-based families actively improving relationships or FAIR treatment model, and it's important to first talk about the FAIR model to understand the adaptations itself.

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FAIR is an intensive outpatient program delivered to parents on a one-on-one setting. So a counselor meets with a parent to deliver a number of different evidence-based services centered around four different components of the intervention.

The first is substance use treatment. The second is mental health counseling. The third is parenting skills development. And the fourth is addressing any unmet needs or ancillary needs that families tend to face that might increase their risk for poor mental health and corresponding substance use.

The four components are delivered with a high level of engagement from the counselor to the parent themselves. And in one county in Oregon, FAIR has been operating for over 10 years. What we know is that counselors are effective in reducing both opioid and methamphetamine use. Counselors can reduce the rates of anxiety and depression in parents and improve parenting skills development while addressing some of these unmet needs that parents tend to experience.

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As an upstream adaptation, PRE-FAIR maintains the high level of support for parents around the core components of FAIR, with the exception of substance use prevention in place of treatment.

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PRE-FAIR is currently being implemented at four provider agencies across five different Oregon counties. There was a partnership established early on with the Oregon Department of Human Services where communities were selected based on the risk for parental opioid and or methamphetamine use disorder, as well as the dearth of services in certain areas for prevention.

It was decided early on that there was a need for both prevention and treatment at the provider agencies, thus there was a request to provide both PRE-FAIR and FAIR in these communities. It's important to note that sites rely on Medicaid reimbursement, so having a full caseload of families is important for the provider agencies themselves. But it's also important that there's a steady referral flow.

And so there's a partnership established with local child-welfare and self-sufficiency staff who are able to reach a number of different parents who might be at risk for parental substance use.

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And so I'll transition over to talking about two different recruitment challenges we've had now that we're over a year into the study. The first is that we are seeing a high level of referrals that require FAIR treatment rather than the prevention or PRE-FAIR referrals. And so looking at the graph here, the gray line at the top, this represents the number of treatment referrals that we're receiving, whereas the blue line underneath, that is the number of individuals who are referred who are eligible for our study.

At about the year mark, treatment referrals outweighed those for prevention at a rate of about six to one. This demonstrated one, the high need for treatment in these areas in these five different counties, but also indicates the strain that's placed on the systems like child-welfare and self-sufficiency in trying to support families who require treatment versus prevention.

The second challenge that we faced is that many parents in need of prevention tend to be slightly older than the age eligibility criteria cutoff, age 30 for our study population.

Again, at the end of the first year, what we were seeing is a rate of about one to one between those who are eligible for the study and could benefit from prevention versus those who were slightly older. So individuals who are above the age of 30. This represents a potential missed opportunity to study this population of parents who are slightly older who could benefit from a prevention program such as PRE-FAIR.

Now, looking back at this graph, you'll see on the blue line there those that are eligible for the study. We do have a recent spike since the month of August in terms of our recruitment numbers, and so I'll talk about the success we've had using two different strategies.

Next slide please.

The first has been the ability to not only establish community partnerships but strengthen those partnerships over time. And so I'm specifically talking about the child-welfare and self-sufficiency programs at the local level. We've worked extensively with leadership across both systems, and this effort has taken quite a bit of time. But what we're seeing right now is a shift towards a focus on prevention.

Again, there's quite a strain on the system as there's a number of families involved who require treatment. So it was difficult to transition into work with the systems to really focus on prevention. And I want to stress that the buy-in for the PRE-FAIR program was there from the beginning. The challenge was how to encourage workers within the system to be able to think about prevention for families when so much of their caseload is dedicated to families that require treatment.

As things are progressing with the study, what we're seeing is that leadership at the local level has taken initiative to work with us in addressing recruitment. One of the things that was recently done was a data poll effort across both child-welfare and self-sufficiency to identify families that might be eligible for our study, and then for local leadership to work with case workers and self-sufficiency staff to encourage families to enter into our study.

Next.

Another strategy that's been highly successful as of late was for us to be able to focus more on the community itself, and what we've seen is we've had success around social media. So we've relied on simplified ads that focus our target parents with simple messaging. And so here you see one of the ads that a parent in these communities might see on Facebook or Instagram.

And when a parent clicks on one of these ads, they're taken to a very brief survey where they can request more information about the program. And this gives us an opportunity to screen individuals into our study. And just to show a demonstration of how successful this has been, in the last three weeks we've had over 70 parents request more information by clicking on this ad. And we know that of the parents that we contact using the social media strategy, that about 96% of them who we talk to are actually eligible for our study.

So we really reach this population through this social media campaign as of late.

Next slide please.

And Lori, can you pull up all three bullets for this slide? Thank you.

And so just the key takeaway here is, and I think this is the most important point, is that we've been partnering with the child-welfare system and self-sufficiency system throughout the implementation of this program. And what this has done is really shown a shift in the way or the support around the prevention program itself.

Again, the need was recognized early on by both these systems. The challenges were really about how to get people into the program. And so this required meeting after meeting with staff, and their willingness to ask questions and tell us what's been challenging for them. And for us to do the hard work of creating materials for example that might be beneficial for say a supervisor to talk to one of their case workers about how PRE-FAIR might benefit the families. And then other materials where a case worker themselves might be able to be guided by say a cheat sheet in terms of what PRE-FAIR is so they can talk to a family and encourage a referral that way.

Our push for self-referrals using our social media site is showing us that our programs are becoming more recognized within these communities. And so as PRE-FAIR and FAIR become woven into the fabric of the communities, this really points to the potential for sustainment in these communities once our study is over.

And so I think the big takeaway here is that we are seeing this shift where community partners are recognizing the benefit for prevention in terms of using the PRE-FAIR program and referring, and then provider agencies being able to provide that service. And with that I will turn it over to Kim.

Thank you very much.

Kim:

Hi. Okay, so I'm going to talk about the POST project.

Next slide, Lori.

So currently POST stands for positive outcomes through supported transition. It is a partnership between a children's hospital, Seattle Children's Hospital, the University of Washington, and a state agency, the Washington State Department of Children, Youth and Families Juvenile Rehabilitation System. Or I'm going to call it DCYF JR from now on because it's a mouthful.

Next slide.

So the goal of our study overall is to evaluate a couple of opioid prevention intervention strategies of different intensity levels among youth with substance use and youth without substance use who are transitioning from juvenile justice setting, from confinement setting back into the community.

Next slide.

And so this is the full spectrum of the juvenile legal system, and if you can advance the slide one more time. Our study is dealing with the right-hand side or the higher intensity end of the system, specifically youth who are in detention and are releasing from detention.

Next slide.

So overall, I think as we did a pilot study we uncovered several potential recruitment challenges. And that included agency concerns about the benefit and whether the study would benefit the youth, and that was probably the paramount concern.

Next slide.

There was also, as we entered into our pilot work, we realized that staff were making assumptions about whether youth would be interested in the study and about the content. And that was especially true, because initially some of our flyers talked about opioid prevention and people just cut the word prevention off and what they think about is the opioid part of it.

And in addition to that, we had a number of youth and we have a number of youth in the system who do not have parents that are actually super involved in their lives. So there were a number of youth that we were missing because we weren't able to reach the parents.

So the parental consent requirement for what is a low risk study because it is evaluating behavioral interventions that don't have a lot of... There's not a lot of possibility for negative outcomes, and they've been studied extensively as treatment interventions previously just not as a prevention strategy.

Next.

And there was also some previous history with the specific where using content from something called the Adolescent Community Reinforcement Approach or ACRA, and there had been an attempt to use this about five years previous to starting our study. And it was not organized well and there was some issues with the intervention team, and so people were left with a bad taste in their mouth about the program itself. So we had to deal with that as well.

Next.

There was also the issue of trying to connect with the youth, and if there wasn't a connection with our interventionists prior to release, this is more of a retention issue that made it difficult to continue the program as they released into the community.

Next.

And then in addition to that, we had youth who were dropping off really quickly once they left because they didn't have the ability to consistently contact the interventionists using cell phones or other internet access points. They had intermittent internet access but not enough to engage in the study.

Next.

CO I'm going to take each of these one by one. And so in terms of the agency concerns about the benefit and staff assumptions, the strategies that we used were to collaborate continuously with multiple levels of the DCYF JR agency from the highest levels of leadership down to the folks who are working with the youth on the floor to try and troubleshoot, and also with the youth themselves, to try and troubleshoot issues and develop strategies for addressing those issues.

And I would say even now as we're well into our full study, we are continuing to revise our processes to improve them. And we also hired personnel within the agency to help recruit and address logistical barriers to getting youth to the consent conference and to the baseline study and to the intervention sessions.

I think that was critical.

Next slide.

So in addition to that, this issue where the name, you can keep clicking through actually. There we go. The original name was Preventing Opioids through Successful Transitions. And again, people just saw the opioids and that was all they saw, and the preventing didn't click. So we actually changed the name to Positive Outcomes through Supported Transitions and removed all the language around opioid prevention from our flyers, and talked more about the content of the intervention, which has a lot of content around helping youth get a job, helping youth find housing if that's what they need.

Basically using the youth's own goals, helping them build a life that was more rewarding than substance use.

Next slide.

And then in terms of the IRB parental consent requirement, after our pilot study and having a difficult time reaching some parents, we discussed with the IRB and successfully negotiated that the intervention was sufficiently low risk. That if we attempt to contact parents of minors under 18 three times, three different ways, and make good faith attempt, if we are not able to contact them then we can bypass the parental consent and go straight to youth consent, youth ascent if they're under 18.

So that allowed youth who were interested in participating and who did not have a parent that they were connected with to participate. It also allowed parents who were involved to still maintain control. So if they do say, No, I don't want my youth to participate, we honor that. So it's a nice balance between getting the parents that are engaged the control that they deserve, and also not depriving youth who maybe need the intervention the most a chance to participate.

Next slide.

So some of the strategies to deal with reputation from the past experiences with ACRA is we held within agency coordinators held meetings to address issues, and we also as an outside study team regularly did that.

We surveyed youth regarding perceived issues with the program and did some qualitative work as well, and then made significant modifications to our recruitment materials and program participation incentives based on the youth feedback. For the example, taking the opioid language out and the youth gave also suggestions. Initially we called them interventionists and they wanted to change to coaches, and that made a big difference as well. Just as a couple of examples.

Next slide.

So participant engagement prior to release, the things that we did to improve that were to start the intervention earlier prior to release. So instead of six weeks, which often left not enough time because there'd be a week where we couldn't get ahold of them, especially during peak COVID, so often they weren't completing the intervention sessions with sufficient time prior to leaving.

We moved that up, doubled the amount of time that the coaches have to complete the intervention work prior to release. We also changed the balance once we were able to, so that we have always had a combination of in-person and virtual sessions, but we boosted the amount of in-person sessions and lowered the amount of virtual sessions especially at the beginning prior to discharge because that tended to increase engagement. And putting that investment in while they were still in the institutions made a big difference in terms of retaining after they left.

We also discussed the post-release program plan with the youth. The coaches did extensively and collected extensive contact information to make sure we could reach them.

Next.

That was what I just said.

Next.

And then in terms of cellular and internet access, we actually ended up providing phones. Roughly about 40% of our youth take one of the phones that we offer. Everyone is offered one. We also pay for cell phone coverage for those that take the cell phones for six to seven and a half months until they complete their final survey, a six month survey, which can be done several months after.

We allow them to complete it up to about nine months after, so on average about six to seven and a half months of cell coverage.

Next.

And then just a word on what of these are relevant to those of you who may be doing research or doing program, more programmatic work versus research? Basically all of these I think are issues that could arise and strategies that could be used in programs that are not research studies, except for obviously the IRB parental consent issue. Although that could happen with agency leadership as well in terms of needing parental consent to participate even if it's not research.

Next.

And now I'm going to pass it on to Lissette.

Lissette Saavedra:

Thank you so much, Kim. Thank you everyone. So so many similarities in these very different and independent studies and settings. It's great to see how these different areas can help inform each other. We heard a lot of really good tips from all the different settings, and a big common thread I'm hearing is the importance of engaging our community partners. We've seen this in our previous work.

All of the projects you heard about today have done this and continue to actively do so in their work, and it is reflected.

And so it's important for these settings in preventing substance misuse, but also the literature and practice experience tells us that there are similar recruiting challenges for this age group. We heard this across, and for males in particular. This is true also in mental health interventions and chronic care conditions in general. This age group, as you know, is also currently experiencing a mental health crisis.

And along with the mental health crisis, an actual big part of mental health mental health crisis that Erin alluded to are issues around staff turnover and the great resignation. It is a real thing. A lot of opportunities have been opened up with telemedicine. And in terms of research and practice, we have felt it in terms of our providers moving on to different opportunities. And that has really affected a lot of the work.

And then it has implications for recruitment and our work broadly and efforts around recruitment, as we heard today. Our practitioners are overwhelmed and looking at long wait lists, and several different types of workforce challenges beyond staff turnover. And of course it has implications for all our prevention work in general. We heard today some options again from Erin in Michigan, but everyone had really good options.

In the beginning when we first started the webinar, we talked about it is important for us as a research and practice community to continue to make efforts to disseminate this information. This is going to be important not only for research but also but for our practitioners.

Can we go to the next slide please? Thank you.

So in terms of considerations for research and practice, we are going to need increased attention to efforts towards equitable recruiting practices and approaches. And this is only possible if we zero in now on who we're not able to reach, and an understanding of why. And what options are feasible to increase recruitment? Early community engagement to get a better understanding of the context that individuals live in and to get a better [inaudible 01:02:38] of their schedules, their priorities, commitments, beliefs, and hesitations.

And here I'm talking about really engaging our youth that you're interested in reaching. Families, providers, and other community champions. And as I keep saying, dissemination is very important and should include guidance for recruitment in practice settings. And when thinking about the dissemination, our challenge oftentimes for peer review is space limitations in journals. That is a reality. And so something I've done in my work is to document it in protocol papers.

Protocol papers are a great space for this. You have almost in many of the outlets unlimited space to actually talk about this and talk about some things that you're seeing already.

You can also anticipate that help your outcome study as well. But another recommendation, again focused on peer reviews, is the supplement section of journals. Oftentimes there aren't as many limits in those area and in that part of the journal, and researchers can use this space to simply call out in the body of the paper and have a section on what they did well, where they were having challenges, and what they recommend.

I've heard from providers in my work for years that this is what they look for when they're reading an outcome study. And this is one of the things that turns them off when it comes to reading the peer review journals. And so unfortunately isn't often there. But here [inaudible 01:04:13] this webinar today is a great opportunity for us to disseminate some of this in alternative outlets. But I think we should also include it in our peer reviews.

Next slide.

And here I have some key takeaways to guide our discussion. So we know recruitment is an important prevention priority and challenges require creativity and early planning.

Again, looking to our partners, looking to the individuals we seek to serve for answers to finding creativity for solutions. And incorporating their voices early on is critical. When we don't include them in our studies, we aren't including their voices. And recruitment challenges should also guide future intervention refinement.

So now I want to open the floor for written and spoken questions. I haven't had a chance to look.

Oh, also Lori does have some information to please include the webinar feedback survey there. Feedback from our webinars is very important, it helps us with future dissemination work. [inaudible 01:05:46].

If all the panelists can maybe come on the video.

Kim:

I was just going to ask that, thank you.

Dr. Barbara Oudekerk:

And I can start while we're waiting for questions to come in. It was great hearing all these presentations. Again, and I've seen the slides obviously, but hearing you talk through it is just so, I don't know, it's so much better. And one of the things that excites me about all of these presentations is that real shift in thinking, and I know I've said this many times, but in the literature we often see that term difficult to reach populations, which makes it seem like there's something about the populations that are very difficult to reach.

Like they're doing something that makes them hard to reach. But in prevention we don't really have anybody who jumps up and says, "I need prevention." And so still we reach some populations and not others. And so really what I loved about the work you're doing is it really showcases the need to take on from the researcher's point of view the responsibility for reaching populations, and pulling them into these research studies. And creating incentives that make sense for them and creating opportunity for them to get involved in services for all youth.

So Ryan, I think it was you who mentioned this directly, but I'd love to hear from all of you. What does it take working with both the community partners, the systems that are helping in referring these populations, but also in talking with the populations themselves. What are the biggest motivators that you've noticed for somebody to want to be involved in a prevention program?

Ryan Singh:

I can go first. I think there's something to add to my presentation. From the perspective of the parents that we're trying to prevent opioid and methamphetamine use in this group. Like Erin has mentioned and like Kim mentioned, we learned that avoiding the idea that this is a prevention program in terms of working with parents has been key.

Going back to that ad I showed on the social media site, we have the opportunity to say this is a parenting program because it is. But that's much more enticing to someone struggling in the moment with the stress of parenting, their own mental health challenges that can be addressed through a program like PRE-FAIR.

And so it's easy to have a conversation with a parent when you are screening someone who struggles with those types of challenges, and then be able to offer a program like PRE-FAIR because of that.

And again, we can almost avoid the idea that this is a substance use prevention program to the parent. Thinking about the systems on the other hand, being that there has been such a strain from the dual epidemics here in Oregon, both opioids and methamphetamine, I think the recognition or the value of prevention is so easy to sell because they see it.

If they had families that weren't at the point of requiring treatment, it would be a more effective system. And so there it's an easier way to pivot back to this idea that what we're doing is substance use prevention, but we're doing it by providing this parenting program for our prevention. And that seems to be successful right now.

Lissette Saavedra:

Thank you, Ryan. Kim, do you want to take the question [inaudible 01:09:28] has?

Kim:

Yeah, sure. Just to add to that, I think that ultimately the bottom line is that there needs to be something, a perceived benefit which might look different for the youth, for the parent, for the agency that you're working with. And so it is finding ways to tailor the message creatively and honestly I think has been the consistent... We've had many discussions where this has been the upshot of them as a group.

So I would say that as well. Anthea, I don't know if I'm saying your name right, apologies if I'm not. But she writes, for the POST project with giving youth phones, what happens when a youth becomes non-responsive before completing the final assessment? We are giving youth tablets, we are struggling to keep them engaged even with this. And I think that is a challenge, and we were very worried about this. And do have some youth that drop off, I think ultimately what's keeping our youth engaged is their relationships with the coaches and that is what's making the difference.

They know that we will turn it off if they're not responding anymore. It's a study, it's designed for them to keep participating in the study. So it will get turned off if they're not participating. I don't know how much that's playing into it, but I think more importantly than that is that they are forging bonds with the coaches.

The coaches are often at the end reminding them about the surveys, that they need to be doing the assessments. And we also do contact check-ins on a regular basis so that if their contact information has changed, they let us know. If they do that check-in they get an extra $5 just for doing the check-in. It doesn't matter if their address has changed or not or if their information has changed. So we're using a variety of strategies to keep engagement, and I think that is helping us make it to the final assessments.

Lissette Saavedra:

That's great, Kim. Thank you. Anyone else want to comment on any similar approaches? There's a question from Kamala for you, Ryan. Her question has to do with social media ads. She writes, our study, a HEAL treatment study, is also doing social media ads, but our biggest challenge is that people don't respond when they text them at the contact info they provided. What strategies have you used to engage people after they've indicated some preliminary interests?

Ryan Singh:

Yeah, I appreciate this question. This has really been something, an iterative effort of ongoing what's working and how we can find a sweet spot in terms of our ads. One thing we do on our end in the beginning is we change our ads frequently. And we try different messages around parenting, around stress, things like that.

In terms of when we receive these notification from parents, the notification once they click on that ad, the survey that they fill out only takes about 60 seconds in total to give us their name, their age, the county so we know which site they would be affiliated with if they were to get into the PRE-FAIR program, and their email address. And so we have just a bit of information there.

I have found that the most success we have is if we are able to make contact with a parent almost immediately, so within the 24, 48 hours at best. If we delay that any longer, we do have a chance of losing parents. We don't necessarily just text, we cold call, we text, we have different email messages that we've sent. And so we've really tried to engage in different ways using this process.

So far I've found that calling individuals quickly after that notification comes through. So that comes through right to me and I screen the individuals for the study, but I get that notification pretty quickly and I can make that phone call if I'm not in the middle of something in the moment.

But that's where I found the most success is being able to call them back. They've been given a little bit of information about the program that their interest is peaked, and then I provide the details in terms of what the counselor can do. And so the benefits to the family.

Again, not necessarily what we see as the benefits, but in terms of what a parent might be interested in. And so part of that is it's community based. The counselor comes to you, works with you in your home, they support you. There's 24, 7 support. That sort of thing has been really helpful for us.

Kim:

I would imagine that makes them feel also like they're an individual, it's like the equivalent of getting a handwritten addressed letter versus the one that you can see has been photocopied. It feels like you're important because you're getting that immediate reaction to what you did.

Ryan Singh:

Completely, and I will say this. This is fairly new. Again, if you think back to that graph, if you remember how we just have that spike since about August, and we really switched the messaging at that point in time. And again in the last three, four weeks we've really seen even a bigger change.

And so we're still learning as we go, I would say, in terms of how we're getting people into the study through the social media campaign.

Erin E.Bonar:

I wonder if I could just add a couple of strategies, we've tried to address Kamala's question too. Maureen, well my co-PI and I, we've had several studies over the past seven years recruiting on social media and using these advertisements, as well as the more recent cold calling people approach.

And one of the things I've been really trying to move our team toward doing, and I think it's having an impact, is when we do send those texts, so Kamala, you mentioned sending them the text message and they don't do anything or contact them and they don't do anything.

Right now we're all getting, I don't know about you all, but I'm getting 10 spam texts a day for election season. I don't know who I gave money to, but now it's constant. And we are all constantly inundated with spam in our emails, spam on our cell phones, spam in our text messages.

And I just try to have all of our recruitment materials, our reminder texts, our letters, our emails be written like a real person would write them, not like a bot or a researcher.

So in some of our text messages we say, this isn't spam, we promise, we're real. We get that IRB approved. Because we have to compete for attention from our target population with things that are constantly distracting, and so we have to find ways to differentiate ourselves.

The other thing, a lot of times with our young adults what we'll do in our text messages is we include images and gifts. We make it more relevant to the population and what they would normally see and pay attention to. And I don't have the data yet. I haven't done a comparison of has this changed our rates or not on various studies, but I think that the feedback we get from individuals is showing that it does seem to engage some people or get their attention.

Lissette Saavedra:

Erin, those are great suggestions, and I'm hearing a lot of these recommendations. Another big thing that comes out is that you all are building trust and you are making better connections, and that sounds like it's an important lens to have as well when thinking about these strategies.

We have an open question about how you all are planning to handle recruiting during the holiday breaks. Will you still be contacting referrals during this time? [inaudible 01:17:16] for about two weeks and we're trying to plan for this, [inaudible 01:17:22]. That's a question.

Kim:

There's a combination, I think. We allow our staff to have vacations and take time off, but it's often staggered. So we do try to continue to recruit, but the weeks around the major holidays, it's not that effective. So I think I wouldn't sweat that, just maybe plan on doing a little bit more before and a little bit more after to catch up.

That's my take on it is that taking that time off is not likely ultimately to change your bottom line, it's more just about making sure you have a plan for picking up the slack when you get back.

Erin E.Bonar:

Yeah, it's setting specific. Our emergency departments don't close during the holidays. In fact, we do give staff days off of course, maybe do reduced staffing during those times. But I think if you're working in a clinical setting versus a school setting versus community agency settings, you might have different challenges with different times of the year.

So for example, our study has maybe a lower recruitment during some of the summer months because we live in a college town and all the students are gone, and so there's fewer young people going into the ER. But we also continue during holiday breaks or when people are off to make sure we're monitoring anything that is automated or done on their own.

So for example, in our portal intervention, we still do log in and send messages, but we just reduce maybe the amount of time we're spending doing that per day.

Kim:

I also feel like just another thought is that, bigger picture is that our recruiter surveyors, they somehow strike a balance where they're able to be neutral about the questions, but the youth want to answer the phone when they call. Or they're personable enough that I think it makes it easier to get the surveys accomplished because they have a connection, not in the same way as with the coaches, but I also think there's this line where they're neutrally collecting the data and they're doing a little chatting right before starting the survey and after.

And we deliberately end with some positive questions so that they're left with a good taste in their mouth about the survey, that helped a lot too, just as bigger picture thoughts.

Lissette Saavedra:

Okay, great.

Kim:

Ty has another question for Ryan and Erin, I don't know if you see that.

Lissette Saavedra:

I see it now. So the question is, do you see potential for healthcare coverage of your interventions when they could help with recruiting patients who receive the services when disseminating and sustaining your intervention's? A great question Ty.

Ryan Singh:

Erin, go ahead. I'll go after you.

Erin E.Bonar:

I'll say a few things just because I touched on this in my presentation. There is some amount of reimbursement for behavioral health that occurs already. I think that what we're seeing now from some of the leadership at the national level, like from Dr. Voco with the promoting the concept of pre-addiction, and I know that there's debate over do we love that term or not.

But the idea that it's analogous to other interventions for pre-diabetes and that prevention is... There's a condition or there's a potential diagnosis code that could be applied to then allow us to bill for these types of services.

However, that seems like a really complex issue, and I think it's taking more than us scientists advocating and NIDA director being creative about how to frame it. We don't have the control over getting payers to reimburse, and I'd just love to see more advocacy at a national level for that.

We are doing the things that are evidence based that can be effective and help people, and we need that support. And it's there to some degree for behavioral health, but things like our therapy written messaging interventions, that probably hasn't ever been thought of as something that would be reimbursable. But I would think it should be.

This is healthcare. Prevention is healthcare, and so we need to be able to sustain it and pay for it and advocate for that to the extent that it's reasonable within our different constraints that we have.

Ryan Singh:

I thought that was a really nice answer. I think two points to Ty's question. The first is here in Oregon, and I'm going back to the partnerships that we've established both at the state level and the local level, but we're seeing opportunities for braided funding to reimburse beyond the level of Medicaid reimbursement here in Oregon. So the work that we do, not everything gets reimbursed by Medicaid money and it's a challenge for the clinics themselves.

But the state is supporting the effort. And again, this shows, this really points to the extent of how strong this partnership is where they've recognized the importance of substance use prevention among parents, young parents in particular, so much so that more money is coming in to support the efforts for the programs to be delivered.

When I read the question, I was thinking especially about the recruitment part. So the social media campaign, we're doing this on the research end, this is for us in our study to do recruitment. Kim pointed out some of the benefits of what we do that trickle over to the actual implementation side of things and to make these programs work in community-based settings.

It doesn't cost a lot of money to do these social media campaigns, but that's not the expectation that provider agencies would pick up and try to recruit individuals through methods like that. I think what it does, as we have the funding to complete the study, we're potentially helping create more awareness for the programs so that by the time the study's over, there's a reputation amongst the community themselves for the programs where agencies within those communities who deliver PRE-FAIR and FAIR won't necessarily have to be relying on strategies like a social media campaign.

Evidence of something like this is happening here in Oregon with the FAIR program in that single county that I discussed earlier, so it's been around for over 10 years. And it's a seamless process for referrals coming in from child-welfare into the clinic themselves. And so in that particular county, the effort to increase recruitment has been a bit different because we were already getting FAIR treatment referrals for so long.

Kim:

I do think there needs to be some movement in terms of coming into the digital age, there should be some consideration to how we recruit youth and people into evidence-based programs at the payer level. I would just say I think we should be advocating for that because it is more and more the way people are looking for health information and a more effective way to connect people with effective health interventions than clinic or hospital-based strategies.

Dr. Barbara Oudekerk:

Yeah, that's an interesting point, Kim, especially if you think about we've been thinking about the structure of this broader research program as having to come through systems because we haven't seen many of those opportunities to recruit through technology or social media or other things.

So typically speaking for prevention, it seems like you have to be connected to a system that can ultimately sustain those referrals. But it's a good point. There could be a lot more opportunities, especially if you think about parents with older adolescents, and they often do want prevention programs and would be looking for something like that. Yeah, that's a good point.

Kim:

And it always, I'm sorry Erin, go ahead.

Erin E.Bonar:

No, you go.

Kim:

I was just going to say, it always falls off at the implementation point. We've developed this great evidence base for interventions and then it doesn't make it, or it takes a really long time to make it into practice. And I just kept thinking when we were all talking that a lot of these strategies could and should be used in non-research health settings, and I think it's time to be a little more creative. COVID has taught us that if nothing else.

Erin E.Bonar:

Well, and I do think we can't ignore, to your point, Kim, about digital health. We need to get with the program a little bit. We can't ignore that technology's already doing this, so the tech companies have preventive messaging.

So if you type in certain things on Facebook, you're going to get a popup about getting your flu shot or whatever. Or there's different things related to suicide prevention. You Google certain things, you get different directed messaging. And Amazon offers healthcare now.

So the idea that it only can exist in a community agency or only in a health system, I think we have to challenge that too. Because if we ignore big tech, they're going to do it themselves without us. And we have I think an opportunity instead maybe to eventually partner in that way, but I think that that requires some creativity from the funders and other folks to allow us to do these types of things in settings that haven't been done before.

Lissette Saavedra:

Thank you so much, Erin. Such a great topic. So much really good information here. I appreciate you all so much and I appreciate the viewers and bringing in great questions.

We will circulate them, but unfortunately we're out of time. Thank you everyone, again, if you can please fill out the feedback form and any other lingering questions you might have and we'll make sure that we get back to you all. Thank you everyone so much.

Erin E.Bonar:

Thank you.