

Research Compensation and Enhanced Contacts in Studies With Persons Who Use Drugs: Lessons From the COVID-19 Pandemic Demand a Reset

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ABSTRACT: Policy changes resulting from the coronavirus 2019 (COVID-19) pandemic have had a substantial and positive impact on the clinical care of persons with opioid use disorder. These innovative paradigm shifts created a ripe environment for re-evaluating traditional approaches to recruiting and retaining persons who use drugs into research studies. For example, changes to methadone prescribing requirements and authorization of buprenorphine prescriptions via telehealth have both increased access to medications. In this commentary, we contribute to ongoing conversations about the ethics of compensation for participants in addiction-related clinical research and share methods of payment that proved successful in research performed during the pandemic. We also discuss approaches to enrollment and follow-up that were implemented during the height of COVID restrictions. These approaches may mutually benefit both participants and researchers in a post-pandemic era.

KEYWORDS: Persons who inject drugs, research compensation, monetary, non-monetary

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Policy changes resulting from the COVID-19 pandemic have substantially impacted the clinical care of persons with opioid use disorder (OUD). These paradigm shifts created an environment ripe to re-evaluate the approach to recruiting and retaining persons who use drugs into research studies.¹ For example, the relaxation of prescription requirements for medications for opioid use disorder (MOUD) enabled patients to receive methadone prescriptions for 28 days instead of daily, supervised dosing, and clinicians were authorized to prescribe buprenorphine through telehealth.²

Meeting recruitment targets is a significant research challenge. In the pre-pandemic era, only approximately half of clinical studies funded by the NIH³ or by public funds in the United Kingdom reached their sampling targets.^{4,5} Moreover, NIH closed 36% of cardiac clinical trials due to inadequate enrollment.⁶ In this commentary we share critical lessons learned during the pandemic as we recruited from an urban population of people who use drugs for CHORUS, an NIH-funded pilot study focused on using peer recovery coaching to increase MOUD, HIV pre-exposure prophylaxis (PrEP) and hepatitis C virus treatment uptake and adherence.⁷ We applied 2 key strategies to address barriers intensified by COVID: (1) digital compensation to track and enhance monetary transfers; and (2) multiple contacts and distributing cell phones to engage participants.

Compensation

Before the pandemic, compensating research participants who use drugs often took the form of payment for “time and trouble” with cash transfers or gift cards,⁸ but ethical concerns were commonly raised in Institutional Review Boards about the potential use of cash transfers to buy drugs, and gift cards were often difficult to use.^{9,10} On the other hand, compelling questions also arose related to fair treatment given that predictions about how compensation might be spent does not usually occur in other research areas. This practice might relate to known biases that continue to exist and impact the care and experience of persons who use drugs. This historic and current stigma persists and impacts research approaches.

Empiric evidence from the literature demonstrates that ethical concerns often raised about research compensation for persons who use drugs are not warranted. For example, a randomized study explored whether cash payments (up to \$70) provided to individuals who use drugs might influence drug taking behavior or result in coercion.¹¹ Findings showed that the amount or the type of compensation (gift certificate or cash) did not have a significant effect on the rates of drug use and did not result in coercion. These findings were subsequently confirmed in another study by the same group that used higher payments (up to \$130).¹² Additional studies have also showed that cash incentives for \$100 checks did not



increase cocaine relapse rates.^{13,14} The more open environment for research methods exploration during the pandemic made it easier to try new approaches to address these concerns.

As part of the CHORUS study, enrollees received electronic debit cards for completing baseline, 3-month, and 6-month interviews. We found that 94% of individuals who were approached enrolled in the study (N = 33). Participants also received smartphones with videoconferencing, phone and text capabilities. The debit cards were reloadable through their expiration date of 3 years after being issued. The cards could be reused multiple times throughout the longitudinal study and could easily be replaced if lost. The debit card provided an easy way for the research team to track and report study payments. An important appeal of this approach was that participants did not need to have a bank account to access the funds available on the debit card. Loss of physical cards is a potential challenge associated with using debit cards; however, cards were infrequently lost. In addition, lost cards could be quickly cancelled and new ones issued. Preliminary findings from the CHORUS study suggests that electronic debit cards could increase inclusion in research by participants who use drugs and enhance the ability of research teams to meet stated targets.

Distribution of Cell Phones for Sustained Contact

Given emerging findings that provision of cell phones, especially to persons experiencing homelessness, results in strong rapport with study staff and enhanced engagement and retention,^{15,16} we distributed smartphones in addition to debit cards to CHORUS participants. We covered the cost for the phones and the phone bills. During satisfaction exit interviews, participants underscored that phones were either “helpful” or “very helpful” as part of the intervention, assisted with navigating the healthcare system, and provided access to substance use-related resources and treatment as well as social support during the pandemic.⁷ Working phones became even more critical as nearly all peer groups and support systems migrated online in early 2020.^{17,18} Phones allowed the research team to remain connected with participants and increase engagement while providing tangible benefits. Nevertheless, some challenges were associated with distributing phones. For example, some participants lost study phones. The majority of participants who lost study phones were unstably housed and thefts were responsible for missing phones. Property-thefts impacting individuals experiencing homelessness has been described in the literature.^{19,20} For example, reports in the literature describe the loss of diabetes-related equipment.²¹ Future iteration of the study will work on developing approaches to minimize the loss of phones, especially among unstably housed individuals.

The Path Forward

The COVID-19 pandemic has led to paradigm shifts in addiction-related policy, and created an opportunity for transformational change. We have identified barriers and

facilitators to clinical care and research in this vulnerable population. With all the research established, we must mutually benefit participants and researchers using alternative compensation methods.

Author Contributions

SAA conceptualized the commentary. MGL, AKM, JAB and SAA contributed to drafting the commentary, provided critical review and approved the final version.

REFERENCES

1. Volkow ND, Blanco C. Research on substance use disorders during the COVID-19 pandemic. *J Subst Abuse Treat*. 2021;129:108385.
2. Davis C, Samuels E. Continuing increased access to buprenorphine in the United States via telemedicine after COVID-19. *Int J Drug Policy*. 2021;93:102905.
3. Fogel DB. Factors associated with clinical trials that fail and opportunities for improving the likelihood of success: a review. *Contemp Clin Trials Commun*. 2018;11:156-164.
4. McDonald AM, Knight RC, Campbell MK, et al. What influences recruitment to randomized controlled trials? A review of trials funded by two UK funding agencies. *Trials*. 2006;7:9.
5. Walters SJ, Bonacho Dos Anjos Henriques-Cadby I, Bortolami O, et al. Recruitment and retention of participants in randomised controlled trials: A review of trials funded and published by the United Kingdom Health Technology Assessment Programme. *BMJ Open*. 2017;7(3):e015276.
6. Zheutlin AR, Niforatos JD, Stulberg E, Sussman JB. Failure of cardiovascular phase 3 randomized clinical trials to report pre-trial and post-trial Parameters: A cross-sectional analysis of ClinicalTrials.gov. *J Gen Intern Med*. 2021;36:1808-1810.
7. Martin AK, Perryman T, Bernstein JA, et al. Peer recovery coaching for comprehensive HIV, hepatitis C, and opioid use disorder management: the CHORUS pilot study. *Drug Alcohol Depend Rep*. 2023;7:100156.
8. Festinger DS, Dugosh KL. Paying substance abusers in research studies: Where does the money go? *Am J Drug Alcohol Abuse*. 2012;38:43-48.
9. Neale J, Black L, Getty M, et al. Paying participants in addiction research: is cash king? *J Subst Use*. 2017;22:531-533.
10. Anderson E, McNair L. Ethical issues in research involving participants with opioid use disorder. *Ther Innov Regul Sci*. 2018;52:280-284.
11. Festinger DS, Marlowe DB, Croft JR, et al. Do research payments precipitate drug use or coerce participation? *Drug Alcohol Depend*. 2005;78(3):275-281.
12. Festinger DS, Marlowe DB, Dugosh KL, Croft JR, Arabia PL. Higher magnitude cash payments improve research follow-up rates without increasing drug use or perceived coercion. *Drug Alcohol Depend*. 2008;96:128-135.
13. Dempsey JP, Back SE, Waldrop AE, Jenkins L, Brady KT. The influence of monetary compensation on relapse among addicted participants: empirical vs. Anecdotal evidence. *Am J Addict*. 2008;17:488-490.
14. Vandrey R, Bigelow GE, Stitzer ML. Contingency management in cocaine abusers: a dose-effect comparison of goods-based versus cash-based incentives. *Exp Clin Psychopharmacol*. 2007;15:338-343.
15. Des Jarlais DC, Perlis TE, Settembrino JM. The use of electronic debit cards in longitudinal data collection with geographically mobile drug users. *Drug Alcohol Depend*. 2005;77:1-5.
16. Stewart C, Kopinski H, Liebschutz J, et al. The provision of cell phones as a recruitment and retention strategy for people who inject drugs enrolling in a randomized trial. *Drug Alcohol Depend*. 2018;184:20-25.
17. Richtel M. A. A to Zoom, Substance abuse treatment goes online. *New York Times*. 2020. Accessed November 8, 2022. <https://www.nytimes.com/2020/11/28/health/covid-substance-abuse-treatment.html>
18. Iyengar K, Upadhyaya GK, Vaishya R, Jain V. COVID-19 and applications of smartphone technology in the current pandemic. *Diabetes Metab Syndr*. 2020;14:733-737.
19. Heerde JA, Hemphill SA. Stealing and being stolen from: perpetration of property offenses and property victimization among homeless youth – a systematic review. *Youth Soc*. 2016;48:265-300.
20. McInnes DK, Li AE, Hogan TP. Opportunities for engaging low-income, vulnerable populations in health care: A systematic review of homeless persons' access to and use of information technologies. *Am J Public Health*. 2013;103:e11-e24.
21. Keene DE, Guo M, Murillo S. That wasn't really a place to worry about diabetes?: housing access and diabetes self-management among low-income adults. *Soc Sci Med*. 2018;197:71-77.