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research brief

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Recovering from Substance Use Disorders: A Case for Peer Recovery Coaches

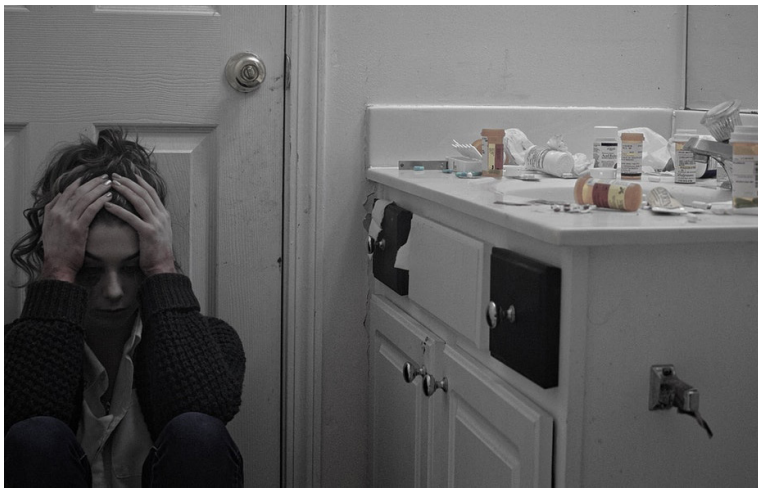
Summary

- Peer recovery coaches (PRCs) are resources that are being increasingly utilized in the treatment of substance use disorders (SUD).
- The role of a PRC is to act as a mentor, guide, and role model to those with SUD by providing a range of support services that include instrumental, emotional, informational, and affiliational support.
- The overall body of evidence suggests that PRCs can be effective in reducing both the reoccurrence and severity of SUDs.
- Barriers to the utilization and effectiveness of PRCs include:
    - Labor market discrimination
    - Lack of professional and financial support
    - Inadequate training
    - Delicate balance between peer and professional roles
- We propose numerous policies aimed at improving the quantity and quality of PRCs in substance use treatment, including:
    - Create continuing education requirements and sustained mentoring of PRCs
    - Integrate PRCs into existing treatment and healthcare settings
    - Set up structures that allow for reimbursement of PRC services
    - Increase investment in research resources to bolster the scientific knowledge base and effectiveness of the PRC approach

Introduction

The misuse of alcohol and drugs is highly prevalent in the United States. In 2017, approximately 20.1 million Americans, that is 7.4% of the U.S. population ages 12 or older, had a substance use disorder (SUD) in the past year. Indiana's SUD rate was similar with 7.1%. Most SUDs involved alcohol (5.4%) or illicit drugs (2.5%); however, nearly one percent of Hoosiers had a pain reliever use disorder [1].

The current opioid epidemic both highlights and exacerbates the reality that our substance use treatment services are under-resourced. Policymakers and public health practitioners are attempting to focus on interventions that have proven to be effective. Peer recovery coaches (PRCs) are resources that are being increasingly utilized in the treatment of substance use and addiction.



The purpose of this brief is to review evidence concerning the effectiveness of the peer recovery approach in the treatment of substance use disorders. After highlighting emerging evidence on the benefits of PRCs, the brief will conclude with a set of pragmatic recommendations to bolster the prevalence and efficacy of PRCs.

PRC definition and roles

It is important to concretely define what a PRC is and does. Although there is no universally accepted definition or scope of responsibilities, the Substance Abuse and Mental Health Services Administration (SAMHSA) provides a general definition of peer recovery support as services delivered by someone who has experienced both an SUD and recovery. PRCs have the experiential knowledge and a desire to help others suffering from an SUD to initiate and maintain recovery by providing a range of support services including "instrumental, emotional, informational, and affiliational support [2-4].

While the term "peer recovery coach" is widely-recognized in Indiana, SAMHSA refers to these individuals as "peer recovery support specialists;" additional or similar terminology may be utilized in other states.

In 2017, approximately 20.1 million Americans, that is 7.4% of the U.S. population ages 12 or older, had a substance use disorder (SUD) in the past year.

PRCs are a promising tool in the mission to reduce the prevalence and harmful effects of substance use and addiction. SUD treatment providers across the country have begun incorporating PRCs. Some of the settings in which PRCs have been integrated include "recovery community organizations, rehabilitation programs, detox clinics, churches, re-entry programs, and other community health settings [5]". Substance use services are gradually adopting a recovery-oriented system of care framework, incorporating various forms of peer support tailored to the individual's recovery needs [6].

Effectiveness of peer recovery coaching in the treatment of SUDs

Research on the effectiveness and benefits of PRCs is still expanding and needs to be further supported so that policymakers can make the most well- informed decisions in regard to allocating funds and

resources to treatment systems. Nevertheless, some studies have shown multiple benefits associated with the use of PRCs in SUD treatment:

- O'Connell et al. (2017) found that those receiving skills training with peer-led recovery support reported an average of nearly 15 fewer drinking days in the past month compared to a standard care group at the 9-month mark of the study [7].

- Min et al. (2007) reported decreased re-hospitalization rates for participants who received a peer-delivered intervention (62%) compared to the control group (73%) [8].

- Tracy et al. (2011) provided evidence that PRCs may be effective in improving long-term SUD treatment outcomes as those who received peer-delivered interventions reported a higher treatment adherence rate (48%) compared to the standard treatment group (33%). In addition, this study found that those who work closely with a PRC are less likely to become repeat offenders when compared to those who do not receive PRC treatment [9].

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- A study of veterans by Smelson et al. (2013) reported that individuals who receive peer-delivered treatment were 71% less likely to drink to intoxication [10].

- Bernstein et al. (2005) found that those receiving peer-delivered treatment had reduced levels of substance use and were more likely to be abstinent compared to those receiving standard care [11].

- A systematic review by Bassuk et al. (2016) concluded that despite significant methodological limitations found in the nine included studies, the research showed a positive effect of peer-delivered recovery support services on participants and substance use outcomes. The overall body of evidence suggests that PRCs can be effective in reducing both the reoccurrence and severity of SUDs [12].

Furthermore, PRCs have expressed that there are benefits that they themselves receive from this type of work on their own road to sustained recovery. In a 2013 study of PRCs, 97% of respondents reported that training made them develop skills that are applicable to life and recovery. In addition, 88% reported training gave them confidence that they can do things to further their recovery and 95% cited their work as facilitating and allowing them to practice their own recovery. The study concluded that PRC initiatives appear to benefit the individual PRC worker and may result in societal cost savings by reducing the dependence on Social Security benefits and other safety net resources [13].

Barriers to PRC incorporation into treatment

There are many barriers to incorporating PRCs into treatment despite their affirmed effectiveness and promising potential in substance use treatment.

Labor market discrimination

Many PRCs themselves have been involved in the criminal justice system, often related to their substance use history. As a result, they may experience discrimination from potential employers who are hesitant to hire individuals with a criminal record, even though research shows that hiring people who have been previously incarcerated is linked to economic growth, lower rates of recidivism, and improved public safety [14].

Hiring the previously incarcerated as peer recovery coaches can offer economic opportunities that will help them stay in recovery, while simultaneously giving people who are seeking treatment for their SUD a valuable resource in the form of an invested individual who has been 'in their shoes', i.e., who has experienced the challenges and obstacles on the road to recovery.

Lack of professional and financial support

The lack of credibility of PRCs as legitimate providers in the opinion of many health care professionals, organizational and financial incapacity of health care organizations to implement PRCs, and the lack of standardized roles are additional barriers that hinder the widespread use of PRCs [5]. The wages of peer providers are generally low, relative to other entry-level health care positions such as personal care aides and home health aides [15,16]. Various payment mechanisms are being implemented throughout the United States but have not been institutionalized in the same way as reimbursements for other, more traditional services have [5]. For example, Georgia became the first state to allow Medicaid reimbursement for services rendered by certified PRCs in 2001 [17]. There is currently no centralized funding source available in Indiana to pay for the implementation of PRCs [32], though the state is working on a structure to reimburse PRC services through Medicaid, as part of an 1115 SUD waiver.

Inadequate training

Concerns about inadequate training regarding some of the issues often exhibited by clients with SUDs also present a significant challenge to PRCs' ultimate effectiveness. For example, a PRC may not know how to properly balance employment-related duties while maintaining their own recovery [18]. In addition, there are no established PRC training standards or competencies so the capacities of PRCs can be varied and in many cases insufficient [19]. This is likely due to the fact that PRCs are a relatively new approach to support people in recovery. Appropriate clinical supervision must also be adequately maintained as PRCs need resources to receive clinical advice to help reinforce their roles and to help prevent a relapse from their own recovery [20]. In addition, supervisors and PRCs must create communicative relationships in order to identify and address issues and to bolster the effectiveness of their organizations and the outcomes of their clients.

Delicate balance between peer and professional roles

PRCs often have to engage in the balancing act between their roles and responsibilities as a professional versus those as a peer. In one study, PRCs reported a concurrent loss of their peer identity and a greater emphasis on the professional role [20]. Scope creep can be a concern as they are often tasked with more responsibilities than delineated by their defined roles. Continued training needs to address these challenges.

Peer Recovery Coaching in Indiana

Although there is still considerable progress to be made, PRCs constitute a growing resource in substance use treatment and recovery systems across Indiana. The Indiana Addiction Issues Coalition (IAIC) and Indiana Credentialing Association on Alcohol and Drug Abuse (ICAADA) are the preeminent sources for PRC training in the state. These organizations have trained over 200 PRCs since 2015, much of this effort was supported by a SAMHSA grant [21]. ICAADA offers two levels of PRC certification: The first level enables individuals to work as certified PRCs in Indiana and the second level provides internationally recognized certification. Both training levels involve completing curricula specific to four domains (advocacy, mentoring and education, recovery and wellness support, and ethical responsibility), passing an examination, and signing a code of ethics statement [22].

The IAIC continues to offer about six to eight PRC training sessions annually throughout the state. One of the aims of the SAMSHA-approved Indiana Peer Recovery and Support Initiative (IPRSI) is to support the use of emergency department-based PRCs in 10 hospital systems across the state [23]. Policymakers earmarked $600,000 from the 21st Century Cures Act grant to help fund recovery coaches in emergency departments. An additional $600,000 was allocated to support mobile response teams respond to crisis situations featuring multiple drug overdoses

[24]. Randomized trials intended to evaluate the effectiveness of PRCs are being conducted at Public Advocates in Community Re-Entry (PACE), a Marion County nonprofit serving the previously incarcerated; further more, a Recovery Coach Resource Center is slated to start in 2019 at PACE [25].

Policy recommendations

Indiana and its residents suffer from the heavy economic burden caused by substance abuse. The most recent estimates place the costs of alcohol use in excess of $4.4 billion [26]. Additionally, tobacco use imposes societal costs (i.e. healthcare costs, tax burdens, and lost productivity) of approximately $6.8 billion [27]. Opioid abuse results in over $650 million in healthcare costs within the state [29] and $1.4 billion are attributable to drug overdose deaths [28]. Suffice to say, there are immense economic benefits to be reaped from the utilization of PRCs in SUD treatment and recovery.

Indiana policymakers, public health practitioners, and other SUD treatment stakeholders need to capitalize on the current political conditions that are favorable to improving the nation's substance misuse prevention and treatment systems.

Treatment that incorporates PRCs has significant documented efficacy and the potential to be even more effective if properly supported. We propose four policies aimed at improving the quantity and quality of PRCs in substance use treatment.

1. *Continuing education requirements and sustained mentoring of PRCs*

   Continuing education requirements and guidelines for PRCs are paramount to sustained PRC effectiveness. Stakeholders recognize the lack of a national credentialing body and the proliferation of a wide range of training and certification programs across the United States can be problematic.

   Consequently, there is a need to establish more standardized evidence-based guidelines. This will help to ensure a certain quality of care while mitigating significant disparities in quality of PRC treatment services. Continuing education requirements should not be financially burdensome to the PRCs as their remuneration rates are relatively low. As one of the nation's leading recovery advocacy organizations, Faces and Voices of Recovery has developed an accreditation framework for Recovery Community Organizations (RCOs) [12]. The purpose is to support "the development of recovery-oriented community-based institutions and programs where peer services are delivered and a commitment to quality assurance and integrity of those services" [30].

   The behavioral health field, by and large, is moving toward greater alignment of training, roles, and responsibilities for PRCs. SAMHSA has undertaken a process to identify and describe core competencies for peer support workers in behavioral health, across mental health and addiction [31].

2. *Integration of PRCs into existing treatment and healthcare settings*

   PRCs should be integrated as crucial components of SUD treatment teams that are the foundation of emerging recovery- oriented systems of care.

   The integration of PRCs into a wider recovery network will improve their effectiveness as their efforts are more efficiently aligned with those of other relevant stakeholders. PRCs should be utilized as innovative resources. For example, Sightes et al. posits the intriguing idea of PRCs employed in the form of a mobile outreach team as this service delivery modality capitalizes on the humanizing qualities of a PRC and may prevent PRCs from operating in a role that is too professional [32].

3. Reimbursement for PRC services

Medicaid currently provides reimbursement for PRCs in 36 states and can be utilized to help defray the costs of providing PRCs in Indiana [32]. This requires garnering a sufficient amount of political capital and will to compel policymakers to support Medicaid-funded PRCs. As mentioned before, Indiana is working on allowing Medicaid reimbursement for peer recovery coaches under the 1115 SUD waiver.

In addition, concerted efforts should also focus on diversifying funding streams as to include local, state, and federal governmental sources as well as funds from private entities. Diversification of funding streams will limit fiscal vulnerability to economic downturns and changes in political winds.

4. Continuous research to bolster the effectiveness of the PRC approach

Continuous investment in research resources to bolster the scientific knowledge base about the effectiveness of PRCs is crucial. It is important that future studies address the methodological limitations that have hindered existing studies, so the effectiveness of the different PRC approaches and services, with regard to the amount, intensity, skill level of the peer, service context, and effectiveness among different target populations can be more sufficiently evaluated and improved [12, 33].

Future research that builds upon the evidence base will make policymakers more confident about incorporating peer providers into their approaches to treat substance use disorders.

Conclusion

There is sufficient evidence to suggest that peer recovery services should be an integral component of preventative and rehabilitative SUD treatment efforts. Utilization of PRCs will provide much needed employment opportunities for the previously incarcerated, lower recidivism for this group, and bolster the capacity and effectiveness of Indiana's SUD/behavioral health workforce. This likely will help improve SUD-related outcomes such as higher treatment access and engagement, lower rates of substance use related morbidity and mortality, and a lower economic burden on society.

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