THE WHAT, WHY, HOW, WHEN, AND WHERE OF PEER PLACEMENT AND INTEGRATION IN MEDICATION ASSISTED TREATMENT

Offering hope to the hopeless

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COURSE OBJECTIVES

• Describe at least 3 objectives of the peer position (primarily for OUD patients)

• Understand the purpose of having a peer.

• Explain the dynamics of a peer intervention.

• Know what the term “team approach” means in the peer position.
**OPIOID EPIDEMIC**

- **Opioid prescriptions tripled over 20 years**
  - One factor behind the surge in heroin and opioid use was the dramatic spike in the use of prescription painkillers.
  - In 1991, doctors wrote 76 million prescriptions. By 2011, that number had nearly tripled, to 219 million. (Frontline, *Chasing Heroin*, aired 2/23/2016)
  - This rise was made more dangerous when drug cartels began flooding the United States with heroin, which was cheaper, more potent, and often easier to acquire than prescription pain meds.

  (IMS Health audit 1997-2013)
OPIOID EPIDEMIC

12 states had more opioid prescriptions than people 2012:

- Alabama: 142.9 (per 100 people)
- Tennessee: 142.8
- West Virginia: 137.6
- Kentucky: 128.4
- Oklahoma: 127.8
- Mississippi: 120.3
- Louisiana: 118
- Arkansas: 115.8
- Indiana: 109.1
- Michigan: 107
- South Carolina: 101.8
- Ohio: 100.1

(Nolan & Amico, 2016)
• Opioids—mainly synthetic opioids (other than methadone)—are currently the main driver of drug overdose deaths.

• Opioids were involved in 46,802 overdose deaths in 2018 (69.5% of all drug overdose deaths).

• Two out of three (67.0%) opioid-involved overdose deaths involve synthetic opioid

(CDC, 2020)
The increase in prescription opioid use is also contributing to employer risk. Prescription drug abuse now costs society $55.7 billion annually, including $25.6 billion in lost workplace productivity and $25 billion in increased healthcare costs, a significant portion of which is passed on to employers through higher insurance costs.

(National Safety Council, 2017, pg. 3)
The rates of opioid-related emergency department visits and inpatient stays have risen dramatically. Due to opioid abuse the increase of serious infection such as Hep C, abscesses, and endocarditis are demanding more treatment from hospital workers. Total hospital costs related to opioid overdoses have been estimated at two billion dollars annually.

(Botticelli et al. 2019)
RISING HOSPITAL ADMISSIONS

- Hospital admissions related to overdoses from heroin and other opioids rose 64 percent in the United States between 2005 and 2014.

- As misuse of prescription painkillers and street opioids ascended nationwide, related hospital stays soared from 137 per 100,000 people to 225 per 100,000 in that decade.

(Preidt, 2016)
NALOXONE (NARCAN & EVZIO)

- Only works on opioids (no effect on a person who has not taken opioids)
- Works on opioids even if other illicit substances are present
- Can’t be used to get high
- Has a long safety history and side effects are rare
- Easily & safely administered by layperson

**Routes of Administration**

- Intranasal (sprayed into the nose)
- Injected into a thick muscle (thigh/arm)

Waking up – person may feel withdrawal symptoms. May also feel confused, anxious or agitated.

(Center for Opioid Safety)
MEDICATION ASSISTED TREATMENT
THE GOLD STANDARD FOR OUD TREATMENT

• 3 types of medications used in MAT
  • Methadone
  • Buprenorphine
  • Vivitrol (XR naltrexone)
METHADONE

- Long-acting medication (24-36-hour half-life for opioid tolerant individuals)
- Blocks euphoric effects of short-acting narcotics
- Prevents withdrawal symptoms and “drug hunger”
- Allows normalization of disrupted physiology
- Does not provide a euphoric rush or “high”
- Has no adverse effects on mental capability, intelligence, or employability.
- It is not sedating or intoxicating (at an appropriate dosage), nor does it interfere with ordinary activities such as driving a car or operating machinery.
• Patients can feel pain and experience emotional reactions.

• Tolerance develops extremely slow (if at all) over long periods of continued use. It is not unusual for a patient to be maintained on the same dosage for several years without needing an increase.

• When taken under medical supervision, long-term maintenance causes no adverse effects to the heart, lungs, liver, kidneys, bones, blood, brain, or other vital body organs.

• Produces very few serious side effects, although some patients experience minor symptoms such as constipation, water retention, drowsiness, skin rash, excessive sweating, and changes in libido. However, once methadone dosage is adjusted and stabilized, these symptoms usually subside.
BUPRENORPHINE

- Partial opioid agonist
  - Suboxone – buprenorphine with naloxone
  - Subutex – buprenorphine without naloxone
  - Long half life (24-60 hour)
  - Has a ceiling effect
  - Good safety profile
OPIOID AGONISTS USED IN HOSPITALS

- **Buprenorphine**
  - Used in ED to alleviate withdrawal symptoms
  - Buprenorphine waiver for physicians
  - Great tool for transitioning patient to treatment
  - Patient can begin Buprenorphine - Methadone

- **Methadone**
  - Can only be used to treat pain in hospital
  - Patient cannot go from methadone to buprenorphine without waiting 2 or 3 days (withdrawal if there's no waiting period)
May be important to mention the “3 day rule” exception

- An exception to the registration requirement, known as the "three-day rule" (Title 21,
  Code of Federal Regulations, Part 1306.07(b)), allows a practitioner who is not
  separately registered as a narcotic treatment program, to administer (but not prescribe)
  narcotic drugs to a patient for the purpose of relieving acute withdrawal symptoms while
  arranging for the patient's referral for treatment, under the following conditions:

1. Not more than one day's medication may be administered or given to a patient at one time
2. This treatment may not be carried out for more than 72 hours and;
3. This 72-hour period cannot be renewed or extended

- The intent of 21 CFR 1306.07(b) is to provide practitioner flexibility in emergency
  situations where he may be confronted with a patient undergoing withdrawal. In such
  emergencies, it is impractical to require practitioners to obtain a separate registration.
  The 72-hour exception offers an opioid dependent individual relief from experiencing
  acute withdrawal symptoms, while the physician arranges placement in a
  maintenance/detoxification treatment program. This provision was established to
  augment, not to circumvent the separate registration requirement.
• Naltrexone – blocks opiate receptors in the nervous system. Nullifies the euphoric and psychotropic reaction for opioids (as well as alcohol).

• Vivitrol® – extended-release Naltrexone is injected 1x per month (effect lasts 30 days). Some program funding may exist to greatly reduce the cost of Vivitrol.

• Can be an effective supplement for those individuals who have successfully tapered off methadone or buprenorphine.
Medication-assisted treatment (MAT) is the use of medications, in combination with counseling and behavioral therapies, to provide a “whole-patient” approach to the treatment of substance use disorders. Medications used in MAT are approved by the Food and Drug Administration (FDA) and MAT programs are clinically driven and tailored to meet each patient’s needs.

SAMHSA.GOV (2020)
The use of peers helping individuals connect to medication-assisted treatment.
PEER MAT EDUCATION

• Peers should be familiar with the MAT program
• Experience being in or working in MAT is big advantage
• Patient requirements and responsibilities
• Patient handbook
• Orientation process
• Understand 65D-30
• Shadowing counselor
WHY BECOME A PEER RECOVERY SPECIALIST?
POSSIBLE REASONS

- Help others
- Give back
- Be part of the solution
- Identify
- Share experience, strength, and hope
- A calling
- Enhance and maintain your own recovery
- Work as part of a team
The only way to do great work is to love what you do.

~Steve Jobs
• Peer support workers are people who have been successful in the recovery process.
• They help others experiencing similar situations.
• Through shared understanding, respect, and mutual empowerment, peer support workers help people become and stay engaged in the recovery process and reduce the likelihood of relapse.
• Peer support services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking a successful, sustained recovery process.
## TERMS AND DEFINITIONS

(SAMHSA, 2019)

<table>
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<tr>
<th>Terms</th>
<th>Definitions</th>
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<tr>
<td><strong>Peer support</strong></td>
<td>Giving and receiving nonprofessional, nonclinical assistance from individuals with similar conditions or circumstances to achieve long-term recovery from psychiatric, alcohol, and/or other drug-related problems</td>
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<td><strong>Recovery</strong></td>
<td>A process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential.</td>
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<td><strong>Peer support group</strong></td>
<td>Where people in recovery voluntarily gather to receive support and provide support by sharing knowledge, experiences, coping strategies, and offering understanding.</td>
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<td><strong>Peer provider (e.g., certified peer specialist, peer support specialist, mentor, and recovery coach)</strong></td>
<td>A person who uses his or her lived experience of recovery from mental illness and/or addiction, plus skills learned in formal training, to deliver services in behavioral health settings to promote mind–body recovery and resiliency.</td>
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<td><strong>Peer mentorship</strong></td>
<td>Where individuals in later recovery provide nonprofessional, nonclinical assistance to individuals in earlier recovery with similar conditions or circumstances to achieve long-term recovery from psychiatric, alcohol, and/or other drug-related problems</td>
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MENTAL HEALTH AND SUBSTANCE USE DISORDERS

Peers interact with persons that may suffer from mental health issues and/or substance use disorders. CPRS are trained and certified to meet with peers for both substance use disorders and mental health conditions. The impact of patients with trauma will be discussed but for the purpose of this presentation the focus will be mainly on the substance use disorder population.
CERTIFIED RECOVERY PEER SPECIALIST

• The CRPS credential is for people who use their lived experience and skills learned in training to help others achieve and maintain recovery and wellness from mental health and/or substance use conditions.

• The CRPS credential designates competency in the domains of Recovery Support, Advocacy, Mentoring and Professional Responsibilities. CRPS credentials also include endorsements to demonstrate the certified professional’s lived experience. Available endorsements are described below.

  * CRPS services are Medicaid billable

CERTIFIED RECOVERY SUPPORT SPECIALIST

• The CRSS credential is for people who work side-by-side with clinical staff to provide recovery support services to individuals with substance use conditions. CRSS applicants may or may not have lived experience as a person in recovery.

• The CRSS designates competency in the domains of Recovery Management; Practical Living Skills and Social Development; Resource Linkage and Follow up; Re-engagement, Crisis Support and Safety; and Professional Responsibilities.

Florida Certification Board
http://flcertificationboard.org
FLORIDA REQUIREMENTS FOR CPRS

- DCF level 2 background screening
- Lived experience
- Formal education (HSD, GED, or +)
- 40 total hours of content specific training
- 500 hours related work experience (< 5yrs)
- 16 hours of On-the-Job supervision
- 3 professional letters of recommendation
- Exam
- 10 hours/year of continuing education

(Florida Certification Board [http://flcertificationboard.org])
Endorsements

Lived experience is a foundation of peer-to-peer support services. As such, CRPS applicants must attest to at least one of the lived-experience endorsements at the time of application. Available endorsements are:

- **Adult (A):** Lived experience as an adult in recovery for a minimum of 2-years from a mental health and/or substance use condition.

- **Family (F):** Lived experience as a family member or caregiver to another person who is living with a mental health and/or substance use condition.

- **Veteran (V):** Lived experience as a veteran of any branch of the armed forces who is in recovery for a minimum of 2-years from a mental health and/or substance use condition.

- **Youth (Y):** Are between the ages of 18 and 29 at the time of application and have lived experience as a person who, between the ages of 14 and 25 experienced a significant life challenge and is now living a wellness and/or recovery-oriented lifestyle for at least two years.

Florida Certification Board [http://flcertificationboard.org](http://flcertificationboard.org)
DIFFERENCE IN PEER REQUIREMENTS

- Employment requirements include specific training and certification.
- State or local regulations dictate which trainings/certifications are required.
- Many states have their own certifications.
- Generally, most of these will include topics such as peer ethics, science of addiction, motivational interviewing, and multiple pathways to recovery.
- Some states reimburse for peer services.

(SAMHSA, 2019)
Physical location and agreed upon purpose of peer services. Settings can include but are not limited to hospitals, treatment programs, community organizations, half-way houses and other locations.
PEER TO PEER MEETING

• Personal real-time meeting and discussion between peer and person with recovery needs.
• Each intervention is unique in that everyone is unique.
PEER COMPETENCIES

• Establishing rapport
• Roads to recovery
• Qualities, roles, and tasks
• Trauma informed care
• Communication
• Cultural competency

• Models of treatment and techniques
• Dimensions of wellness and WRAP
• Ethics and boundaries
• Working as a team member
• Conflict resolution
• Using lived experience

(Learning Optimism, 2015)
ESTABLISHING RAPPORT

- Introduction “Hi Joe, how are you today?” (wait for response) “My name is Kyle; would it be okay with you for us to talk?”
- Empathy
- Honesty
- Compassion and kindness
- Patience
- Non-judgmental
- Optimism
- Bearers of hope
ALLIANCE

HOW IS IT BUILT?

- Listening
- Language
- Shared experience
- Motivational Interviewing skills
PEER SUPPORT AND TRAUMA

• We can begin to listen to each other in new ways, hearing the story rather than evaluating and assessing the problem.

• At times unique circumstances will require different approaches and understanding by the peer. Like altered styles of communication with persons of different cultural or ethnicities, the peer will need to demonstrate appropriate words, body language, eye contact, and physical distance when establishing relationships with those who have or are suffering from the effects of trauma.

(Weaver & Wilmer, 2015)
SUPPORTING PEER CLIENTS WHO HAVE EXPERIENCED TRAUMA

- Model resiliency
- Use words and terms that promote hope, courage, and empowerment
- Ask how to best support them
- Encourage them to join a trauma survivor’s group
- Discuss developing a solid support network
  - Peer specialists
  - Friends
  - Family members
  - Faith leaders
  - Other professionals (therapists, social workers, etc.)

(Weaver & Wilmer, 2015)
PEER TASKS

• To listen
• To encourage
• To guide
• To mentor and coach
• To help navigate the system
• To help connect to resources
• To explore risk
• To explore strengths
• To facilitate recovery classes and groups
• To represent peers
• To keep adequate documentation
• To serve as a supporter
• Multiple pathways to recovery
  Clinical
  • Licensed/credentialed professionals/treatment programs
  Non-clinical
  • Recovery based services (Peer, education, employment, faith)
  Self-management
  • Education, determination, self-motivation
CLINICAL PATHWAYS

- Treatment programs
  - Detox
  - MAT
  - Therapist/counselors
  - Physicians
  - Inpatient outpatient
NON-CLINICAL PATHWAYS

- Alcoholics Anonymous
- Narcotics Anonymous
- Rational Recovery
- Celebrate Recovery
- Secular Organizations for Sobriety
- Smart Recovery
Motivation
COMMUNICATION

• Active listening
  • Demonstrating full attention may contribute to peer fully disclosing information
  • Validates the feeling of the person you’re talking to
  • Decreases defensiveness
  • Minimizes chances of misunderstanding
  • Helps build trust and can resolve conflict
  • Improves cross cultural communication
  • Leads to improved outcomes
Summarizing statements:
“I heard you say that your boss is always talking down to you and that you hate being humiliated in front of other workers. It makes you want to quit and find another job. Is that right?”

Clarifying questions:
“So, did you say that you’re ready to go into treatment so that you will feel better?”

Relating statements:
“After I tell my story I always feel like I didn’t do a very good job and as a result people are judging me for it.”

Statements of affirmation:
“It took a lot of guts to admit you needed help.”
"Motivational Interviewing is a way of being with a client, not just a set of techniques for doing counseling" (Miller and Rollnick, 1991).

There are a lot of similarities between MI and peer support techniques.

Express empathy
Rolling with resistance Reflective statement Support self-efficacy
Open-ended questions Summarize Affirm
Elicit change talk
The language of empathy uses few words; it feels more than it speaks. It doesn’t preach or lecture – it listens. It can reach out and touch the spirit of another addict without a single word spoken.

NA World Service Office, Just for today, pg. 337
MOTIVATION

• Motivating an individual to consider or commit to treatment
  • Assessing motivation: Can you do it? Will it work? Is it worth it?
  • What are the barriers?
  • How do you motivate?
  • What works? What doesn’t?
  • Four C’s
    • Competence, Choice, Consequences, Community
CULTURAL CONSIDERATIONS

- Difference in...
  - Age
  - Beliefs
  - Race
  - Gender
  - Drug of abuse
  - Transference & Countertransference
CULTURAL COMPETENCE

- An awareness of one’s own cultural world view
- A positive attitude towards differences in cultures
- Knowledge of varying cultural practices and worldviews
- Cross-cultural skills- Developing cultural competence results in “the ability to understand, communicate with, and effectively interact with people across cultures.”

(Learning Optimism, 2015, pg. 103)
CULTURAL STATISTICS

- The epidemic has hit nearly everyone, regardless of race
- Every racial demographic has seen more overdoses since 1999, with heroin spiking especially after 2010. Whites and Native Americans have experienced the largest rise in death rates, particularly when it comes to opioid-related fatalities. By 2014, whites and Native Americans were dying at double or triple the rates of African-Americans and Latinos, according to the CDC.
SAMHSA’S 8 DIMENSIONS OF WELLNESS

- Emotional
- Environmental
- Financial
- Intellectual
- Occupational
- Physical
- Social
- Spiritual

A peer specialist considering these dimensions in working with a peer client will allow a holistic approach.

(Swarbrick, 2006)

“Body and soul cannot be separated for purpose of treatment, for they are one and indivisible. Sick minds must be healed as well as sick bodies.”

(C. Jeff Miller)
WRAP (WELLNESS RECOVERY ACTION PLAN)

KEY CONCEPTS
- Hope
- Personal responsibility
- Education
- Self-advocacy
- Support

- Daily maintenance plan triggers
- Early warning signs
- When things are breaking down
- Crisis plan
- Post crisis plan
BURNOUT/COMPASSION FATIGUE

- Another word for it is “secondary trauma”. People most susceptible to this are those who have responsibility for providing some type of care to persons in crisis or in very difficult situations.

Signs of this may be:
- feeling tired/lack of energy
- not wanting to come to work
- angry
- resentful
- avoiding doing tasks relating to your work.

SELF-CARE

- Give yourself permission to feel the effects of trauma
- Discuss with peers and professionals
- Use organizational supervision (individuals and groups) to address stress related to working with those effected by trauma.
- Develop a wellness or recovery plan
- Pursue fun outside of work
- Maintain a healthy balance between work and personal life.
CODE OF ETHICS FOR CRPS

• Help individuals I serve meet their needs and reach their self-determined goals
• Advocate for those I serve and encourage them to make their own decisions
• Advocate for my client’s full integration into the community of his/her choice.
• Maintain standard of proper personal conduct and treat others always with respect and dignity.
• Respect privacy and maintain confidentiality
• Remain current with new knowledge about peer support and recovery and seek to incorporate it into my work
• Never intimidate, harass, exert undue influence, physical force, verbal abuse, or make unwarranted promises of benefits to individuals I serve.
• Never engage in sexual/intimate activities with individuals I serve.
• Never practice or condone any form of discrimination based on ethnicity, race, cultural affiliation, gender identity, sexual orientation, mental/physical disability, age, religion, national origin or any other form of discrimination based on a client’s personal characteristics.
• Never abuse any substances under any circumstances at any time.
• Never accept gifts of significant value from individuals I serve.
VALUE OF USING LIVED EXPERIENCE

- Promotes engagement in treatment and moving forward in their recovery
- Peers have experience navigating through multiple systems
- Some peers have faced “wrong doors” and learned skills successfully meet their needs
- These experiences are valuable in working with peers through frustration and disappointment (not just providing them with a resource list).
- Takes away the “you don’t know what it’s like” justification.
- Sharing that relapse and crisis can be opportunities for reflection and growth.
TEAMWORK AND WORKPLACE

- Developing a recovery culture
- Using a strengths-based approach
- Remain aware of the workplace environment
- Remains consistently person-centered.
- Provides a welcoming and comfortable physical environment.
  - Not helpful - Labeling individuals solely based on diagnostic criteria
  - Toxic (unhealthy) work environment

(Learning Optimism, 2015)
TEAMWORK AND WORKPLACE

• “If we ask people to look for deficits, they will usually find them, and their point of view will be colored by this. If we ask people to look for success, they will usually find it, and their view of the situation will be colored by it.

(Krall, 1989 p. 32)

• Qualities and habits of an effective team member:
  • Flexibility
  • Punctuality
  • Sharing space
  • Answering the phone
  • Email etiquette
  • Gratitude
  • Dress
  • Group meetings

(Learning Optimism, 2015)
HOSPITAL/TREATMENT PROGRAM

• How does this all start? MOU (who is responsible for what?)
• Access to hospital (credentialing, background checks, hospital orientation, etc.)
• Introduction of peer to staff
• Attire
• MAT education for staff
• Professional courtesy
  • Ethics and confidentiality
• Knowing the system (flow chart)
  • What staff are most involved in the process?
    • Point of contact, ER physicians, charge nurse, social workers, discharge planners, etc.
INTEGRATION OF PEERS

• Trainings and resources for ED staff can disseminate details about peer specialists and help empower both staff and peer.

• In-person trainings, research, articles, workflow structures, and group discussions can help ED staff understand the exact role and scope of peer workers, as well as the value that peers bring to patient care.

• Trainings and resources should be provided on a continual basis, particularly in the early stages of program development, to ensure that all staff across all ED shifts are given access to this information.
• Along with the agreement between the hospital, the peer worker, and the treatment provider, each person involved needs to know where they fit into the process. The goal is a seamless transition between all departments demonstrating a well coordinated effort to have the patient move from ED to treatment setting.
FLOW CHART EXAMPLE

FLOW CHART

PROCESS EXAMPLES

- EMS or Walk-in to ED?
- Assessment - Interested/not interested?
- ROI – admit – meet with peer
- Type of treatment Detox or MAT?
- Detox availability? MAT appointment
- Cab/UBER to treatment facility
Release of information

• What information?
• To whom?
• For what purpose?
• HIPAA and PHI
DATA – COLLECTION AND FOLLOW UP

• Hospital Spreadsheets – types of info collected (monthly totals):
  
  
  • MAT specific – COWS? MAT used in hospital? MAT history? Medical Dx? Monthly totals – number screened; MAT administered; number referred, and number linked.
  
    • What’s purpose of data? What’s done with it?
WHY HAVE A PEER?

• Improved outcomes for organizations and treatment programs
  • Peers support efficacy in:
    • Engaging and retaining people in MH and SUD services
    • Supporting individuals in playing active role in treatment through empowerment
    • Lowering re-hospitalization rates
    • Reducing utilization of crisis and emergency room services

(Hendry, Hill and Rosenthal, 2014)
EFFECTIVENESS OF PEERS

“There is a growing foundation of research that indicates the effectiveness of peer support services in improving a myriad of health and wellbeing outcomes. A systematic review evaluating the use of peer support workers reported significant decreases in substance use and improved recovery capital (e.g., housing stability, self-care, independence, and health management) for individuals who used peer support services. Research also points to an increased likelihood of abstinence among those exposed to peer support workers.”

(Richardson & Rosenberg, 2018, pg. 2)
INDIVIDUAL/GROUP SUPERVISION

Individual
• Provides an opportunity for the peer and the supervisor to exchange information
• The peer can share positive outcomes, needs, barriers, to perform duties
• Peer can discuss specific issues relating to clients.
• Peer and supervisor can monitor progress
• Supervisor can provide technical assistance
• Supervisor can work with peer to problem solve

Group
• Opportunity for team building and sharing successes
• Help others understand policy changes
• Technical assistance to the entire team
• Discuss mutual clients
• Discuss mutual barriers
• Opportunity for short term and long-term planning.
• Peers can share strategies used and their outcomes
ONGOING SUPERVISION

• Helps the peer know they’re not alone
• Accrue hours of supervision for other certification
• Continue to monitor and look for ways to improve
• Peer is on the front line; who better to share ways of improving?
• Introduce new ideas and innovative ways to better serve the client.
PEER SPECIALIST SUPPORT GROUPS

• Peers need to share their experiences and challenges with other peers.
• Having a regularly scheduled meeting for this to occur is healthy for the peers.
• Parallel services (peer/recovery and peer/peer) are mutually beneficial.
  • What other benefits can you think of for peers to meet with each other regularly?
  • Why is this so important?
CASE STUDY INITIAL APPROACHES

• Need help and have a family/friend here for support
• Person resistant to treatment
• Person ambivalent towards treatment
• Been there, done that
• Was doing good, but recent (serious) relapse
• Angry, combative, and agitated
HARM REDUCTION MODEL

• A strategy towards individuals or groups that aims to reduce the harms associated with certain behaviors. Regarding substance abuse, it accepts the fact that a continuing level of use/abuse is inevitable and defines objectives as reducing adverse consequences. It looks at the level of health, social and economic outcomes, as opposed to the measurement of drug consumption.

• Harm reduction has evolved over time, from its initial identification in the 1980’s. At the time, it was recognized that abstinence was not a realistic goal for those with addictions. In addition, those individuals who were interested in reducing, but not eliminating, their use were excluded from programs that required abstinence.
There is persuasive evidence from the adult literature that harm reduction approaches greatly reduce morbidity and mortality associated with risky health behaviors. For example, areas that have introduced needle-exchange programs have shown mean annual decreases in HIV seroprevalence compared with those areas that have not introduced needle-exchange programs. Access to and use of methadone maintenance programs are strongly related to decreased mortality, both from natural causes and overdoses, which suggests that these programs have an impact on overall sociomedical health.

(U.S. National Library of Medicine)
ROSC MODEL OF TREATMENT

- What’s ROSC?
- ROSC (Recovery-Oriented Systems of Care)
  - “Networks of organizations, agencies, and community members that coordinate a wide spectrum of services…”

(Sheedy & Whitter, 2013, p.227)
• Acute-Care Model
  • Decision-making dominated by the professional
  • Short-term service relationship
  • Expectation of complete resolution of the problem post-treatment
    • Services delivered in a uniform series often consisting of Screening
    • Admission
    • Initial assessment
    • Treatment
    • Discharge
    • Termination of service relationship
  • Re-entry into treatment is interpreted as a failure on the part of the individual rather than inadequate treatment design
WORKING WITH OTHER PROFESSIONALS

• Stay in your lane?
• Boundaries
• Respect
• Ethics
• Scope of practice
Working in the private sector opens a pathway to thousands of new employment opportunities. Peer supporters have the capability to work on multiple levels of the system of care. In many cases the private sector offers higher wages and more room for upward job mobility.

- Entry level peer support
- Advanced level peer support
- Supervisory positions
- Administrative positions
- Management

For many years there has been an ongoing discussion about the establishment of a national certification.

Most of us thought this would be accomplished by a peer-run organization, but as time went by no group stepped up to meet the challenge.

(SAMHSA, 2020)
IMPROVING THE QUALITY OF LIFE

- Explaining the disease model of addiction
- Health education – community resources
- No “one-path” to recovery
- Planting the seed
- Believe in the ability to recover
CONCLUSIONS

The initial steps of getting individuals with OUD into MAT treatment have many challenges. With a coordinated effort between organizations and treatment providers, peers are uniquely qualified to add a missing piece to the current system. The peer position can be a vital factor in getting the suffering person into treatment for a healthier lifestyle.
FINAL THOUGHTS & QUESTIONS
REFERENCES


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