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"I have to be around people that are doing what I'm doing": The importance of expanding the peer recovery coach role in treatment of opioid use disorder in the face of COVID-19 health disparities

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ABSTRACT

The COVID-19 pandemic and ongoing opioid epidemic are causing notable morbidity and mortality among low-income and minority populations. Peer recovery coaches (PRCs), people with lived experience of substance use and recovery, are uniquely positioned to support underserved, minority individuals who face the greatest barriers to care. This commentary combines research and clinical perspectives to describe the potential role of PRCs in reaching and supporting particularly vulnerable populations in the setting of substantial changes in the opioid use disorder (OUD) recovery landscape during COVID-19. During this time, PRCs can provide guidance from their own experience navigating changes to routines and social support systems, reduce social isolation, build trust and buy-in, and support engagement in care. Specific barriers include access to technology and underlying distrust of public and medical authorities. This article highlights the importance of expanding the reach of the PRC workforce as well as supporting their specific needs at this time to combat the intersecting devastation of two epidemics.

Worldwide, disparities and inequities are exacerbated in the face of COVID-19. In the U.S., prevalence and mortality rates show a disproportionate burden on Black/African American and Latinx populations (Hooper, Nápoles, & Pérez-Stable, 2020). Underlying causes include: distribution of pre-existing conditions associated with socioeconomic status, inadequate access to health care, long-standing distrust of public and medical authorities, and varying levels of protection under stay-at-home orders (CDC, 2020). As described elsewhere, "social distancing is a privilege" that is not afforded to those who rely on public-facing jobs and/or experience unstable housing (Yancy, 2020).

This is not a new story; the opioid epidemic has and continues to ravage low-income and minority populations. Though national opioid overdose deaths declined between 2017 and 2018, rates increased among ethnoracial minorities (Wilson, 2020). COVID-19 and the opioid epidemic are colliding within the same vulnerable populations, presenting unique challenges with compounding effects (Wakeman, Green, & Rich, 2020). Early national data show significant increases in rates of drug overdoses since March 2020 (Alter & Yeager, 2020), likely resulting, at least in part, from increased social isolation and challenges maintaining access to care (Alexander, Stoller, Haffajee, & Saloner, 2020).

Peer recovery coaches (PRCs), individuals with lived experience of substance use and recovery, are well-suited for an important role supporting people with opioid use disorder (OUD) during COVID-19. Individuals from similar demographic backgrounds who have gone through the recovery process themselves can promote patient engagement, buy-in, trust, and retention (Cabral & Smith, 2011). Thus, PRCs can work to combat COVID-19 health disparities by continuing to foster motivation for recovery, social support, and help navigating resources—especially for underserved, minority individuals who face the greatest burden of OUD and COVID-19 *and* the greatest barriers to care.

Our team conducted qualitative research prior to COVID-19 as part of a larger project investigating barriers to methadone maintenance treatment (MMT) retention at a community-based drug treatment center serving primarily low-income, minority patients. We identified idle time and lack of structure as key predictors of poor treatment outcomes (unpublished data). When asked about their biggest barrier to staying engaged in MMT, one patient participant shared that her "biggest thing

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is time … just having nothing to do." Other participants described difficulty navigating recovery without a supportive social circle. As one participant put it, "I have to be around people that are doing what I'm doing." These challenges, amplified in the context of COVID-19, are not unique to low-income or minority people in recovery. Many people can relate to the drastic change in routines and schedules as the world works to navigate closures and changes in or loss of jobs. However, the uncertainty and breakdown of accountability options may also jeopardize recovery and precipitate relapse. Given the disproportionate burden of the pandemic on low-income and minority populations, attention, resources, and creativity toward supporting their care is required.

The flexibility inherent in PRCs' roles may allow them to more effectively support hard-to-reach, vulnerable patients, and help to establish daily structure and routines (Satinsky et al., 2020). PRCs can provide guidance from their own experience navigating changes to routines and access to social support systems, while themselves also serving as a social support. Furthermore, PRCs may be able to bridge a gap in trust of the health care system that is contributing to some of the disparities in COVID-19 morbidity and mortality. By establishing trust, PRCs can disseminate and promote reliable health and safety messages about COVID-19, as they do already with harm reduction messages, as well as provide linkage to other recovery services, such as recovery housing, as they often have a strong understanding of available resources in the community.

Not only did patients conceptualize unstructured or "idle" time as a challenge to overcome in the recovery process, but patients considered "productive" or purposeful activities/behaviors both a facilitator of successful MMT outcomes and an indicator of doing well (as defined by patients). Prior to COVID-19, patients' daily MMT clinic attendance was often an important part of that structure. One participant explained that, though she met stability criteria for more take-home bottles, she chose to attend daily dosing. Swift federal and local responses to COVID-19 have maintained and even expanded access to MMT by loosening restrictions on take-home doses and increasing telemedicine options (Leppla & Gross, 2020; SAMHSA, 2020). Some medical providers and stakeholders have been lobbying for more access to take-home dosing before and outside the context of a viral pandemic (Green, Bratberg, & Finnell, 2020). In the months and years to come, we will have the opportunity to investigate the impact of this treatment flexibility on rates of patients newly initiating MMT and on MMT retention (Greenblatt, Magidson, Belcher, Ghandi, & Weintraub, 2020). We must adapt and evaluate a PRC role to support MMT engagement in the context of changing regulations as well as continue to support the PRC role across substance use treatment modalities, including other medications and psychosocial treatments.

With telemedicine increasing, we run the risk of further excluding vulnerable individuals who lack consistent access to technology. PRCs are more likely to serve low-income, hard-to-reach populations that may lack tools needed to pivot to virtual recovery support. PRC knowledge and recommendations can help to ensure that hard-to-reach patients are not further marginalized. Some suggestions to do so include reverse telemedicine, in which clients use technology at treatment centers to connect with providers, mobile units for WiFi hotspots or in-person meetings in outdoor settings, and cellular data and phone minutes provided to individuals in treatment programs. However, further research should help us to better understand barriers and the effects of increasing inequity in the digital divide. Furthermore, policy-makers must continue work to establish reimbursement structures for PRC services (Chapman, Blash, Mayer, & Spetz, 2018), and should ensure that phone-delivered services, regardless of video availability, are billable. Funding should also be considered for telehealth platforms as well as training for both PRCs and patients. Specifically, PRCs have expressed a need for specialized training in telehealth as they are expected to adopt new delivery approaches and have varying comfort levels with the requisite technology (Fortuna et al., 2020). Identifying accessible, sustainable options for PRC services in the expansion of telemedicine will support vulnerable patients during the COVID-19 pandemic, but also in the future, beyond the acute pandemic context.

Another crucial consideration for program leaders is how to support PRCs, including intentional planning for PRCs to receive resources for self-care as they navigate their own recovery and health. PRCs themselves are likely also facing psychosocial and financial stressors, and increased risk for relapse in the context of greater isolation. PRC supervisors are increasing team meetings and check-ins to foster comradery and identifying ways to promote use of mental health services during this time. They are also recognizing the importance of ensuring PRC access to high-quality health care and public health training for their own health and safety.

Thoughtful decisions regarding support of PRCs through remote supervision and training are vital. Effective models for remote training and supervision that promote PRC self-care can be sustainable beyond COVID-19 and improve patient care and PRC well-being. If supported, PRCs are uniquely positioned to address intersecting effects of the opioid and COVID-19 epidemics. Lifting up the PRC workforce to meet telemedicine opportunities as well as the needs of low-resource communities will have long-term effects on care delivery and recovery support.

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CRediT author statement

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Declaration of competing interest

None.

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