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Peer Recovery Specialists-A Need for More Information

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Abstract

Use of Peer Recovery Specialists (PRS) has out-paced the knowledge-base on their effectiveness and mechanisms of action. PRS are a common component of the mental health support system for individuals undergoing treatment for mental health and substance use disorders. However, the research on PRS is mixed, and there are many questions which need to be addressed by additional research. This editorial briefly reviews the state of the literature and suggests areas for future research including training and supervision, barriers and systemic factors associated with agency use of PRS, mechanisms of action, and limits of effectiveness for PRS.

Keywords: Peer recovery; Substance use; Mental health; Treatment

Introduction

Peer Recovery Specialists (PRS) are a common form of support for those with mental health and substance use issues. They serve a unique role, as they are not counsellors, therapists, or physicians. Instead, they are other individuals who have experienced the same mental health or substance use issues as the person receiving treatment and can provide encouragement, understanding, and hope as a patient begins going through their own treatment [1,2]. Importantly, PRS have undergone their own recovery process to improve health and wellness, live a more self-directed life, and seek their full potential [3].

While many states and organizations employ PRS, the research around whether or not PRS are helpful in treatment is mixed. For example, the results of one meta-analysis suggested that PRS provide minor benefits to patients, if any at all [4]. On the other hand, a recent clustered randomized trial within the Veteran's Health Administration (VA) found that when PRS were added to usual care, patients receiving PRS showed more improvement over a year than those in usual care alone [5]. From a patient outcomes perspective, the results from the VA trial suggest that PRS support patient recovery (i.e., symptom management, stable housing, and meaningful activities and relationships;) [3] and patient self-efficacy in managing his or her health, which can be considered important to long-term favorable outcomes.

Although patient outcomes in general are important in evaluating PRS, other considerations also loom large. First, in what contexts are PRS most and least effective? Effectiveness of PRS may differ based on disorder (e.g., mood *vs* schizophrenia), comorbidity (i.e., substance use *vs* substance use and other mental health issue), or cultural match between PRS and clients (e.g., matched on race or ethnicity). Second, what training process is best for PRS? While organizations such as The Association for Addiction Professionals provide certification for PRS (e.g., National Certified Peer Recovery Support Specialist), it is unknown if this certification or another type of certification is needed for effectiveness. There appear to be no generally known and professionally regulated standards to become a PRS. Requirements could include curriculum, number of training hours, shadowing, and if continuing education is needed after obtaining certification. Third, who is qualified to conduct supervision of PRS? Must they also be or have been a PRS? Fourth, what barriers are faced by PRS? Are they under-utilized due to program manager bias? Fifth, what systemic factors drive or deter organizations in the use of PRS, including reimbursement structures?

While PRS may provide helpful support to persons receiving mental health and substance services, many questions still remain to determine whether PRS are effective, and if so, the mechanisms and limits of their effectiveness. We must better understand optimal training and supervision for PRS, contextual factors impacting effectiveness (e.g., cultural match), barriers to use of PRS and systemic factors associated with utilizing PRS. Such understanding can assist in better use of resources for organizations dedicated to improving patient health and well-being.

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