Peer Support Groups and Medications for OUD

Perspectives from Individuals and Care Providers

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Key Findings

- Individuals were interested in peer support groups that were supportive of people on medications for opioid use disorder.
- Some individuals had left peer support groups because they were not supportive of methadone or buprenorphine.
- Care providers and healthcare providers working with people with opioid use disorder were largely supportive of the medications for opioid use disorder.
- Care providers and healthcare providers working with people with opioid use disorder often refer out to peer support groups, but about a third did not know if these groups were supportive of the use of methadone, buprenorphine, or naltrexone.
- More rigorous evaluation of the effectiveness of peer support is warranted.

Introduction

Medications are increasingly a front-line treatment for opioid use disorder (OUD), and more people in Washington State are using medications for OUD (MOUD). Peer support groups are an important piece of recovery from substance use disorders for many individuals and have a long history. However, such groups often have a philosophy promoting complete abstinence from opioids (including those dispensed/prescribed by healthcare providers) that may be in conflict with the use of (MOUD) like buprenorphine, methadone, and naltrexone (Narcotics Anonymous, 2016).

A meta-analysis of ten studies found that peer support groups showed benefits for people with substance use disorders, including improving engagement in treatment, reducing craving, and increasing self-efficacy. The meta-analysis noted some important limitations of the evidence for the benefits of peer supports including that there have been few rigorous evaluations of the outcomes of peer supports, and that the peer supports studied were delivered in combination with other services such as drug treatment, so isolating the effects of peer supports could be challenging. In addition, the individuals likely to engage in peer supports may be different than those who do not engage (Tracy & Wallace, 2016).

A recent multi-site study in the NIDA Clinical Trials Network found that buprenorphine and mutual aid support groups were both associated with abstinence from opioid use among individuals seeking treatment for opioid use disorder for prescription opioids (Weiss et al, 2019). Another study found that Narcotics Anonymous (NA) attendance was correlated with longer treatment retention, though requiring attendance in a group did not improve outcomes, and patients reported “cognitive dissonance” between NA’s focus on abstinence from all opioids, and the medical message supporting medications (Monico et al, 2015).

This survey explores the perspectives of those with OUD towards peer support groups. The survey also examines provider attitudes towards MOUD, referrals to peer support groups, and their knowledge of the groups to which they refer.

Methods

Survey participants were individuals with self-identified OUD, and care providers -- including healthcare providers -- who work with people with OUD.

Survey questions were developed by staff at ADAI and reviewed by three care providers in the field. Providers' comments and suggestions were then integrated into the survey.

Individuals were asked about their opinions and experiences with peer support groups and MOUD. Care providers and healthcare providers were asked about their personal attitudes about peer support groups and people on MOUD, as well as organizational attitudes. They were also asked if they make referrals to peer support groups, and if those groups are supportive of the use of MOUD. The survey questions are included in the Appendix.

The survey and associated recruitment materials were submitted to the University of Washington Human Subjects Division (Institutional Review Board) and determined not to be human subjects research.

The survey asked different questions for participants who had OUD compared to those who are care providers. The survey link was posted to the stopoverdose.org Facebook and Twitter pages, and advertised on Facebook for Washington residents over the age of 18. It was posted for two weeks. An email was also sent to a professional listserv with a link to the survey. The listserv was composed of professionals working to address the opioid epidemic including those working in treatment settings and with peer recovery supports groups.

After the initial survey was posted and responses were captured in Survey Monkey, the survey was subsequently adapted with questions specifically for healthcare providers and shared by the Washington Society of Addiction Medicine and by the Washington State Hospital Association. This was done to increase the overall response to the survey and to include the perspectives of professionals working specifically in healthcare, rather than drug treatment, settings.

Survey responses were reviewed to ensure there were no duplicates and data were analyzed in SPSS to create descriptive statistics.

Results

Twenty-four individuals with opioid use disorder and 93 care providers who work with opioid use disorder completed the survey. Twenty-one healthcare providers responded to the healthcare provider specific survey.

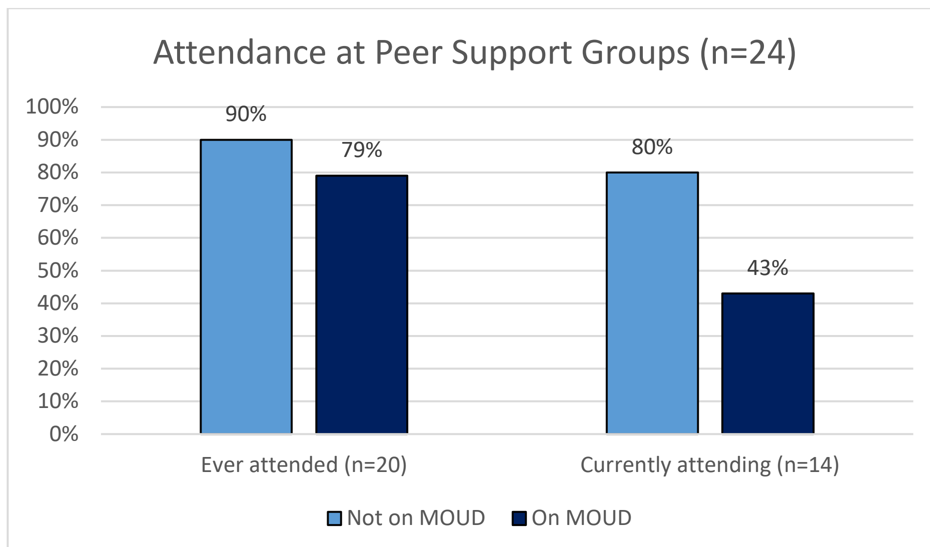
People with OUD

Twenty-four individuals with OUD responded to the survey.

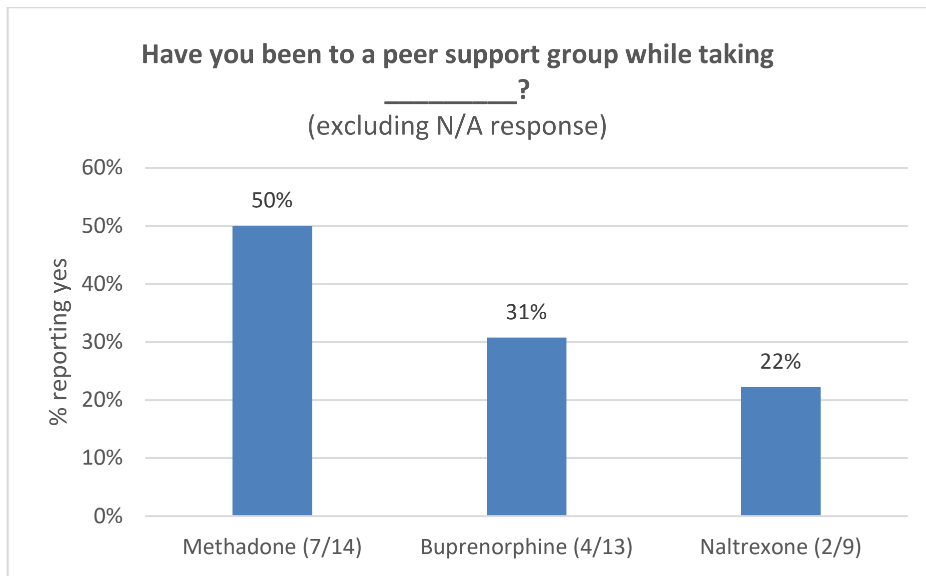
Table 1. Characteristics of respondents with opioid use disorder (n=24)

Age			Gender			What medication do you use to treat your opioid use disorder?		
30-39	4	17%	**Female**	16	70%	Buprenorphine	8	33%
40-49	6	25%	**Male**	6	26%	Methadone	5	21%
50-59	5	21%	**Trans**	1	4%	Naltrexone	1	4%
60+	9	38%	**Missing**	1	4%	None	10	42%
How many years ago did your opioid use get out of control?			How many years have you been on medications to treat your opioid use disorder when you add all the time together?			Housing Status		
Less than one year	1	4%	**Less than one year**	6	25%	**Permanent Housing**	22	92%
1-5 years	6	25%	**1-5 years**	7	29%	**Temporary**	2	8%
5+ years	17	71%	**5+ years**	7	29%	**Homeless**	0	0%
			No response	4	17%			

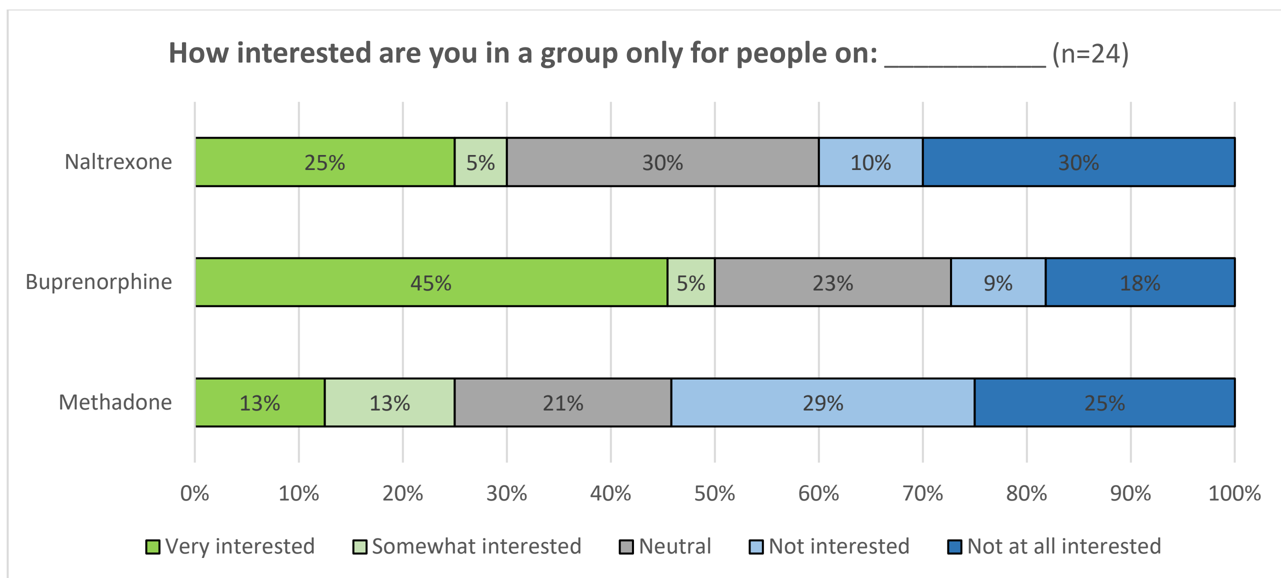
The majority of respondents were female, and age was fairly evenly distributed, everyone who responded was over 30. A third of respondents (n=8) were on buprenorphine, 21% were on methadone (n=5), and one person was on naltrexone. Ten respondents were not currently taking any MOUD. The large majority of people responding to the survey were housed.



Ninety percent of people who were not currently on MOUD had ever attended a peer support group, compared with 79% of these who were currently on MOUD. Eighty percent of respondents not on MOUD were currently attending a peer support group, compared with 43% of those currently on MOUD.

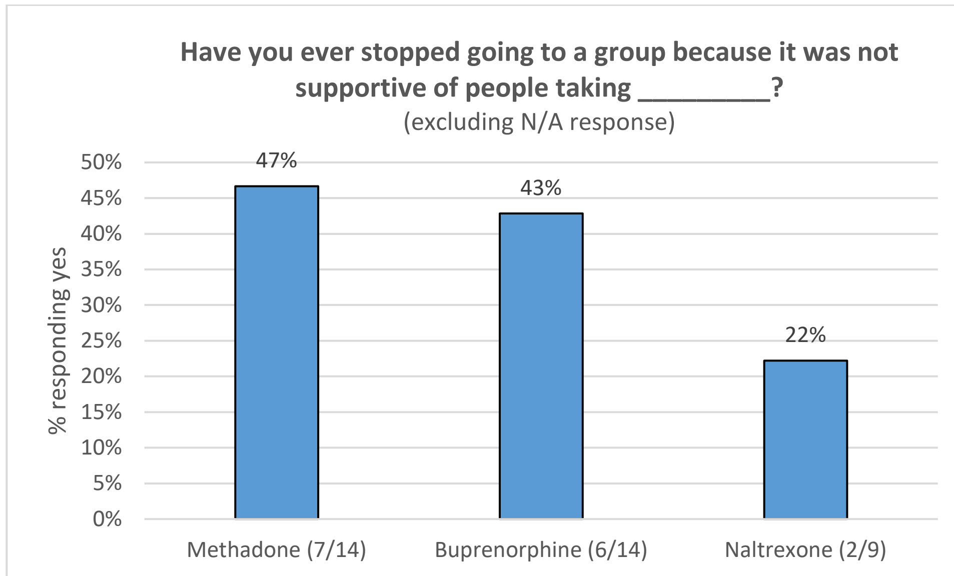


Half of respondents reported that they had attended a peer support group while on methadone, about a third while on buprenorphine, and 22% while on naltrexone (those who reported N/A were removed from the denominator).



There was interest in groups for people on specific medications, with the highest level of interest in a group specifically for people on buprenorphine (50% somewhat or very interested). Among those on buprenorphine currently, 88% were interested in a group specifically for people on buprenorphine (data not shown).
Some individuals expressed that they had stopped going to a peer support group because it was not supportive of people on opioid treatment medications. Forty-seven percent (47%) reported they had stopped going to a

group because it was not supportive of people on methadone, 43% because it was not supportive of people on buprenorphine, and 22% for naltrexone (among those who did not respond N/A).



In the comments individuals expressed that peer support groups are helpful for recovery because "*It helps so much hearing others that have the same yet different challenges.*"

A few people expressed that many peer support groups are not supportive of opioid treatment medications, and that this can be harmful for people in recovery using these medications.

> *"For individuals involved in the 12-step programs, many programs have communities that are very hostile to MAT people, and it is often impossible to know beforehand. I have seen/personally encountered advice to stop MAT in a way that would have been potentially life threatening if I had done as recommended. If i had not been sure of myself I might have taken incredibly bad and harmful advice."*

Two people expressed that peer support groups should be open and supportive of anyone pursuing recovery.

> *"Whatever works best for you. We who have struggled with addiction should never judge anyone else about their own addiction or their choice of how they decided to quit using."*

> *"In my opinion, peer support groups should not hold any views/attitudes toward individuals on MAT, other than that they be welcome to a support group. The only requirement for attendance should be a desire to recover... With that said, more peer support/led meetings and groups would be of great benefit for folks on MAT to ensure a safe and supportive transition into recovery."*

Care Providers

This section describes characteristics of substance use disorder care providers and their views of their organizations. A later section compares views of medications and support groups across different provider types.

The 93 care providers who responded to the initial survey worked in a range of settings, with the most frequent being healthcare, opioid treatment programs, and outpatient drug treatment programs. The majority of respondents were female (73%, n=85), and all but one were 30 or older. Respondents had differing roles in their programs, including medical provider, administrator, other direct service staff, counselor, and other.

Table 2. Care provider characteristics (n=93)

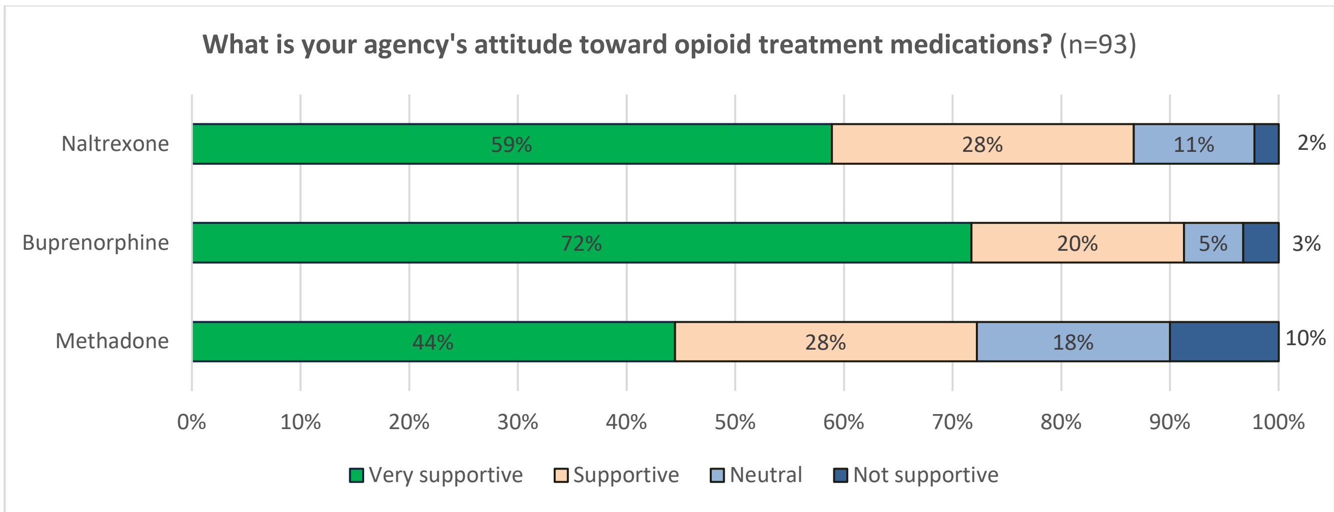
What treatment setting do you work in?			Gender		
Healthcare	34	29%	Female	85	73%
Opioid Treatment Program	26	22%	Male	32	27%
Outpatient drug treatment program	21	18%	Age		
Community based agency e.g. syringe exchange	12	10%	25-29	1	1%
Recovery Café	1	1%	30-39	23	20%
Oxford House	1	1%	40-49	25	21%
Recovery Help Line	1	1%	50-59	33	28%
Other	22	19%	60+	35	30%
What is your role at your agency?					
Medical provider	27	29%			
Administrator	24	26%			
Other direct service staff	18	19%			
Counselor	16	17%			
Other	8	9%			

Table 3. Characteristics of organizations

What medications does your organization prescribe or dispense? (n=93)		
Methadone	12	10%
Buprenorphine	68	58%
Naltrexone	49	42%
None	20	17%
Peer support groups requirements or referrals (n=93)		
Requires participation in peer support groups	20	24%
Hosts peer support groups	32	36%
Refers out to peer support groups	67	74%

Most organizations that responded to the survey prescribed or dispensed at least one of the opioid treatment medications, with the highest proprotion prescribing or dispensing buprenorphine (58%) and the lowest dispensing methadone (10%).

The majority of organizations did not require participation in peer support groups (24%), but did make referrals to peer support groups (74%, n=67).



Most respondents believed that their organizations were supportive of MOUD with the highest levels of support for buprenorphine (92% very supportive or supportive) and the lowest for methadone (72% very supportive or supportive).

In the open-ended comments section, care providers identified challenges around peer support groups, including: stigma against and lack of support for MOUD in Narcotics Anonymous and Alcoholics Anonymous; lack of peer support groups that are supportive of MOUD; and the growing need for supportive services generally in Washington.

Care providers also offered suggestions for improving access to groups that are supportive of MOUD, including: more options for separate groups for people on MOUD and not on MOUD; increasing support for MOUD in existing groups; education for organizations that interact with people with OUD, but are not healthcare or substance use disorder focused, on how to support clients; a holistic approach to patient/client health; and increased housing supports for homeless clients.

Healthcare Providers

Twenty-one healthcare providers responded to the survey specifically for this group. The majority were doctors (75%, n=15), while the rest were a mix of nurse practitioners, a physician assistant, a quality program manager, and a substance use disorder professional. The majority were primary care/internal medicine (57%, n=12) or addiction medicine providers and most worked in a primary care setting.

Table 4: Occupation, gender, and age of healthcare providers, n=21

Occupation			Gender		
Doctor	15	71%	Female	6	29%
Physician Assistant	1	5%	Male	15	71%
Nurse practitioner	2	10%	Age		
CDP/Case Management	1	5%	25-39	4	19%
Quality Program Manager	1	5%	40-49	2	10%
Social Worker	1	5%	50-59	4	19%
			60+	11	52%

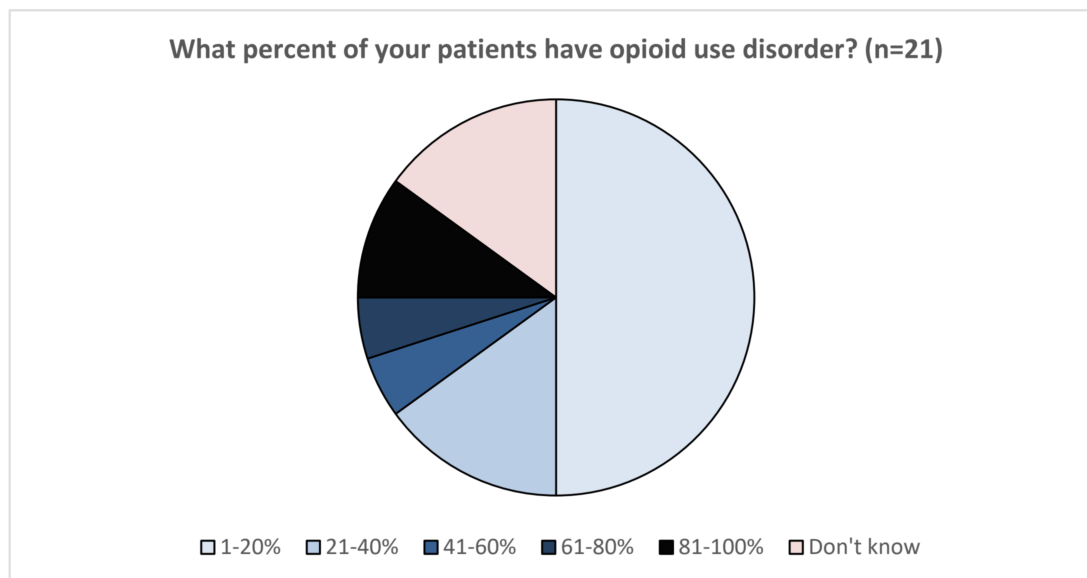
Table 5: Type of medicine and practice setting (multiple responses possible)

Area of medicine (n=21)			Setting (n=21)		
Primary care/Internal Medicine	12	57%	Primary care	14	67%
Addiction medicine	9	43%	Other	6	29%
Psychiatry	3	14%	Specialty care	5	24%
Pain medicine	3	14%	Outpatient drug treatment	5	24%
Emergency department	2	10%	Emergency department	2	10%
Clinical Training	1	5%	Opioid treatment program	1	5%
Neurosurgery	1	5%	Inpatient	1	5%
Obstetrics & Gynecology	1	5%			

Table 6: Organizational characteristics

What medications does your organization prescribe or dispense? (n=21)		
Methadone	3	14%
Buprenorphine	19	90%
Naltrexone	14	67%
None	2	10%
Peer support groups requirements or referrals (n=21)		
Requires participation in peer support groups	3	15%
Hosts peer support groups	5	25%
Refers out to peer support groups	19	90%
Has a policy that addresses opioid treatment medications	15	71%

Most of the providers who responded worked at organizations that prescribed buprenorphine (90%, n=19) or naltrexone (67%, n=14) and a minority dispensed methadone (14%, n=3). The minority required participation in peer support groups (15%, n=3) or hosted peer support groups on site (25%, n=5), though the large majority referred out to peer support groups (90%, n=19).



The majority (53%, n=10) reported that 1% to 20% of their patients had OUD. Most providers screened some (30%, n=6) or all (40%, n=8) of their patients for opioid use disorder (data not shown).

Healthcare providers were asked if there was anything else they would like to share regarding peer support groups and MOUD. The general theme was that many peer support groups are not supportive of MOUD and that patients are not able to be open about their use of these medications as part of recovery. Providers also said that there should be more types of peer support groups available to help their patients.

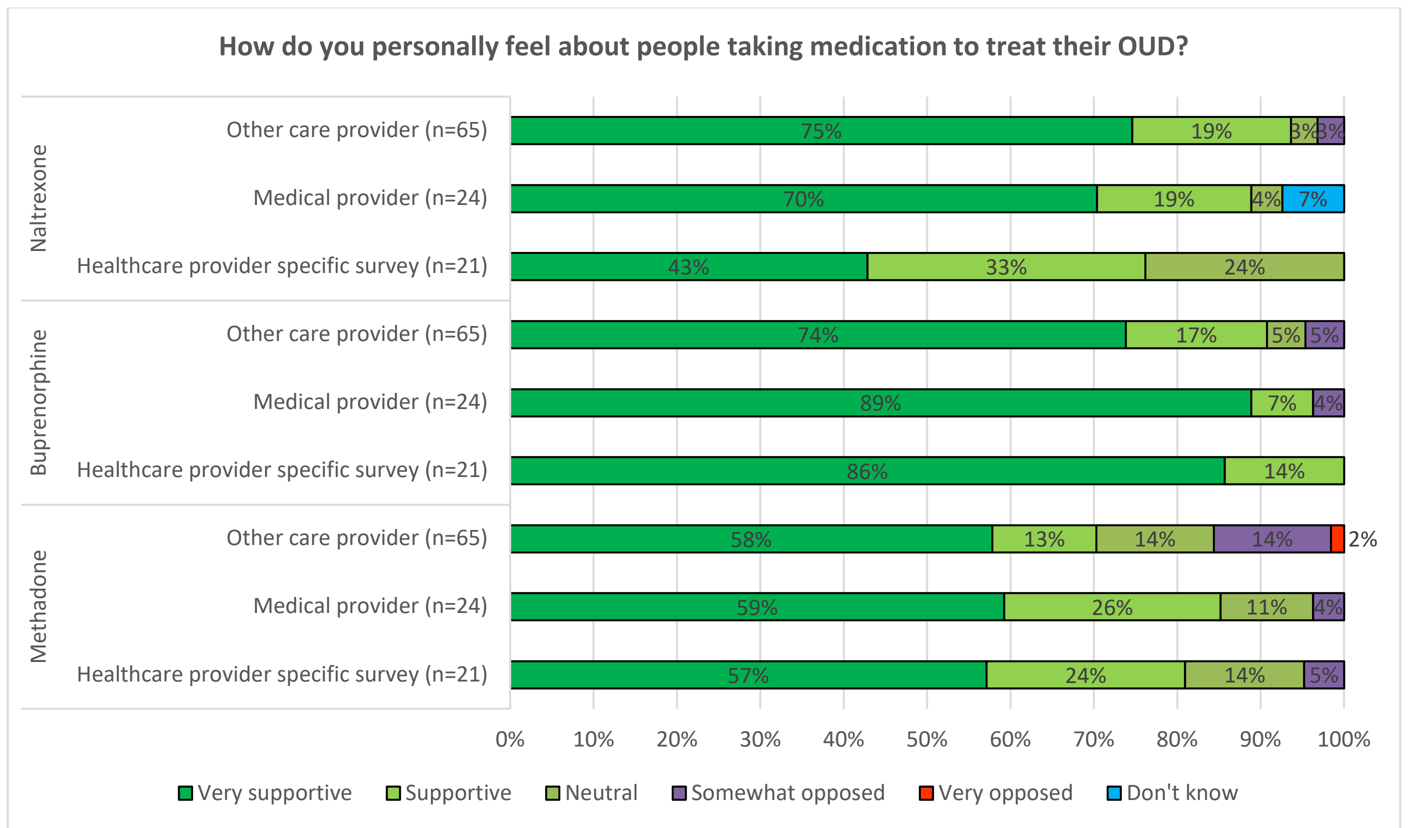
> *"There is a major need for non-religious peer support groups that are welcoming to people on all forms of opioid treatment medications."*

> *"If my patients attend Narcotics Anonymous, I usually advise them to be careful about telling others about their use of medications."*

Comparison across Surveys

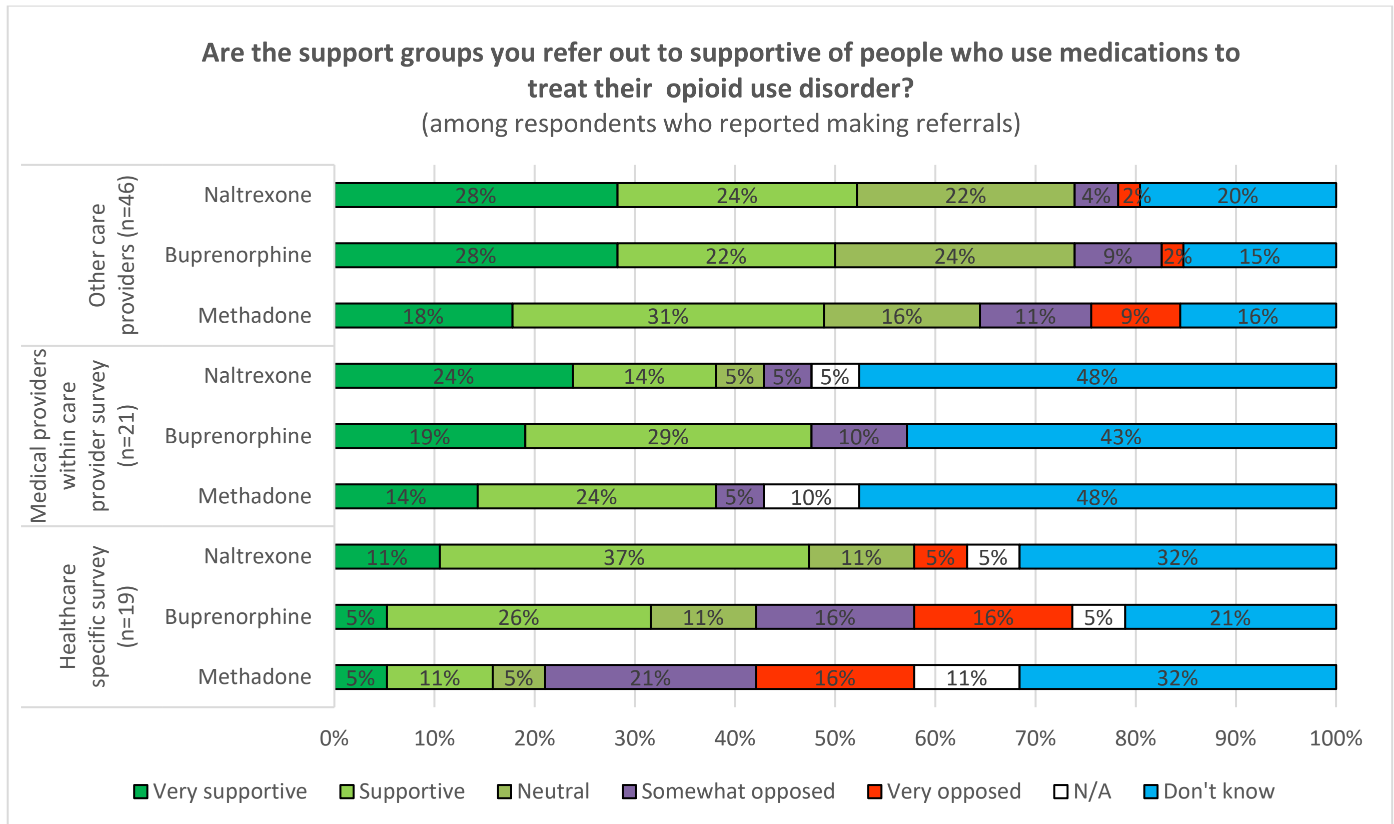
We compared responses across the two surveys on two key questions, personal opinion of MOUD and perception of support groups' supportive for MOUD. We compared across three groups, healthcare providers from the larger care providers survey and from the healthcare specific survey, and other respondents to the care providers survey.

All care providers were asked about their personal opinion of people using MOUD. There were high levels of support for MOUD overall, with most care providers reporting they were supportive or very supportive of all three medications. Methadone had the lowest level of support, and buprenorphine the highest. Healthcare providers reported higher levels of support for MOUD than non-medical care providers in both surveys.



Care providers were asked about their perception of the peer support groups to which they provide referrals. Among care providers who reported making referrals, many did not know if the support groups they referred to were supportive of people who use MOUD.

Healthcare providers were less likely to feel that the support groups to which they referred individuals were supportive of MOUD. Only 16% of the healthcare providers from the healthcare provider specific survey felt that the support groups they referred out to were supportive of people on methadone, compared with 49% of the other care providers.



Discussion

Peer support groups are a part of recovery for many individuals with OUD. However, people with OUD did not always feel that support groups were supportive of MOUD, and about half of those on methadone or buprenorphine had left a group for this reason.

Individuals with OUD were interested in different types of support groups, including those exclusively for people on specific treatment medications, and mixed groups of people on and not on MOUD. People on buprenorphine expressed the greatest interest in a group specifically for people on MOUD.

Several approaches to increasing access to groups could be considered to increase the number of peer support groups that are openly supportive of MOUD. One would be to educate and destigmatize the use of MOUD in existing peer support groups through education and outreach. Another approach could be to develop or expand

groups that are explicitly supportive of MOUD, or for people on specific medications, especially buprenorphine. Ideally both actions would be taken in parallel. While it would be ideal for all groups to be supportive of people being on MOUD, given the strong enmeshed culture of many of these groups, this would likely be a lengthy process. In the meantime, establishing groups overtly positive towards people being on MOUD should be implemented now, as it can be done in real time without having to change the culture/beliefs of other people and organizations.

Healthcare providers and other care providers who work with people with opioid use disorder reported referring people to peer support groups, though many did not know if those groups were supportive of MOUD. A directory that includes information about peer support groups' attitudes towards MOUD could be useful for providers and individuals in finding an appropriate peer support group. The Washington State Recovery Helpline is open to incorporating this information into their treatment locator databases.

Regardless, for health and safety of their patients on MOUD, those providers referring or mandating that their patients/clients attend support groups should ensure that such groups are supportive of medications, just as they would ensure appropriate care would be provided to other providers to whom they refer for other services.

Limitations

The response to the individual survey was low, possibly due to the sensitive nature of the topic, and people's reluctance to participate in a survey about OUD through Facebook. Alternative methods of surveying such as in-person surveys may have a higher response rate and may provide more information on this sensitive topic. We asked whether respondents were currently on MOUD, but did not ask if they had ever been on MOUD. This limited our analysis as some questions were about past behavior rather than current behavior.

The individual respondents were mostly housed, and their perspectives may not be representative of those living in temporary housing or without housing. However, this is an important perspective to obtain, as other data sources such as syringe exchange surveys include mostly impermanently-housed people. The respondents were mostly 40 and older; their perspectives may not be generalizable to younger people with OUD. The survey for care providers and the survey specifically for healthcare providers had some variance between questions and were not able to be merged. Many of the questions were asked the same way and were able to be compared, but future surveys on this topic should ensure that they are fully compatible.

The survey for healthcare providers had a small number of respondents, so the results are likely not generalizable to a broader group. Also, the survey was shared through WASAM, so we may have been more likely to sample healthcare providers who were supportive of MOUD than the general provider population. There is a similar limitation with the survey for substance use disorder providers since the survey was shared through a listserv for people interested in OUD and overdose interventions.

Despite these limitations, the surveys paint a clear picture of a need for more diverse peer support groups for people who are taking methadone, buprenorphine, or naltrexone as part of their recovery from OUD, and a need for a resource guide that clearly outlines these options to improve referrals from healthcare providers and other care providers.

Acknowledgements

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