



Peer Recovery Support:

Evolving Roles and Settings

A Literature Review



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Introduction

The emergence, growth and maturation of peer recovery support services (PRSS) have radically changed the addiction field, opening a range of formalized supports that did not previously exist for people in or seeking recovery from addiction. PRSS are non-clinical services designed to support individuals before, during and/or after treatment. They also provide supports for most individuals who initiate recovery without treatment.¹

An important element in the history of PRSS is the concurrent development of the addiction-recovery movement and the organized-recovery community, which consists of a vastly growing number of recovery-community organizations (RCOs) that have sprouted across the country.² Many RCOs offer supports and services provided by peers—individuals and family members who share the lived experience of addiction and recovery—in a variety of recovery-community and offsite settings. RCOs that provide PRSS have had the added advantage of building capacity through staff development, organizational infrastructure, and community-organizing and advocacy activities.

When individuals exit addiction-treatment programs, or other institutions such as the military or correctional facilities, they often find themselves in families and communities that are ill-equipped and under-resourced to support their recovery. RCOs serve to bridge critical gaps by providing peer supports and services to help stabilize early recovery and sustain long-term recovery. They ensure that supports and services have an authentic recovery orientation and are grounded in community wisdom and experience. RCOs are uniquely equipped to promote recovery and dismantle barriers to achieving it. They often dovetail advocacy and programming by publicly recommending and supporting progressive public policies and attitudes that are based on a clear understanding of substance use, the science of addiction and the science of recovery.

Toward an Evidence Base

Over the past 20 years, peer services have become an increasingly prominent part of the addiction field and workforce. This progression stems from the evolutionary maturation of peer services and external factors that include advancements in science defining addiction as a chronic brain disease, recovery-oriented systems of care (ROSC) as a vehicle to extend the care continuum, and shifts in health care funding and practice through policies such as the Affordable Care Act and Medicaid expansion.^{3,4} Yet, peer services have been met with skepticism in many parts of the addiction field, with questions generally centering on their legitimacy and value. Some of these questions are based on the relative newness of peer practice; the shift it brings to organizations, services and systems; stigmatizing attitudes that persist about lived experience of addiction; and the lack of credibility of community wisdom. Most of the outstanding questions center on the efficacy of peer practice: What are the outcomes, and what is the evidence that it works?

The discussion about evidence-based practice is complicated. For a practice to achieve the official status of evidence-based, it needs to be put through a rigorous and resource-intensive research process involving randomized control trials. For this to happen, the practice needs to become prominent enough to accumulate the resources (e.g., research, philanthropic, and public policy) to be recognized as a worthy pursuit. Before approaching this point, a practice garners one of several designations that include “Innovative”, “Emerging”, “Promising”, and “Best practice”.

Early developers and practitioners of addiction peer services employed the term “practice-based evidence” as a counterpoint to the emphasis on evidence-based practice. Individuals, programs and organizations that have developed peer services have witnessed the profound impact those services have had on the lives of people seeking or in recovery, as demonstrated through anecdotal evidence and program-evaluation data.

Some quantitative program-performance data has been gathered by the Substance Abuse and Mental Health Services Administration (SAMHSA) grantees through Government Program Results Act (GPRSA) surveys. The GPRSA measures are short-term (one year past intake), which is an unrealistic measure for a period of recovery stabilization that can take up to and beyond five years. GPRSA surveys were designed to measure treatment outcomes rather than recovery outcomes. It is clear now that treatment outcomes cannot be substituted for recovery outcomes, and there is both growing agreement on what recovery outcomes should be, and discussion and exploratory research on how they can be measured and quantified. In spite of these limitations, GPRSA data show limited but positive outcomes of programs funded under the Recovery Community Services Program and subsequent initiatives funding PRSS.

The combination of a growing body of qualitative evidence and quantitative GPRSA evaluation data point to the existence of practice-based evidence that is worth pursuing to establish a rigorous evidence base. Although evaluation and research are related, the goal in establishing an evidence base for PRSS will require moving from program evaluation—which is of limited value because it is isolated to program participation and does not factor the positive or negative impact of other services or resources—to research.

The question facing PRSS programs is how to move from program-evaluation data to broader research initiatives. SAMHSA hosted a technical expert panel in 2018, bringing together recovery-community leaders, researchers, and state systems leaders to identify gaps in the research to review recovery support services in six domains: 1) mutual aid, 2) continuing care, 3) peer recovery support services, 4) recovery-community centers, 5) recovery housing, and 6) educational recovery support services. The Recovery Research Institute conducted a literature review⁵ in advance of the gathering that identified gaps in the research. Recommendations from the panel included increasing general exploratory and explanatory research focused on the six domains, conducting studies to determine which services work best for specific populations, and examining peer-support engagement of individuals using medications for opioid-use disorders.

The most notable accomplishment of the panel was that it brought together a diverse set of stakeholders and experts in recovery practice, researchers, and state systems officials, as each of these stakeholder groups was unfamiliar with each other and the entire picture under review. Participants from the meeting left with a sense that developing a research and evidence agenda was something worth pursuing. Particularly for the researchers who attended, there was a sense of meaning and purpose in articulating and actualizing research that would serve to legitimize recovery-support services.⁶



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1. Mutual aid
2. Continuing care
3. Peer recovery-support services
4. Recovery-community centers
5. Recovery housing
6. Educational recovery-support services.

The movement of peer practice toward an evidence base is a long-term goal that needs to move from an aspiration to a reality. It will require adequate planning to move through a rigorous research process while maintaining fidelity to the peer model in all settings to ensure an authentic practice grounded in a firm philosophical sensibility. Many PRSS are at the point of maturity and readiness to undergo the process of becoming an evidence-based practice: A level of practice-based evidence has been established and is ready to be taken to the next level. This will take a dedicated effort of political will and resource allocation. It will require a process that will bring together researchers with recovery-community leaders who are overseeing development of PRSS to decide upon the right methods and tools. As more and more PRSS become established as evidence-based practices, they will become more fully embedded in the overall field as strong components of recovery-oriented systems of care, and be eligible for dedicated funding and reimbursement to ensure their sustainability.



Unique Considerations

Beyond the methodological challenges, developing an evidence base for PRSS could be hindered by lack of conceptual clarity. Growing the PRSS evidence base will focus, in part, on peer worker roles and the settings in which peer support occurs. This will require careful thought about those two elements—and that of the overarching philosophy—to ensure that research answers questions about authentic peer practice.

Philosophy and Fidelity

In their current formalized state, addiction PRSS are relatively new, born out of a robust grassroots history of people with shared experiences of addiction and recovery helping one another. Peer services are increasingly scrutinized because of workforce realities, reimbursement metrics, risk-management requirements and accountability measures. As we strengthen the evidence base, we must be vigilant that the design and implementation of PRSS do not become too formalized and over-regulated to the degree that the essential “juice”—the simple act of “one alcoholic helping another”—is extracted from what makes peer practice

effective. It is vital that the grassroots origins remain a fundamental guide, a marker of fidelity, and a fulcrum from which to leverage and lift to an evidence base.

Lifted directly from the wisdom of Alcoholics Anonymous,⁷ this juice is a core element of all peer-based recovery services. The peer relationship—a person in recovery helping another—is a unique one built upon shared experience and trust and which embodies such principles as reciprocity and mutual healing.⁸ Regardless of the setting in which peer services are implemented, these foundational principles that safeguard inherent “peerness” need to be sacrosanct: honored, valued and elevated. Without this point of awareness and vigilance, peer services will lose their unique transformative power and efficacy, and become blurred with other service roles. In the context of research, this means clearly examining whether and how the service/model under consideration upholds those principles or deviates from them.

Roles, Competencies and Tasks

On the field level, the role of peer workers—that is, peer practitioners—is simple: Provide outreach, advocacy, mentoring, and recovery support to those seeking or sustaining recovery. This general role definition expands and becomes more complex as one moves from a high-level view into one focused on specific contexts and settings. However, this is no different from any practice, be it physician, counselor or social worker: Each has a profession-specific role description that is tempered by a system context and further defined within a specific program setting. An emergency room physician has the same core body of knowledge and general role as one in family practice, but their job descriptions and position-specific trainings look very different.

In establishing an evidence base, the concept of role is further complicated by the distinct histories of mental-health peer workers (the most well-researched), community/public health peer workers (moderately researched), and addiction peer workers. It can be challenging to discern which evidence could be valid across those histories. Additionally, although the competencies and tasks are similar across those different varieties of peer support, there are some distinctions as to which ones are core and how they are applied, which may need to be accounted for in research design.

Setting as Service

As noted above, setting matters. Whitman et al.⁹ stated that the concept of setting as service marks the importance of the social-physical environment to the experience of people recovering from substance-use challenges. One setting of recent focus has been recovery-community centers (RCCs), which were initiated by SAMHSA Recovery Community Services Program grantees in the mid-1990s as a brick-and-mortar “container” for the peer programs they were developing. As these centers sprouted across the country, they introduced a new element of service: the recovery-community center as a hub that operates as a service unto itself.

As part of the development of RCCs, programs acknowledged existing models for adaptation and customization according to recovery culture. The first model of note was the mental-health clubhouse model, which was peer-run, with aspects of a drop-in center, often providing a safe place for individuals to stay during operating hours. Early visioning of the recovery-community centers went beyond a hangout space, encompassing a wide array of peer-driven supports, services and resources. The second model was well-established in the recovery community: the 12-Step clubhouse. Clubhouses have existed across the country since 1947,¹⁰ providing a space for various 12-Step meetings and sober social/recreational activities, such as sober dances and game nights. While 12-Step clubhouses are not officially affiliated with any 12-

Step program,¹¹ they have traditionally served to house only 12-Step meetings and function for members of 12-Step communities. Like many other aspects of peer services, the challenge was to take the best features of a 12-Step clubhouse as design considerations for an RCC that would serve a wider recovery community. In some places like Vermont,¹² 12-Step clubhouses were converted directly into RCCs by using the existing infrastructure to build out a broader recovery program.

Aside from 12-Step clubhouses, the idea of the setting as the service was not new in the recovery community¹³—long before this iteration of PRSS, there were peer-directed, place-based programs such as recovery houses, recovery high schools, and collegiate recovery programs. These and many other settings where peer-support workers are housed show promise and warrant further research.

The Oxford House model is a well-known example of setting as service. This community-based approach to addiction recovery provides an independent and supportive living environment that has been established as an evidence-based practice.¹⁴ These hubs for a range of recovery services and offerings were also a service unto themselves. They did, and still do, present sustainability challenges in accessing funding schemes that operate solely on fee-for-service models. The reduction of PRSS to a singular service role (i.e., recovery coaching) made it adaptable to a fee-for-service model at the expense of other peer services, especially place-based recovery environments and affiliational supports. Without a sustainable funding model, ongoing support for place-based peer-service environments continues to be a challenge.

Purpose of the Current Literature Review

There is a vast range of peer and broader community settings, and there is emerging evidence that explores the efficacy of PRSS offered within them. The National Council for Mental Well-Being conducted a literature review to synthesize the current evidence on this topic and identify persisting gaps in the research.

Methodology

The literature on the use and benefits of PRSS is growing. Past literature reviews^{15,16} have described the academic research and practice-based literature establishing a formal evidence base for peer support and mutual aid broadly. The current literature review considers both the academic research and practice-based literature related to PRSS in institutional and community-based settings. The goal of this more focused approach is to deepen our **understanding of the formal peer roles and corollary job functions and tasks** in recovery-oriented services that occur in **diverse settings**. This is not an exhaustive review but rather seeks to help the reader understand the evolution, value and challenges of PRSS in a variety of settings.

The National Council conducted searches of relevant medical, psychological and public-health databases, including PubMed, EBSCOhost and PsycInfo. Relevant literature published between 2015 and 2021 was included in the review; several of these were themselves reviews that referenced earlier research studies, which were also included in the current review when pertinent.

A broader scan of gray literature and resources was conducted by reviewing resources available through relevant governmental agencies and non-profit organizations such as SAMHSA, the U.S. Department of Health and Human Services and Faces & Voices of Recovery. Because so much of the history of PRSS is grass-roots in nature, this broader scan was essential to acquire a comprehensive view of the leading information in the field.

The purpose of the literature review was to:

1. Define the addictions peer-support worker (PSW) core roles and tasks.
2. Determine the settings, both peer and non-peer, in which PSWs are engaged, the PRSS offered, and the efficacy of the services provided.
3. Identify cultural considerations for providing and receiving PRSS.
4. Identify gaps in research and needs for future research and resource development.

Though the general literature on PRSS addresses many facets, our review focuses on those most relevant to understanding the core elements, value and challenges of peer practice and PRSS provision in diverse settings.

Findings

Key Findings

Finding 1

PSWs are uniquely positioned to provide four different types of support: emotional, informational, affiliational and instrumental; the range of services provided in each category has grown across time.

Finding 2

PSWs' primary tasks across diverse settings include providing one-on-one guidance, facilitating peer recovery groups, and assisting with system navigation/peer bridging; they are engaged in additional roles and tasks based on context and setting.

Finding 3

PSWs work in a variety of peer-settings, including recovery community centers, recovery fitness centers, recovery housing, collegiate peer recovery programs, and recovery high schools.

Finding 4

PSWs work in a variety of broader community settings, including treatment agencies, emergency departments and mobile crisis units, criminal justice and corrections and child welfare.

Finding 5

There is evidence to support PSW efficacy for work with culturally diverse populations, including American Indian communities.

Types of Peer Support

Because of the knowledge gained through lived experience of addiction and recovery, and specialized training received, PSWs are uniquely positioned to provide four key types of social support missing from the addiction and recovery field: emotional, informational, instrumental and affiliational.¹⁷ Emotional support is perhaps the most readily understood, as it is central to the peer role; PSWs offer empathy, encouragement, and care to the peers with whom they work. In providing informational support, PSWs share knowledge and information about the recovery process and often provide skills training related to achieving and maintaining a life in recovery. Instrumental support is a tangible form of support, providing concrete assistance to accomplish tasks, such as providing transportation. Through affiliational support, peer specialists help connect individuals to the greater recovery community, wrapping them in a supportive

environment.¹⁸ Taken together, these forms of support enable peer specialists to help individuals begin and move through the stages of recovery,^{19, 20} navigate the treatment system from intake to discharge, and connect to other systems to sustain a life in recovery.

Table 1. Categories of Peer Social Support (Burden and Etwaroo, 2020)

	Description	PRSS Examples	Assisted PRSS Examples
Emotional	Demonstrate empathy, caring or concern to bolster self-esteem and confidence	<ul style="list-style-type: none"> • Recovery check-in • Peer-led support groups 	<ul style="list-style-type: none"> • Telephone recovery support • Video recovery check-ins • “Zoom” support groups
Informational	Share knowledge and information and/or provide life or vocational-skills training	<ul style="list-style-type: none"> • Discussing therapeutic court process • Training for job readiness • Offering wellness seminars or classes • Training on self-advocacy • Offering parenting classes 	<ul style="list-style-type: none"> • Telephone recovery support • Video recovery check-ins • “Zoom” support groups
Instrumental	Provide concrete assistance to help accomplish tasks; increase access and opportunities; reduce barriers	<ul style="list-style-type: none"> • Accessing community health and social services • Providing housing/child-care vouchers • Providing public transportation passes 	<ul style="list-style-type: none"> • Telephone recovery support • Video recovery check-ins • “Zoom” support groups
Affiliational	Facilitate contacts with other people to promote learning of social and recreational skills, create community, and foster a sense of belonging	<ul style="list-style-type: none"> • Arranging outings or activities, such as sober sports, alcohol-and drug-free dances, movie nights • Celebrations and rituals 	<ul style="list-style-type: none"> • Telephone recovery support • Video recovery check-ins • “Zoom” support groups



Core Roles and Services

Peer supporters have many different titles and roles, depending on setting and context. In the substance-use disorder (SUD) realm, the most well-known is that of peer recovery coach, but there are others, including in-reach peer recovery specialist, peer navigator, or crisis interventionist, summarized in Table 2. The core body of knowledge is the same across the roles, but the focus of the core competencies varies according to role and in different contexts.

Table 2. Examples of Peer Recovery Specialist Titles and Tasks in Specific Contexts

	Key Tasks	Locations
Peer Recovery Coach	Guide and mentor person seeking or in recovery; help identify and remove obstacles and barriers; support connections to the recovery community and other resources useful for building recovery capital	Recovery-community centers (RCCs), correctional settings, inpatient and outpatient SUD-treatment programs, behavioral-health clinics, community-based settings, treatment and recovery (problem-solving) courts
In-Reach Peer Specialist	Support people involved with criminal justice system as mentor, guide and/or resource connector while incarcerated, on probation or in lieu of probation, or in re-entry process	Jails, prisons, jail-diversion programs, drug courts, community-based programs
Recovery/Crisis Interventionist	Provide support and guidance to person at early (crisis) intercept point along recovery-support continuum, linking person to treatment or other recovery-support services as requested	Hospital emergency rooms, police and fire departments, community-based street outreach or harm-reduction programs, crisis centers
Peer Navigator	Provide support and guidance in accessing appropriate services from complex medical, treatment, and social service systems, including application process for health insurance and other entitlement benefits	Community-based street outreach or harm-reduction programs; community health clinics; public health departments

PSWs most commonly serve as coaches or mentors for individuals in early recovery or seeking to enter treatment, throughout the phases of treatment, and post-treatment²¹, helping the peer to build recovery capital. This one-on-one support often combines all four categories of peer social support; as the peer needs become apparent during the intentional conversations, the PSW shifts from offering a caring, empathetic ear to sharing information to assisting with problem-solving and identifying resources.

One common task of PSWs is facilitating recovery groups. Groups may follow a wide range of structures, formats and curricula related to addiction recovery, whole health and wellness, and cultural connection. For example, a randomized control trial of the Whole Health Action Management group intervention found that participants experienced improvement in personal activation for any type of health care, an increased sense of good health and hopefulness, and improved likelihood to still be employed six months after the group ended.²²

Regardless of the setting, function or role of peer specialists, it is critical to maintain the inherent “peerness” of the support they provide. Peer specialists are best incorporated when they are

supported by a trained supervisor to use their strengths and lived experience to provide person-centered services; they should be empowered to provide support in the way that best fits those they work with. Peers should not just be tacked onto any program, as one study found. When peer specialists were trained to support a treatment-focused cognitive-behavioral therapy (CBT) intervention for veterans, no benefit was experienced.²³ This study found that this was because the peer specialists were not allowed to provide support in the “peer way”; the philosophies of person-centered peer support and rigid treatment-focused CBT were not compatible.

Peer Settings

The literature shows that PSWs operate in many peer settings, including recovery-community centers, recovery fitness centers, various types of recovery housing, colleges and recovery high schools.

Recovery Community Centers

RCCs operate on the principle that recovery is more than medical stabilization or acute treatment; recovery happens in community, assisting individuals to harness and enhance recovery capital—personal, social, environmental and cultural resources for sustaining recovery over time. As seasoned peers, in this setting PSWs model and reinforce successful recovery strategies and offer a variety of PRSS, including recovery coaching, employment-related linkages, and social and recreational activities.²⁴ The recovery support and services that PSWs provide, especially early in recovery, are targeted to result in decreases of substance-use issues, greater abstinence, and positive changes in health, well-being, and quality of life.²⁵ The results of a limited single-group study showed that RCCs hold promise: It found that RCCs attract, engage, and provide benefits for individuals with SUD who may face the greatest challenges on their path to recovery. It documented significant improvements in abstinence, substance use problems, mental well-being, and quality of life during the first three months of RCC participation.²⁶

Recovery Fitness Centers

A growing body of research has shown positive benefits of exercise on reducing substance use and preventing relapse.^{27, 28, 29, 30, 31} As this evidence has emerged, both addiction-treatment providers and peer-recovery support programs have begun to incorporate exercise and physical activity into the continuum of care. One example of the integration of exercise and physical activity into peer recovery is the Phoenix, a national nonprofit, peer-based recovery-support organization started in 2006 that provides free, active programming—such as rock climbing, CrossFit, yoga, running, hiking and boxing—to anyone in recovery from an SUD. The Phoenix combines exercise and physical activity with the traditional tenets of peer recovery such as psychological safety, positive expectations, self-efficacy and social connectedness. In a paper describing the Phoenix model, researchers assessed each of the four domains and found statistically significant associations between attendance at the Phoenix and psychological safety, suggesting that creating an inclusive, non-judgmental community of peers can effectively help individuals rebuild their lives in recovery.³²

A recent study conducted focus groups and interviews of 26 individuals with substance-use disorders who participated in a 12-week health and fitness program.³³ The 12-week program was connected to a large fitness center that had a relationship with a substance-use-treatment program. In addition to the health and fitness program, vocational training was provided with the program as well. The results of the focus groups suggested that participants believed that “the

program serves as an aid for recovery, confers physical benefits from participation, and helps participants feel that they are part of the community with a way to ease back into life.”

Recovery Housing

Supportive housing can play a critical role in facilitating recovery and assisting individuals with substance-use disorders to re-establish themselves in the community. Recovery residences have long been a significant part of peer recovery support; some form of recovery housing has existed in the United States since at least the mid-1800s.

Recovery houses provide a spectrum of living environments that are free from alcohol and illicit drug use with a focus on peer support and connection to other recovery services and supports. Recovery-housing providers offer safe, healthy environments that support residents in their recovery. A range of models represent different levels of care that are intended to support individuals at multiple points during their recovery process, as their need for intensive supports change across time. Recovery housing fosters communities where individuals can improve their physical, mental, spiritual and social well-being.³⁴ All recovery houses are founded on the social model of recovery, which emphasizes social and interpersonal aspects of recovery rather than individually oriented approaches. It also emphasizes peer-to-peer rather than practitioner-client relationships to support recovery. The extent to which a recovery house adheres to the social model can be assessed across six domains:

1. **Physical environment:** The extent to which the program facility offers a homelike environment.
2. **Staff role:** The extent to which staff are seen as recovering peers.
3. **Authority base:** The extent to which experiential knowledge about recovery is valued.
4. **View of substance abuse problems:** The extent to which residents view substance abuse as a disease and are involved in 12-Step groups.
5. **Governance:** The extent to which the program empowers residents in decision-making.
6. **Community orientation:** The extent to which the program interacts with the surrounding community in a mutually beneficial manner.

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The National Alliance for Recovery Residences (NARR) has begun to define types of recovery housing along, with standards. NARR defines recovery residences as sober, safe, and healthy living environments dedicated to promoting recovery from alcohol, drugs and other associated problems.³⁶ NARR has identified four levels of care, with varying degrees of support.

1. **Peer-run recovery residence:** This level is best for those who have stabilized their alcohol and drug abuse and are mature enough to self-manage and commit to their recovery, with a stay from 90 days to several years.
2. **Monitored recovery residence:** This level offers a minimal amount of support and structure, with access to affordable services over a longer period.
3. **Supervised-recovery residence:** This level provides greater support and structure, typically best for those individuals transitioning from a drug-rehab or residential treatment center.
4. **Service-provider recovery residence:** This level had the highest degree of support and structure and is best for individuals new to recovery and may need life-skills development.



Numerous studies, concept papers and toolkits have been developed over the last few decades that have bolstered the evidence of the benefits of recovery housing. In 2014, a comprehensive review was completed of different programs and services that were common in the mental-health and substance-use treatment fields.³⁷ Due to the paucity of studies and their methodological limitations, the researchers rated the evidence for recovery housing as moderate. However, they did find that the studies consistently showed positive outcomes related to substance use and improvements in functioning, including increased employment and decreased criminal activity.

Other studies have focused on recovery housing in specific areas of the country. One such study focused on recovery homes in Philadelphia.³⁸ This study described the characteristics and services offered in recovery houses in Philadelphia and made suggestions for further research to better understand the most appropriate funding mechanism and services offerings.

Under the umbrella of recovery housing, Oxford Houses may be the largest and most well-known subset. Oxford Houses are single-sex adult homes in which individual members are expected to pay monthly rent and assist with chores. Oxford House has no prescribed length of stay for residents and there is no professional staff. Each house operates democratically with

majority rule regarding most policies and an 80 percent majority required for accepting new members. Residents must follow three simple rules: pay rent and contribute to the maintenance of the home, abstain from using alcohol and other drugs and avoid disruptive behavior.³⁹ This model promotes the development of long-term skills to maintain abstinence. As of 2019, there were 2,754 Oxford Houses operating in the U.S. serving more than 40,000 people. A longitudinal study was done to examine the outcomes of individuals who stayed at Oxford Houses over time.⁴⁰ The data demonstrated more positive outcomes for residents who stayed four months or longer in the residences. Oxford Houses have also shown favorable outcomes when compared to more clinically focused residential facilities.^{41, 42}

Collegiate Peer Recovery Programs

Drug and alcohol use are prevalent on college campuses nationwide. According to the 2019 National Survey of Drug Use and Health (NSDUH), 33 percent of college students ages 18–22 reported binge drinking in the past month compared with 27.7 percent of other people of the same age. The NSDUH also found that 8.2 percent of college students ages 18–22 reported heavy alcohol use in the past month compared with 6.4 percent of other people of the same age.⁴³ Given the high rate of substance use in this population, the need for treatment and longer-term recovery supports is great. However, the use and availability of alcohol and drugs on college campuses make it difficult to find and identify peer support and environments that are drug-free and value recovery.⁴⁴

Since the mid-1980s, a small number of colleges and universities have been providing PRSS through what is commonly known as collegiate recovery programs (CRPs). Although some models differ slightly, CRPs generally offer drug and alcohol-free housing, onsite recovery-support groups (e.g., Alcoholics and Narcotics Anonymous) and counseling provided by a small core staff. The goal of CRPs is to create a campus-based “recovery friendly” space and supportive social community to enhance educational opportunities while supporting continued students’ recovery and emotional growth.⁴⁵

Over the past three decades, several studies of note have been done assessing their effectiveness. In 2007, Botzet, Winters and Fahnhorst⁴⁶ surveyed 83 students and alumni of the StepUp program at Augsburg University; they included a modified version of the Global Appraisal for Individual Need (GAIN) to assess drug use, mental-health status, life skills, and social functioning. Twenty of the 83 students completed a second assessment six months after the initial assessment. The researchers found that students involved in the StepUp program either were largely able to maintain sobriety and a favorable grade point average. StepUp students also reported high levels of participation in a variety of social support, which indicates the maintenance of sobriety.

In 2009, a similar study by Bell and colleagues⁴⁷ surveyed 15 students to gather information on challenges faced by recovering students on a university campus and on what are the most helpful components of a CRP are. The survey indicated that the CRP programs were important to the students and a critical component of their success in a university setting. Many students reported that they likely would not have attended or completed college without the programs. The survey further indicated that staff support and availability, frequent campus recovery meetings, academic advising and having a place to go during the day for informal interaction with other students and with program staff were critical program components for their success.

A meta-analysis by Ashford et al.⁴⁸ was designed to explore the research on student experiences in collegiate recovery programs. The meta-synthesis provided additional support

to show that collegiate recovery programs and communities have implemented strategies that effectively support students in recovery. CRP best practices such as peer networks, drop-in centers and the provision of various recovery supports are noted in the empirical evidence from at least 10 included qualitative studies of student experiences.

Another 2018 study by Brown et al.⁴⁹ explored the recovery, professional, and quality-of-life status of student alumni that engaged in undergraduate CRPs. The study examined alumni recovery status, primary recovery supports used, relapse rates since graduation, and recovery capital/quality-of-life scores. The results of this study indicated that CRP alumni remain actively in recovery, with relapse rates only slightly higher than the national average of students currently engaged in CRPs (10.2 percent vs. 6.8 percent). These findings provide preliminary evidence that collegiate recovery programs adequately prepare engaged students for future recovery and professional life and that CRPs are a valuable resource to college students with substance-use disorders.

Recovery High Schools

Addiction and substance use among high school adolescents continues to be a significant public-health concern. In the most recent “Monitoring the Future” survey, 40.7 percent of 10th graders and 55.3 percent of 12th graders admitted to using alcohol in the past year, with 16.8 percent and 9.6 percent, respectively, having engaged in binge drinking.⁵⁰ The survey captured an increase in amphetamine, inhalant, and cough-medicine misuse among 8th graders. Given that substance-use disorders can have a significant impact on the health and development of adolescents and have a negative impact on school performance, resources that can provide support to adolescents with substance-use disorders are in demand.

Recovery high schools (RHSs) have existed since the late 1970s. Generally, they provide post-treatment education and recovery support for young people with substance-use disorders. In 2008, Moberg and Finch conducted a comprehensive study of 17 schools and found that most RHSs function as an embedded but separate set of programs within an existing school building or structure.⁵¹ Typically, there is great care taken to ensure that physical and social barriers exist between the RHS and standard programming within the school. Most students who attend RHSs have already participated in formal substance-use treatment program. RHSs offer a full range of academic courses as well as clinical services (such as group and individual therapy) and peer recovery support activities for students to engage in. The essential goal of RHSs is to provide a supportive environment for recovery and to ensure students stay academically on track. academically.

While RHSs have been around for more than a half century and are generally seen as helpful, there is not much empirical research on their effectiveness.^{52, 53, 54} Moberg and Finch (2008)⁵⁵ did a retrospective pre- and post-test analysis that suggested the program resulted in significant increases in knowledge related to substance use and in mental-health symptoms among the students. The research also found that students viewed the therapeutic value of the programs favorably. A 2018 study by Finch and colleagues⁵⁶ examined the effectiveness of RHSs and their benefits on attendance, academics and reduction of substance use for students with SUDs six months after selection into the study. The results were consistent with other studies, which found reductions in substance use (marijuana) for participants in RHSs. Building on the work previously done, a 2019 study by Weimer et al.⁵⁷ looked at whether there was a cost benefit to RHSs. The study indicated that there was a cost benefit to RHSs, particularly around increasing the likelihood of high school graduation. RHSs reduced substance use within a supportive recovery environment that, in turn, increased the probability of high school graduation which has significant monetary value in the greater society.

Broader Community Settings

The use of PSWs is growing with new programs and partnerships launching across the social-service, treatment and recovery continuum. This spread of recovery-oriented approaches and services promises to improve overdose prevention, treatment adherence and outcomes, system navigation and connection to the recovery community.

Medication-Assisted Treatment Programs

Peer support is effective for engaging individuals in treatment and encouraging them through the transition from treatment to early recovery.^{58, 59} When peers walk with someone through each step of treatment, engagement increases. Recent research has focused on how PSWs engage individuals in medication-assisted treatment (MAT) programs, with one study finding 86 percent of participants showing for their first MAT program appointment and 72 percent still in treatment 30 days after their first dose.⁶⁰ Some peers may be unfamiliar with or hesitant to address the use of medications in recovery groups or in one-on-one meetings but new curricula can be developed to destigmatize the use of MAT in peer-led settings.⁶¹ One innovative program leverages peers in three rural emergency departments to initiate buprenorphine for opioid-use disorder. A study of this program found that peer navigators increased treatment adherence in this program, with 78 percent of patients attending their first follow-up appointment and 59 percent in treatment at the 30-day check in.⁶² Peer specialists have also been found to support engagement in a MAT program through telephonic intervention. Participants in one program not only were more likely to enroll in a MAT program, but they were also significantly less likely to experience an opioid overdose in the subsequent 12 months.⁶³

Emergency Departments and Mobile Crisis Units

While often associated by those in the addiction field with post-treatment, aftercare and recovery services, PSWs are becoming more integrated into systems-based outreach and overdose-response programs and into harm-reduction programs (which are grounded in a different history of peer support). While each program may differ in structure, there are key components, common challenges and facilitating factors to consider as PSWs are integrated into these settings.

In most programs, PSWs are on call, either waiting in the emergency department (ED) or at a nearby location, as part of the overdose-response team in the ED to provide naloxone training and navigation of addiction-treatment and recovery services.^{64, 65, 66, 67, 68, 69, 70} Programs of this type introduce patients to a PSW during their hospitalization and continue the services post-discharge. One randomized control trial found patients introduced to peers during their hospitalization were more likely to engage in recovery coaching than those not connected to a peer and at the six-month post-discharge check-in, 80 percent were still engaged in recovery supports.⁷¹ There is a need, however, to ensure adequate staffing to cover all hours of the ED and prevent delays in connecting individuals with naloxone and referral information. A primary barrier, though easily addressed through trainings and established standards of care, is a need to increase literacy among ED staff on the role, efficacy and new workflows involved with integrating peer specialists into the ED. Programs that take this piece on intentionally found 80 percent in strong agreement that these services are appropriate for EDs among medical staff.⁷² Utilizing peer specialists is effective in rural settings as well; one study of such a program in three rural EDs found that 77 percent of those enrolled in the program had multiple engagements with a peer specialist post-discharge, despite the inherent challenges of rural settings.⁷³

In 2019, Waye et al.⁷⁴ studied the efficacy of a two-pronged, peer-led approach based out of Anchor Recovery Center in Rhode Island—AnchorED and AnchorMORE. AnchorED placed PSWs in EDs to support those recovering from an overdose and to train them in the use of naloxone, while AnchorMORE used PSWs for community outreach and education. This approach proved fruitful in engaging new individuals in their services and programs. The 8,614 AnchorMORE interactions considered in this study resulted in referrals to detox services and residential treatment, connection to MAT, introductions to 12-Step and recovery services, and 854 naloxone kits distributed. Of AnchorED's 1,392 contacts, 89 percent received naloxone trainings and 87 percent agreed to post-ED engagement, but—important for recovery centers—45 percent of new individuals at Anchor Recovery Center cited AnchorED as their referral source.

Another noteworthy article studied the pilot of the Relay Program in New York City. This program adds a 90-day period of peer navigation and support to the initial peer-led ED overdose response for those who agree to participate. Of the 74 percent of patients who agreed to participate, nearly half were reached for their 24- to 48-hour follow-up session, and a third were still engaged at their 30-, 60- and 90-day check-ins. Relay's peer specialists provided a wide range of referrals, including 165 to harm reduction services, 104 to MAT, 72 to outpatient substance-use disorder treatment, and 66 to inpatient substance-use disorder treatment. They also distributed 1,007 naloxone kits. Throughout the pilot, 53 to 79 percent of all appointments were kept by patients in the Relay program.⁷⁵

Criminal Justice System

Peer specialists are beginning to fill gaps throughout the criminal justice system at the various intercepts of the sequential intercept model (SIM). Release from prison or jail can be a vulnerable moment for those in early recovery, but programs are beginning to leverage peer support to ensure that individuals are well-served throughout their criminal justice involvement, including in first-responder, pre-arrest, and deflection and diversion programs. Three programs offer insight into how peer support can successfully be utilized at this juncture.

A primary challenge for those transitioning out of incarceration is housing.⁷⁶ In the past, these individuals may have been placed in a “halfway house” or other low threshold setting. However, these models do not necessarily leverage peer support. New partnerships have placed individuals in therapeutic communities, Oxford Houses and NARR Level 2 recovery residences upon release. Each of these models integrate peer support into the structure, functioning and programming in the house. Initial studies find benefits for using each: 1) Therapeutic communities were associated with significantly lower rates of re-incarceration and substance use; 2) Oxford House placement was associated with better employment and substance use outcomes, particularly for those on parole; and 3) Those placed in NARR Level 2 recovery residences successfully maintained their gains regarding substance use over an 18-month period post-release.⁷⁷

A program at Baltimore City Jail in Baltimore, Md., sought to utilize peer support to link individuals to MAT upon release to prevent overdose and support those seeking recovery supports. This program, called PCARE, featured a clinical team composed of a primary-care provider, a nurse and a peer recovery coach located in a van outside of the jail. When released, individuals were told about this program and encouraged to meet with the team in the van. During this discussion, they were offered a buprenorphine prescription, if appropriate, and linkage to other harm-reduction and recovery services through the peer recovery coach. An initial study of PCARE found that, of the 190 total patients, 68 percent returned for at least two

visits and that 32 percent were still engaged in treatment after 30 days. The average length of treatment was eight weeks.⁷⁷

There is concern that peer support may not be enough to engage individuals in recovery services upon release. One study found a disparity in engagement in peer recovery support groups, voluntary treatment and even mandated treatment falling along the rural/urban divide.⁷⁸ Those released back into rural communities were less likely to engage in recovery services even though they were significantly more likely to have been arrested for a drug-related offense than their urban counterparts.⁷⁹ This suggests a need to re-evaluate how peer and recovery-services are delivered in different geographic settings. There may be a need for more peer-support specialists or different strategies for engagement across larger geographic areas.

There is practice-based evidence suggesting that peer services in treatment and recovery courts (and other problem-solving courts) can support individuals to reach the requirements of these proceedings more effectively.⁷⁹ In these settings, peer specialists may provide mentorship, appear in court with clients for support, provide recovery education and training and join forensic assertive community treatment teams.⁸⁰ Programs such as PRO-ACT in southeastern Pennsylvania also incorporate family peer support throughout the drug-court process in order to provide parenting classes, recovery education and other forms of parent-effectiveness support. A program in Houston integrates peer mutual-aid groups run by a local recovery center into their drug-court peer services to boost support and encourage the individual to participate in the greater recovery community as a function of sustaining their gains.⁸¹

An emerging use of peer specialists in criminal justice institutions is to provide peer services in prisons. There are two primary approaches: 1) bring peer specialists who were formerly incarcerated into prisons to provide peer support; and 2) train people who are currently incarcerated to work in this role. While the efficacy of these programs has not been well-studied academically, those involved with the programs are able to speak to benefits and challenges of this approach. Programs recruit participants with lived experience of addiction and recovery to be officially trained as peer specialists, requiring them to demonstrate the same competencies as peer specialists on the outside. Roles and functions include mentoring, facilitating support groups, providing emotional support and preparing for reintegration upon re-entry.⁸²

Child Welfare

There is limited academic research on the use of peer specialists in child-welfare programs, but several jurisdictions have started to integrate them into their programs as an additional support for parents, particularly parents living with an addiction. This practice-based evidence suggests that peer specialists can support improved results for families with complex needs because of their lived experience with similar challenges and navigating the system and services. Outcomes

Best-Practice Competencies for PSWs in Child Welfare

- 1 Establishing connection with parents.
- 2 Supporting engagement with services.
- 3 Practicing child-welfare adherence.
- 4 Promoting self-efficacy with parents.
- 5 Inspiring hope and serving as a model of reunification.
- 6 Embodying person-centered, trauma-informed approaches.
- 7 Advocating for parents.
- 8 Encouraging supportive relationships.
- 9 Teaching navigation of systems.
- 10 Practicing ethical conduct and professional boundaries.⁸⁶

include improved rates of treatment completion by parents, children spending less time in out-of-home care, more families reunified, lower rates of system re-entry for children, and increased participation from all family members in services and court proceedings.⁸³ Peer specialists in this role are funded by a mix of Medicaid dollars, state mental-health and addiction services, foundations and non-profits, grant programs, child-welfare services allocations, and waivers implemented by the Administration for Children and Families.⁸⁴

Several programs call peers “Parent Partners” and develop networks of support facilitated by child-welfare agencies or the state. These networks leverage the parents’ lived experience to support each other’s emotional needs, provide guidance as they navigate the system and give hope that family reunification is possible. Some models operate more like a peer mutual-aid group, while others are led by a paid parent partner. A gap these programs still must address is father engagement and father-specific programming, which is a shared challenge across the child-welfare field.⁸⁵

Culturally Diverse Populations

Cultural and other population-specific programming is important to enhance the peer-support worker role and PRSS efficacy. In one study, women working as peer-support specialists identified the importance of gender-specific programming for their own recovery before transitioning into this role.⁸⁶ Through gender-specific recovery groups, they found they had several shared experiences, such as past traumatic relationships and involvement with criminal-justice and child-welfare systems, compounding their experiences of trauma and, ultimately their substance use. While there is not yet literature on groups designed for those who identify as trans or non-binary, this study suggests that gender-specific recovery groups for these individuals may also be effective and important.

A qualitative analysis of two programs in American Indian communities found that PRSS fill a gap in recovery-support resources.^{87, 88} However, there are four important considerations for PRSS for American Indian communities:

1. The components of the peer recovery services must be based on the cultural traditions, context and history of the community served.
2. Tribal leaders, community members and others living in recovery in the community must believe in and trust the approach developed.
3. Flexibility is key, and the approach should be adapted to the tribal community setting, its traditions, language and culture.
4. Tribal communities tend to be small, and community members may observe others and their actions.

An urban American Indian community created and piloted the Transition Recovery and Culture (TRAC) program to specifically support their peers with substance-use and mental-health challenges through self-help groups. To study this program, researchers utilized the medicine-wheel framework and cultural reviewers to ensure that the results were culturally responsive to this unique program; the federally recognized GPRA tool was also used. Through participation in the TRAC groups and increased engagement with family, participants experienced decreased substance use, reduced depression and anxiety, and improved housing, employment and general health.⁸⁹



Peer-led groups and recovery coaching may also be effective for clients of color living below the poverty level and experiencing homelessness. A study in Baltimore, Md., used interviews with clients, community providers and peers to understand how to incorporate peer specialists effectively to meet their needs.⁹⁰ Not only did they agree that peer specialists were appropriate providers to deliver substance use-related interventions, they also imagined an expanded role for them, including case management and other linkages to care.

While most models focus on adults, peer support is also appropriate for adolescents. The alternative peer group connects teens through group meetings and social events to create a positive social influence, promoting recovery.⁹¹ This model is developmentally appropriate and incorporates peer support for parents to improve parent-child relationships as they navigate treatment and recovery. Other programs train youth themselves to serve as peer-support specialists, even certifying them with their state entities.⁹² Programs are now exploring virtual and social media-based youth peer support. YouthEra in Oregon offers youth-centered peer support on Twitch, Instagram, Discord, and virtual one-on-ones with trained youth peer-support specialists.⁹³ While there is limited academic research on adolescent addictions-related peer support, programs report success with early intervention and recovery supports for this population.

Future Research and Considerations

There is a wide variety of formal academic research and gray literature on PSWs and PRSS across a wide range of organizations and settings. Much of this research points to their importance and benefits in assisting people in reaching and sustaining long-term recovery. For those looking to start or expand peer services, there is a significant evidence base to support these endeavors. Despite this growing body of research, gaps remain, and further research is needed.

Core Roles and Tasks

The growing body of research often focuses on peer support delivered in a specific setting. But few of these studies explicitly consider the design of peer work as a significant factor in the effectiveness of an intervention. Decisions about the content and organization of PSW tasks, activities, relationships and responsibilities affect program outcomes at multiple levels, including whether PSWs feel engaged or stressed at work, and whether the wider service achieves its objectives. Research tends to either focus either on broad roles (e.g., recovery coach) or very specific intervention (e.g., 10 recovery check-in sessions) without looking at work design. To understand best practices, the field may need evidence related to competency-level job tasks and whether such tasks reflect peer principles with fidelity.

Setting as Service

There is a growing body of literature on the various settings where one can find and benefit from mutual support, such as gyms, cafes, schools and residences, yet little is known about the elements and governance structures of these support settings that are most effective at promoting long-term recovery. As these settings continue to expand and seek out community support, more research will be needed to help peer service providers and communities better understand the elements necessary to make these settings successful. Recommendation for future research related to specific settings is summarized below.

Recovery community centers/Recovery fitness centers: While there is limited research on the incorporation of physical activity and exercise in peer recovery-support programs, the approach appears promising. As researchers continue to examine the clinical benefits of physical activity and exercise, more work is needed to learn how peer-led and -supported activities can maximize the health benefits of exercise and take advantage of the shared sense of community and psychological safety that are hallmarks of peer-support programs.

Recovery housing. While significant data exists on the benefits of recovery housing, challenges remain. Despite widespread adoption of recovery housing as part of the recovery continuum, payment for recovery housing is still difficult and often not sustainable in many communities. More research and data need to be collected on sustainable payment models for recovery housing. Many communities still are not accepting of recovery housing and have policies in place that hinder the operation of recovery houses in some parts of the community. More data is needed on how providers and lawmakers can create an optimal environment for recovery housing, and more research is also needed to identify the specific characteristics of recovery housing that are most helpful for residents.

Collegiate recovery programs. Findings in the current literature suggest that though more research is needed into the most optimal type and structure of CRP.

Recovery high schools. Although the empirical research on RHSs is limited, the findings are generally positive for the use and impact of RHSs on the reduction of substance use and the continuation of academic pursuits. However, challenges remain; the students who attend RHSs are mostly White and middle class. More research needs to be done to explore the possibilities of RHSs within different socio-economic communities and different racial and ethnic groups. A 2016 study began to explore the use of RHSs within predominantly Hispanic communities.⁹⁴ While this was a positive step, more research on the benefits of RHSs within diverse populations needs to be conducted.

Child welfare. As noted, there is limited academic research on the use of peer specialists in child-welfare programs, yet there is growing engagement of PSWs. More research on these program models and their effectiveness is warranted.

Cultural Considerations

Although research on the benefits of peer support workers and peer support services across cultures exists, far more research needs to be done to understand cultural considerations more fully. Culture is a central part of many peoples lived experience and peer services should always strive to respect and honor one's cultural experiences. Race, culture, and other social determinants of health can play a critical role in the success of one's recovery journey. As peer support services are expanded into more diverse settings, understanding more about the cultural adaptations necessary to implement peer services across settings will become a critical part of the work that needs to occur to provide effective services. Another area of consideration is culturally specific practices that are grounded in cultural values, principles, customs and healing rituals that often include a vital spiritual component. As White and Laudet⁹⁵ have noted, while spiritual practice—a part of many individual and organizational recovery programs—is touched upon in academic literature with mostly positive regards, it remains elusive to concrete metrics.

Funding

While Medicaid now pays for peer services in many states, sustainable funding remains an issue—grants, contracts and other time-limited funding still make up a significant percentage of the funding for peer workers and peer services. We need more research focused on the impact of various funding mechanisms on the sustainability of peers and peer services across various settings. To sustain peer workers and services, we more research into what types of funding structures lead to long-term sustainable services and into which funding mechanisms provide the most flexibility to allow peers and peer services to be as effective as possible for the people who need them.

Conclusion

The emergence, growth, and maturation of PRSS have radically changed the addiction field, opening up a range of formalized supports that did not previously exist for people in or seeking recovery from addiction. As they become more widespread, there is a significant need for moving from practice-based evidence toward a rigorous evidence base that emanates from equally rigorous research and takes into account the unique considerations related to peer practice, including the underlying core philosophies; whether and how well programs implement peer support with fidelity to those philosophies; the distinct roles, competencies, and tasks of PSWs in the SUD field; and the reality of unique settings as services in their own right.

The current literature review summarized both the academic research and practice-based literature related to PRSS in institutional and community-based settings to deepen our understanding of the peer roles, job functions, and tasks in a wide range of settings. The research is promising—and there is much more to do to elevate PRSS further.

About the Peer Recovery Center of Excellence

The **Peer Recovery Center of Excellence** (CoE) is housed at the University of Missouri Kansas City (UMKC). Partners include the National Council for Mental Well-Being, University of Texas-Austin, and University of Wisconsin-Madison and our appointed peer-led Steering Committee. Peer voice is at the core of our work and guides our mission to enhance the field of substance-use peer-support services.

The Peer Recovery CoE has four focus areas: Integration of Peers into Non-Traditional Settings, Recovery Community Organization Capacity Building, Peer Workforce Development, and Evidence-Based Practice & Practice-Based Evidence Dissemination. In addition to trainings and publications, the Peer Recovery CoE accepts [technical assistance requests](#) from any individual, organization, community, state or region in need of training relating to substance-use disorder peer-support services.

Partnership with the National Council for Mental Well-Being

The Peer Recovery CoE partnered with the National Council for Mental Well-Being to produce this literature review. The National Council leads efforts within the Peer Recovery CoE related to Evidence-Based Practices & Practice-Based Evidence.

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