Peer Recovery Support: Evolving Roles and Settings

A Literature Review – Year 2 Update

March 2023

Disclaimer

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Introduction

The emergence, growth, and maturation of Peer Recovery Support Services (PRSS) have radically changed the substance use and mental health recovery fields, 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 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 addi ction 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 innovative public policies and attitudes that are based on a clear understanding of substance use, the science of addiction, and the science of recovery.

Literature Review Purpose

In 2021, The National Council for Mental Wellbeing conducted a literature review (Peer Recovery Support: Evolving Roles and Settings, a Literature Review) to synthesize the current evidence related to the continued evolution of PRSS and the broader integration of peers into increasingly diversified community settings as well as to identify persisting gaps in the research. Since 2021, further research has been conducted on these topics with new and highly relevant themes, directions, and outcomes. In an effort to continue to highlight emerging literature and best practices in the field, the National Council for Mental Wellbeing has developed this document as an update to the previous Literature Review.

Building an Evidence Base

As noted in the previous Literature Review, 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 controlled trials or other study designs. For this to happen, the practice likely needs to become prominent enough to accumulate the resources (e.g., research, philanthropic, 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, or 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. Practitioners point to these real-world successes as proof that traditional research methodologies should not be seen as superior to practice-based evidence. Instead, research and practice-based evidence can and must work synergistically to support each other in developing a more robust evidence base rooted in both traditional research as well as practical applications of best practices.

The movement of peer practice toward an evidence base is a long-time 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 the 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, act as strong components of recovery-oriented systems of care, and be eligible for dedicated funding and reimbursement to ensure their sustainability.

Methodology

Through collaboration with the Peer Recovery Center of Excellence, subject matter experts, and professionals working in the peer support field, the National Council for Mental Wellbeing identified scholarly, peer-reviewed, and practice-based literature that further expands on key themes identified in the previous Literature Review, as well as new themes of note. 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.

Previous Literature Review Themes

Year 2 Literature Review Update Key Findings

1. Peer Settings

- Research and evidence continue to show success integrating peers and principles of peer recovery into non-medical settings.

2. Culturally Diverse Populations

- Research has shown success in combining core principles of peer recovery with culturally competent care to create appropriate, community-based programs.

3. Recovery Social Networks

- Peer recovery programs are essential at helping people in recovery develop new, supportive social networks, which in turn further advance the key resource of positive recovery capital.

4. Recovery Capital

- Recovery Capital is defined as the internal and external resources that support a person's recovery. Research continues to show the importance of recovery capital in establishing a foundation and motivators for continued recovery and furthermore has shown that positive recovery capital is a sustainable and durable basis of recovery.

1. Peer Settings

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

- Research found promise in these non-traditional (i.e., non-medical) settings of care in that they created a network of recovery supports beyond medical stabilization and/or acute treatment.

- The literature also documented successes using PSWs in other social services that may not be peer-centric, but still benefit from the presence of PSWs and integration of peer recovery principles.

    - These settings included Medication-Assisted Treatment (MAT) programs, emergency departments, mobile crisis units, criminal justice settings, and child welfare settings.

Update - Continued Expansion into New Settings

In the previous Literature Review, the research demonstrated the efficacy of integrating peers into a variety of community settings, including recovery community centers, recovery fitness centers, recovery housing, and recovery high schools. Further research has continued to highlight the value of PSWs in a variety of settings. This is noteworthy as it expands upon previous evidence that established a key facet of peer recovery is individualizing goals and services and shows that so long as the core principles of peer recovery remain intact, PSWs can be successfully applied across settings and audiences in adaptable programs.

Higham, Pickersgill, Higham, Hancock, and Critchlow[3] observed three settings where a peer recovery organization, The Well, worked to integrate PSWs through:

- A partnership with an acute care hospital to reduce isolation and improve recovery capital as well as aiming to improve mental health, resilience, and coping strategies among those with co-occurring substance use and mental health challenges
- A recovery residence program that attempts to link the client group [residents] into community recovery hubs
- A resettlement initiative for individuals leaving prison to attempt to effectively reengage them with Behavioral Health Companions and community resources

In all these settings, peers worked with people in recovery to build individual recovery capital as well as to create a network of services to further support their recovery and develop community. All three settings found improvements in treatment and/or recovery outcomes as a result of peer integration, including lower utilization of acute hospital care, increased rates of abstinence from substance use, and increased community engagement through employment and volunteering.

Additionally, self-reported outcomes from all settings showed that participants felt less isolated and more connected to their communities. The development of community recovery capital is especially important. By creating a robust network of recovery services and peers, a community can develop a self-sustaining cycle as people in recovery use services and become peers themselves, reinforcing the recovery resources in the community.

Other research has further supported findings that integrating peers into medical settings can improve both treatment and recovery outcomes. One study found that when peer recovery coaches were integrated into general medical settings, there was a shift from utilization of acute services (ED and inpatient hospitalizations) towards higher engagement in outpatient services (primary care, mental health services, medication assisted treatment), noting: "In the six months following recovery coach contact, there was a 44% decrease in patients hospitalized and a 9% decrease in patients with an ED visit."[4]

Integrating peers into medical settings also helps establish and rebuild mutual trust between medical providers and people in recovery, who can experience traumatic or stigmatizing care in interactions with the medical system. PSWs have proven to be effective "bridges" between people in recovery and healthcare workers. When trusted by healthcare professionals, PSWs can act as an advocate in both directions – advocating on the patients' behalf to medical professionals as well as advocating on behalf of medical professionals and helping to re-establish the patients' trust in medical systems.[5]

Unique Setting Highlight – Hospitality Industry

While evidence-informed research and practice has shown that integrating peer supports into healthcare and social service settings results in better recovery outcomes, it is essential to recognize that peer recovery and support programs are also found and thrive in a variety of settings. Culinary Hospitality Outreach Wellness (CHOW) is a non-profit working to "support wellness within the hospitality industry and to improve the lives of our community through shared stories, skills, and resources." CHOW trains and supports people working in the hospitality industry to create spaces where they can help themselves and their peers to prevent, cope, and/or recover from negative effects of industry work, such as substance use or impacts on mental health.

CHOW trains hospitality workers to facilitate meetings and create support networks within their workplace and industry as well as provides materials (e.g., wellness check-in cards, workbooks) that teach principles and practices of peer support adapted to fit the unique difficulties of working in the hospitality industry. Research has shown that peer recovery supports are most effective when people identify with each other along multiple aspects of shared community. Programs like CHOW harness the trust and shared identity of an existing community (i.e., hospitality industry workers with lived experience of substance use or mental health challenges and recovery) and use that as a starting place to introduce peer supports.

CHOW's model serves as an example of community-centered, proactive peer support. In healthcare and social service settings, support often starts as the result of a precipitating event. In community-based settings, peer support develops organically to create a social network with members who have deep experiential knowledge. Such networks help individuals to build the knowledge, skills, and recovery capital needed to improve their health and wellbeing, and to sustain a life in recovery across time. By embracing principles of peer recovery support and adapting them to specific populations and settings, programs like CHOW harness the proactive facets of peer support.

2. Culturally Diverse Populations

- Previous literature showed that PSWs were more effective when shared identity went beyond identity based on recovery, and additionally included shared identity based on gender, race, socio-economic class, age, religion, or other cultural aspects of identity.

Update – Continued Focus on Equity in Recovery

The Foundation for Opioid Response Efforts (FORE) notes "a 40 percent increase in the per capita rate of opioid-related overdoses among Black Americans between 2016 and 2018. During the same period, opioid overdose rates among white Americans rose 6 percent."[6] Despite this, research has found that White Americans are more likely to have access to buprenorphine treatment than Black Americans.[7] FORE has implemented grant programs partnering PSWs with medical students to facilitate better access to medication assisted treatment (MAT), which led to a $600k grant from Florida's Department of Children and Families to further advance the initiative.

The Transitional Recovery and Culture (TRAC) Program, a peer recovery program which utilizes principles of both peer recovery and American Indian and Alaska Native (AIAN) medicine, was successful in developing recovery capital among participants over the course of a six-year evaluation. Researchers found "significant change for the following recovery capital resources: stable housing, being occupied, attending recovery groups, interacting with family and friends, past substance use activity, and self-reported health status."[8]

While there have been efforts in recent years to further incorporate an equity lens to recovery research, researchers have also consistently noted that equity needs to be an area of particular attention in the research base going forward. Stanojlović and Davidson write in a literature assessment published in 2021 that:

> “In general, we found ample evidence that peer recovery support is successful in closing these gaps and helping people transition from one stage of the care continuum to another by addressing some of the barriers that people face… However, we could benefit from more research on culturally and gender specific PRSS in order to address many of the barriers that minorities and women in particular are facing in the initial stages of treatment and recovery initiation.” (Stanojlović & Davidson, 2021)[9]

Similarly, in a supplement to the Stanford Social Innovation Review, writers argued that an increased focus on implementation science and desire to identify best practices should not come at the expense of broadening the evidence base to include diverse experiences, noting that that:

> “Despite the field’s attention to evidence-based practices, fidelity, replication, and scaling strategies, implementation support practitioners are not seeing equitable access to interventions or equitable outcomes for service recipients. There are several reasons for this disconnect: Community members are not routinely invited to develop or select interventions that are intended for them; power dynamics between funders and community members hamper authentic engagement with residents; and structural racism and other forms of oppression, such as transphobia and ableism, are not explicitly acknowledged as part of the context in which interventions are being implemented.”[10]

New 2022 Literature Review Themes

3. Recovery Social Networks

Research and practice have shown that while one-on-one peer relationships are valuable, there is significantly more value and effectiveness when an individual is engaged in a recovery community where their housing, employment, and social networks are made up of peers and supportive structures to facilitate their recovery. One barrier to building positive recovery capital can be the hesitancy to leave existing social networks, some of which may encourage or reinforce behaviors detrimental to recovery. Research has noted two large barriers to leaving old social networks:

1. Fear of isolation, particularly when beginning recovery
2. Fear that mutual aid or recovery-centered social relationships may be transactional, or bonds will not be as strong as previous social relationships.

An analysis by Anderson, Devlin, Pickering, McCann, and Wight[11] examined the changes in social networks of people in recovery before and after they initiated recovery. Their analysis looked at size and density, closeness of members, and positive and negative influence(s) of social network members (among other metrics) to determine how recovery was associated with changes in the breadth and quality of social relationships. They found that participants' social networks typically remained the same size, or even expanded, and included more positive social influences in recovery-centered social networks.

> "There was a significant transition in network composition, with the replacing of AOD [alcohol or other drugs]-using peers with recovery peers and a broader transformation from relationships being framed as negative to positive. However, there was no significant transition in network structure, with AOD-using and recovery networks both consisting of strong ties and a similar density of connections between people in the networks."

Their findings indicate that engaging with recovery-centered social networks not only reduces feelings of isolation, particularly in early recovery, but also facilitates increased positive recovery capital, as close social ties "provided a pathway into more structured opportunities for volunteering and employment."

Similarly, a study by Martinelli, van de Mheen, Best, Vanderplasschen, and Nagelhout[12] found that when initiating recovery, many people report cutting ties with old social networks. However, when people in recovery engaged long-term with mutual aid groups, they were able to replace old social networks more effectively with networks that positively impacted their recovery. When these new social networks were established: "participants [saw] mutual aid

groups and the people in the groups as close social contacts, which is a fundamentally different role than a treatment professional usually fulfills."

Taken together, these studies indicate that recovery-oriented social relationships and social networks can be both as large and meaningful (if not larger and more meaningful) than pre-recovery social networks, while encouraging positive behaviors and providing access to greater recovery capital (e.g., recovery-oriented volunteering, employment, or housing).

4. Recovery Capital

As stated previously, the concept of "recovery capital" is the internal and external resources that support a person's recovery and is central to peer recovery. External resources may include community supports, social networks, employment, transportation, housing, etc., while internal resources may include factors like each individual's skills, knowledge, and motivators for recovery. Addressing multiple dimensions of recovery capital is important for sustained recovery and creating a network of recovery systems, rather than siloed points of recovery support.

One study sought to identify which factors or behaviors might serve as predictors of relapse following departure from recovery housing, hypothesizing that length of stay and voluntary vs. involuntary departure would correlate with recovery outcomes. Researchers found that, in and of itself, "length of stay was not a significant predictor of relapse,"[13] and that "leaving the home involuntarily (vs. voluntarily) was the only predictor of…relapse." These data seem to indicate that using length of stay as a sole metric to gauge recovery is not enough, and that engaged, voluntary participation (and eventually, departure) from recovery housing better predicts recovery outcomes. This supports a shift in mindset away from quantity (more time in recovery housing = more recovery capital) towards quality (how can time spent in recovery housing be a foundation on which to build more recovery capital, via a network of recovery systems.)

Other research has examined the interdependent and compounding nature of recovery capital. Another study of individuals residing in Sober Living Recovery Homes (SLHs) found that:

> "….as residents [of SLHs] develop and implement practical skills, goals, and specific plans, they might be acquiring other types of recovery capital, such as job training, medical care, mental health services, and improved self-esteem. In this way, acquisition of specific types of recovery capital assets can have a synergistic effect that fuels acquisition of other types of recovery capital."[14]

Research has shown that when individuals have a strong foundation of recovery capital, it serves not only as an avenue for advancing recovery, but can also serve as a preventative buffer against stressors and increase resiliency. For example, one study hypothesized that due to isolation and stress caused by the COVID-19 pandemic, people in recovery would have added difficulty maintaining sobriety. However, the results found that for people with strong recovery capital prior to the pandemic, there were not significant rates of relapse, indicating that

"recovery capital showed a consistently protective effect [against relapse] and may serve as a highly suitable intervention target as it is modifiable"[15]

Other practice-based evidence further supports that recovery capital is particularly important for populations facing difficulties or significant life changes outside of recovery, such as people returning from incarceration. Through a Bureau of Justice Assistance grant, the Erie County Jails Co-occurring Enhancement Reentry Initiative has partnered with the Erie County Sheriff's Office to develop and implement a program providing peer support for formerly incarcerated people with co-occurring substance use disorders and mental health conditions. This population has a higher likelihood of having experienced trauma due to their extensive interactions with the criminal justice and medical systems, and peers can serve as a trusted resource outside of these systems that can help develop recovery capital by leveraging their own lived experiences.[16]

Another study of a peer service model for persons with SUD who are reintegrating into their communities following incarceration (Substance Use Programming for Person-Oriented Recovery and Treatment [SUPPORT]) found that while program retention was a barrier:

> "those who received peer recovery coach support in the reentry program had recovery-based improvements, including improved self-reported mental and physical health and reductions in substance use behaviors. The treatment group also saw improvements in measures of treatment motivation and self-efficacy."[17]

Research by Patton and Brown has further delineated recovery capital into two factors: push factors (pain factors or negative recovery capital) and pull factors (positive recovery capital). Their framework suggests that recovery capital cannot be effectively sustained unless negative factors are reduced and, as such, peers and peer organizations should work to both mitigate push factors (e.g., unresolved trauma, housing insecurity, social relationships that encourage substance use) while simultaneously cultivating pull factors.[18]

Recommendations for Continued Research

In building a strong evidence base of peer support programs, it is important to document not only novel advances but also the scientific basis behind foundational aspects of peer recovery, such as shared characteristics of recovery organizations[19] and the evolution of how PSWs have historically been utilized.[20, 21]

Research should continue to examine the efficacy of peer integration into various settings. As researchers work to develop and document a knowledge base (e.g., Vest, Reinstra, Timko, Kelly, and Humphreys' scoping review of literature around collegiate recovery programs[22]), we can create a strong evidence base of best practices in emerging settings. Furthermore, understanding and providing effective supervision of peer workers will continue to be essential to ensure effective integration of peers into increasingly diverse as well as traditional settings.

As noted previously, equity should be a key aspect of all recovery programs, and research should continue to incorporate knowledge and practices from diverse populations and areas of the country. As the country becomes more diverse, the importance of understanding the needs and cultural nuances of implementing peer services in diverse populations cannot be understated. Investing resources in researching these nuances will be critical to continued expansion of peer services in diverse populations.

Given the growth of peer services and peer service workers in more diverse community settings, it has become increasingly important to understand the impact of peer workers and peer services on community outcomes (crime reduction, civic engagement, etc.). Much of the current research in this area focuses primarily on individual recovery-based outcomes, which is important in helping the mental health and substance use field understand the benefits of peer services and peer service workers on individual recovery goals. However, as policymakers, funders, and other community stakeholders attempt to understand the broader impact of these services, more research on community outcomes will be needed. Potential future updates could explore these themes further to facilitate this enhanced understanding as more research is introduced and the field continues to evolve.

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