# Incorporating Peer Support into Substance Use Disorder Treatment-Learning Collaborative

## (Session 2 of 4)

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# Speakers and Moderators

**Kevin Lombardi MD, MPH**
Director of Research

**Fide Pineda Sandoval, CHES**
Training and Technical Assistance Manager

**Olajumoke Oladipo, MPH**
Health Communications and Research Analyst

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# Speaker

**Kevin Lombardi MD, MPH**
Director of Research

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# Incorporating Peer Support into Substance Use Disorder Treatment

*Session 2: Substance Use Disorder (SUD), chronic disease and the role of peer support*

*Dr. Kevin Michael Lombardi MD, MPH*

*Director of Research*
*The National Center for Health in Public Housing*
*North American Management*

# Dept of Research T/TA Model

- Literature Review
- Epidemiology
- Findings and recommendations
- Clinical case review
- Discussion
- Implementation and advising


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# What are Peer Recovery Support Services?

PRSS are peer-driven mentoring, education, and support administrations delivered by individuals who, because of their own experience with SUD and SUD recovery, are experientially qualified to support peers currently experiencing SUD and associated problems.

# Lived Experience in New Models of Care for Substance Use Disorder: A Systematic Review of Peer Recovery Support Services and Recovery Coaching

*David Eddie[1]*, Lauren Hoffman[1], Corrie Vilsaint[1], Alexandra Abry[1], Brandon Bergman[1], Bettina Hoeppner[1], Charles Weinstein[2] and John F. Kelly[1]*

*[1] Recovery Research Institute, Center for Addiction Medicine, Massachusetts General Hospital, Harvard Medical School, Boston, MA, United States, [2] Department of Psychiatry, Massachusetts General Hospital, Harvard Medical School, Boston, MA, United States*

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**Edited by:**
*Dana M. Litt, University of North Texas Health Science Center, United States*

**Reviewed by:**
*Kevin A. Hallgren, University of Washington, United States*
*Katie Witkiewitz, University of New Mexico, United States*

***Correspondence:**
*David Eddie*
*deddie@mgh.harvard.edu*

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Peer recovery support services (PRSS) are increasingly being employed in a range of clinical settings to assist individuals with substance use disorder (SUD) and co-occurring psychological disorders. PRSS are peer-driven mentoring, education, and support ministrations delivered by individuals who, because of their own experience with SUD and SUD recovery, are experientially qualified to support peers currently experiencing SUD and associated problems. This systematic review characterizes the existing experimental, quasi-experimental, single- and multi-group prospective and retrospective, and cross-sectional research on PRSS. Findings to date tentatively speak to the potential of peer supports across a number of SUD treatment settings, as evidenced by positive findings on measures including reduced substance use and SUD relapse rates, improved relationships with treatment providers and social supports, increased treatment retention, and greater treatment satisfaction. These findings, however, should be viewed in light of many null findings to date, as well as significant methodological limitations of the existing literature, including inability to distinguish the effects of peer recovery support from other recovery support activities, heterogeneous populations, inconsistency in the definitions of peer workers and recovery coaches, and lack of any, or appropriate comparison groups. Further, role definitions for PRSS and the complexity of clinical boundaries for peers working in the field represent important implementation challenges presented by this novel class of approaches for SUD management. There remains a need for further rigorous investigation to establish the efficacy, effectiveness, and cost-benefits of PRSS. Ultimately, such research may also help solidify PRSS role definitions, identify optimal training guidelines for peers, and establish for whom and under what conditions PRSS are most effective.

**Keywords: peer recovery support services, recovery coaching, peers, substance use disorder, addiction**

## INTRODUCTION

Substance use disorder (SUD) is one of the most pervasive and intransigent clinical and public health challenges facing the United States (Office of the Surgeon General, 2016). While many who meet criteria for SUD are able to achieve remission without formal treatment (Cunningham and McCambridge, 2012; Kelly et al., 2017), many millions of affected individuals require some combination of acute care, medical stabilization, long-term recovery management, and recovery support services to sustain remission, akin to the care of other chronic health conditions such as diabetes and hypertension (McLellan et al., 2000). There is evidence that such multifaceted, long-term care models for SUD are helpful (Dennis et al., 2003; Scott and Dennis, 2009).

Existing health-care and treatment models, however, are often not structured in ways that facilitate treatment engagement, and linkages to services that can support long-term remission of SUD (McLellan et al., 2000; White and Kelly, 2011). To begin to address this care gap, many healthcare institutions have begun to implement peer recovery support services (PRSS) to help initiate and maintain patients' engagement with SUD treatment and other recovery support services, and mitigate relapse risk.

First arising in the 1990s, PRSS for individuals with SUD emerged from a variety of predecessors inside and outside of the addiction field. "Patient navigator" models have played important roles for several decades in the professional coordination of care for chronic medical conditions such as cancer (e.g., Robinson-White et al., 2010; Freeman, 2012), and later included peers with lived experience to aid engagement (e.g., Giese-Davis et al., 2006). Such navigator models have also been developed in the care of individuals with severe mental health conditions (e.g., Corrigan et al., 2017). There is also a long tradition of community-based 12-Step mutual-support (e.g., "sponsors"), that can provide free ongoing recovery monitoring and management using peers with lived experience, though this class of peer support should not be conflated with more structured PRSS that are increasingly being incorporated into clinical settings and can support multiple pathways to recovery.

In the SUD field, PRSS are most often peer-driven mentoring, education, and support ministrations delivered by individuals who, as a result of their own experience with SUD and SUD recovery, are experientially qualified to support peers with SUD and commonly co-occurring mental disorders. These services represent a new category of specialized resources that are not formal treatment and not mutual-help, which offer support as well as linkage to traditional addiction treatment and mutual-help recovery programs (White and Evans, 2014). These PRSS roles emphasize respect for the diverse pathways and styles of recovery, and stress the need for long-term continuity of recovery support through mobilization of personal, familial, and community help (Valentine, 2010; White, 2010). They can be delivered through a variety of organizational venues and a variety of service roles including paid and volunteer recovery support specialists.

SAMHSA has previously defined PRSS as a peer-helping-peer service alliance in which a peer leader in stable recovery provides social support services to a peer who is seeking help in establishing or maintaining their recovery (SAMHSA, 2009). This broad definition provides a useful starting point that may help guide PRSS practice and research, however, it doesn't describe the wide range of roles peers serve in or the highly variable nature of their professional involvement with this work (e.g., *ad hoc*, lay, peer volunteers vs. full-time, trained, paid peer workers). In many clinical settings, unpaid lay peers are called upon to provide support to patients with SUD across all stages of recovery.

Common functions of PRSS include facilitating and supporting patients' engagement with SUD treatment and transition between levels of care (e.g., between inpatient and outpatient programs), in addition to connecting patients with community based recovery support services and mutual-help organizations in ways not possible for conventional treatment providers who are bound by ethical considerations like not forming dual relationships with patients (Valentine, 2010; White and Evans, 2014). PRSS can also help individuals navigate systems to build recovery capital, attain employment, attend mutual-help groups, and address criminal justice issues.

Probably the largest area of SUD peer-service growth over the past decade, however, has been in the uptake of peer recovery coaches. Recovery coaches are peers trained to provide informational, emotional, social, and practical support services to people with alcohol or other drug problems through a wide variety of organizational sponsors, including recovery community centers, as well as hospital and outpatient clinical settings (White, 2009). Typically they are paid employees working part- or full-time with some degree (a high school diploma or GED is usually required) of formal training and certification. Due to lack of agreed standards in terminology, in some clinical settings the term recovery coach may also refer to "recovery allies" who support individuals with SUD, but do not have lived experience with addiction. Such supports are not covered in this review.

Regardless of the nature of their role, peers have the ability to engage patients outside the confines of traditional clinical practice. This ability to fill critical care gaps is the most probable reason for their widespread uptake across a diverse range of SUD treatment settings and the reason they have emerged as a critical component of recovery management (White, 2009). SAMHSA has made efforts to identify and describe core competencies for peer support workers in working with individuals with SUD as well as other psychological disorders (SAMHSA, 2015), and with time, PRSS roles and qualifications will become better defined.

While a compelling case has been made for PRSS in a number of theoretical articles and book chapters (e.g., White, 2009, 2010, 2011; Bora et al., 2010; Cicchetti, 2010; Valentine, 2010; Powell, 2012; Laudet and Humphreys, 2013; White and Evans, 2014), to date empirical research on the topic is somewhat limited. Previous reviews of the PRSS literature published in Reif et al. (2014) and Bassuk et al. (2016) reported that overall, existing research at the time showed PRSS were commonly associated with reduced substance use and SUD relapse rates, improved relationships with treatment providers and social supports, increased treatment retention, and greater satisfaction with treatment. Bassuk et al. ultimately concluded that there is

# Characterizing the study

SUD and associated problems. This systematic review characterizes the existing experimental, quasi-experimental, single- and multi-group prospective and retrospective, and cross-sectional research on PRSS. Findings to date tentatively speak to the potential of peer supports across a number of SUD treatment settings, as evidenced by positive findings on measures including reduced substance use and SUD relapse rates, improved relationships with treatment providers and social supports, increased treatment retention, and greater treatment satisfaction. These findings, however, should be viewed in light of many null findings to date, as well as significant methodological limitations of the existing

# Key Context: Introduction

## INTRODUCTION

Substance use disorder (SUD) is one of the most pervasive and intransigent clinical and public health challenges facing the United States (Office of the Surgeon General, 2016). While many who meet criteria for SUD are able to achieve remission without formal treatment (Cunningham and McCambridge, 2012; Kelly et al., 2017), many millions of affected individuals require some combination of acute care, medical stabilization, long-term recovery management, and recovery support services to sustain remission, akin to the care of other chronic health conditions such as diabetes and hypertension (McLellan et al., 2000). There is evidence that such multifaceted, long-term care models for SUD are helpful (Dennis et al., 2003; Scott and Dennis, 2009).

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Regardless of the nature of their role, peers have the ability to engage patients outside the confines of traditional clinical practice. This ability to fill critical care gaps is the most probable reason for their widespread uptake across a diverse range of SUD treatment settings and the reason they have emerged as a critical component of recovery management (White, 2009). SAMHSA has made efforts to identify and describe core competencies for

# Methods and Results



evidence for the effectiveness of PRSS. Overall, however, both reviews highlighted concerns about the methodological rigor of the then existing research, which included an inability to distinguish the effects of peer recovery support from other recovery support activities, small samples and heterogeneous populations, inconsistency in the definitions of peer workers and recovery coaches, lack of any, or appropriate comparison groups, and inconsistencies in the quantity of peer-provider supervision. Ultimately, Bassuk et al. noted that although evidence for the effectiveness of PRSS exists, these limitations should offer pause, and that additional research is necessary to determine the effectiveness of different peer approaches and types of peer support services, with regard to the amount, intensity, peer skill level, service context, and effectiveness among different populations served.

PRSS, and recovery coaching models are increasingly and rapidly being rolled out in health care settings, despite little empirical knowledge of best practices and sense of to what degree services will help, and for whom. The aim of the present article is, therefore, to report the most up to date research on PRSS through systematic review. This review includes six new articles published following Bassuk et al.'s review. It also extends previous reviews by utilizing broader inclusion criteria (e.g., including cross-sectional studies and clinical interventions linking patients to 12-Step programs using 12-Step program volunteers) that provides broader context for this fast-growing literature. The review also identifies, wherever possible, for whom and under what conditions PRSS may have utility to inform health care and community-based PRSS delivery. We also highlight important gaps in the knowledge base that will inform the direction and scope of treatment and future research in this important, emerging area.

## METHODS

A systematic search of the literature (as of 10/13/2018), using the search terms "recovery coaching," "peer recovery support," "peer-based recovery support services," and "individual peer support" in combination with substance use terms, identified 158 records across four publicly available databases (i.e., PubMed, EMBASE, CINAHL, and PsycInfo; see **Appendix A** in Supplementary Material for search term syntax). Given the relative novelty of this line of investigation we cast a wide net in terms of article inclusion criteria. We included randomized controlled trials (RCTs), quasi-experimental studies, single- and multi-group prospective and retrospective studies, and cross-sectional/descriptive studies related to SUD. All age ranges, substances used, and available outcomes were included. Non-peer reviewed items, however, were not included (e.g., book chapters, dissertations, institutional reports). Reports had to include at least one substance use or related outcome.

A title screen removed 101 duplicate records, and 11 records on non-relevant topics (e.g., peer support for recovery for problem unrelated to addiction). An abstract review removed an additional 17 records: seven book chapters (removed because they were not peer reviewed and did not report original data), seven records on non-relevant topics, two review articles, and one article because it reported on a mandated to treatment sample. A full text review removed another 17 records: seven review and ten theoretical articles. The remaining 12 studies were included in the analysis and are summarized in **Table S1** (Supplementary Material) in addition to 12 relevant articles identified subsequently (see **Figure 1**, literature review diagram) resulting in 24 included reports.

## RESULTS

### Results Overview

We found seven RCTs, four quasi-experiments, as well as eight single- or multi-group prospective or retrospective studies, and two cross-sectional investigations conducted on this topic. The review included 24 reports from 23 original studies containing a total of 6,544 participants. On average, the reviewed studies included more men than women (females, 37.3%; males, 62.7%), although in the majority of studies the racial makeup of samples was diverse, and representative of the populations being studied. Outcomes reported were varied and included self-reported and bioassayed substance abstinence vs. non-abstinence, Addiction Severity Index scores (Mclellan et al., 1992), outpatient substance use treatment attendance, 12-Step meeting attendance, general medical, and mental health appointment adherence, utilization of inpatient substance use treatment services, inpatient readmissions, social functioning, number of psychiatric hospitalization nights, length of living in the community without rehospitalization, number of rehospitalizations, criminal charges, and deaths. The range of follow-up length varied from 1 week to 3 years following the intervention. Below we summarize the review findings by study design type from the most to the least, scientifically rigorous design types.

### Randomized Controlled Trials

Bernstein et al. (2005) conducted the first RCT of a peer recovery support intervention in a sample of 1,175 individuals with SUD reporting past 90-day cocaine and/or heroin use who were receiving general medical care from an urban hospital walk-in clinic, but not SUD treatment. Participants engaged in one of two interventions: either a brief, single session, structured peer education session targeting drug use cessation, which included written advice and a referral list as well as a "booster" telephone call (experimental group), or written advice and referral list for treatment only (control group). Compared to controls, at 6-month follow-up participants receiving a brief peer-support intervention were more likely to be abstinent from cocaine, and trended toward greater heroin, and combined cocaine and heroin abstinence ($p = 0.05$), with OR's 1.51–1.57. This favorable abstinence outcome, however, was not supported by bioassay results; no significant between group differences were observed for bioassayed drug use. Similarly, Addiction Severity Index drug subscale and medical severity scores were not significantly different, and no group differences were noted in detoxification or treatment admissions among those who were abstinent. It is possible that a brief, single-session peer interaction is not sufficient to elicit statistically significant levels of behavior change



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## Methods and Results

# METHODS

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# Case Study: Peer Support

Which of the following study type has the strongest level of evidence for integration into clinical practice:

1. **A case study that is almost identical to your current patient.**
2. **A retrospective review article recently published in JAMA**
3. **A case-control study that was performed in your state of practice.**
4. **A meta analysis of prospective studies that is directly related to your patient**

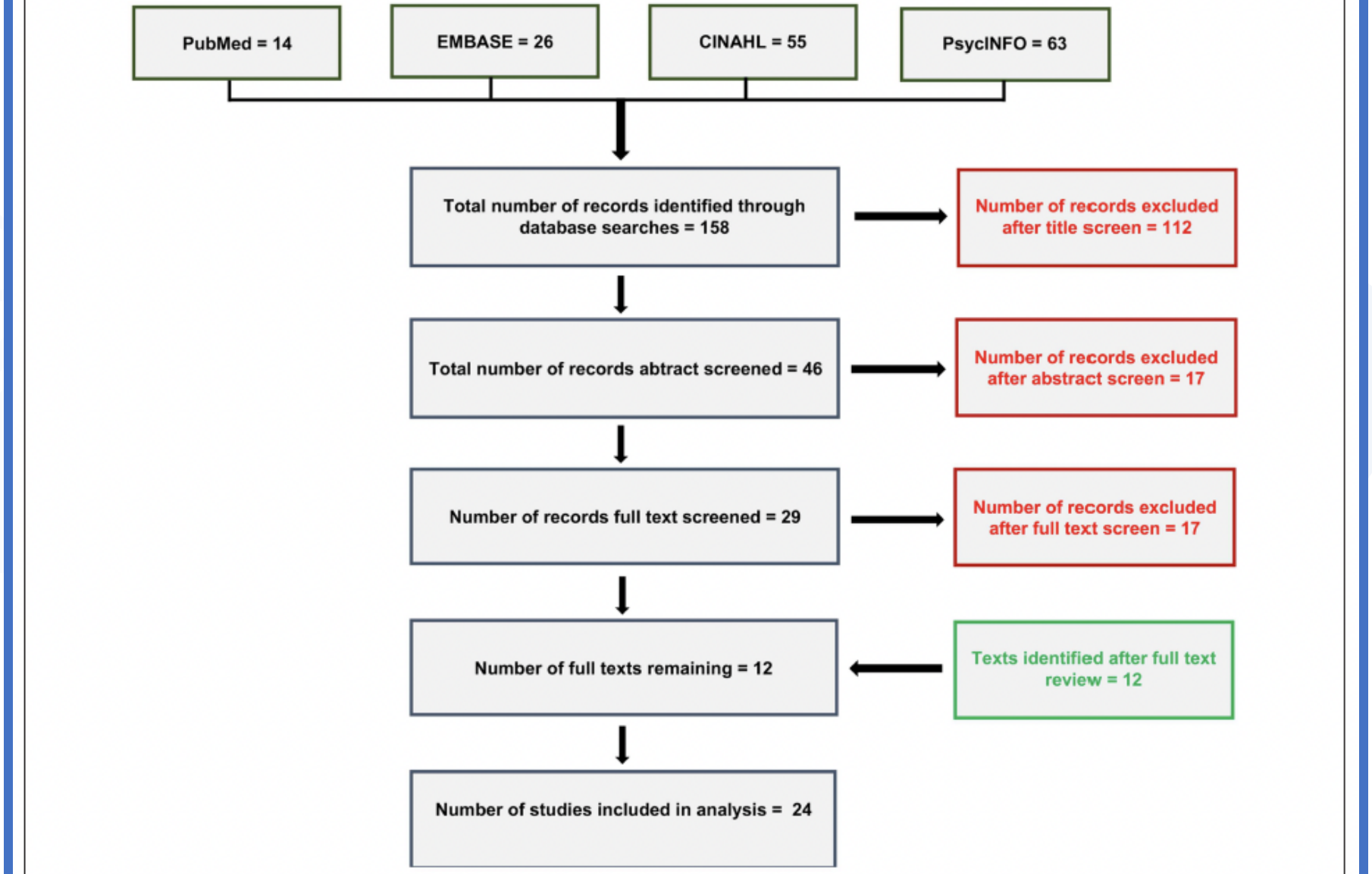


**FIGURE 1** | Literature review diagram showing article review and selection.

## Randomized Controlled Trials

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# Case Study: Peer Support

You are a Community Health Worker considering referring a patient to peer support recovery services for intervention.

**The patient is a 45-year-old woman with a history of Opioid Use Disorder (OUD) with x3 accidental overdoses since 2015.**

**Based on what we have reviewed, what benefits might this patient receive for engaging in PSRS?**

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developed and tested a brief, three-session, intensive referral to 12-Step intervention for Department of Veterans Affairs outpatients ($N = 345$). Participants were randomly assigned to a standard referral in which they were given a schedule for local 12-step meetings and were encouraged to attend, or intensive referral to 12-Step that included linking patients to 12-Step volunteers and using journals to check meeting attendance. For those receiving intensive referral, counselors arranged a meeting between the patient and a participating member of a local Alcoholics Anonymous or Narcotics Anonymous group by calling the peer volunteer in-session to arrange for them to meet patients before a 12-Step meeting so that they might attend the meeting together. Intensive referral was associated with greater likelihood of being involved with 12-Step groups and better alcohol and other drug use outcomes over a six-month follow-up period. Subsequently, Timko and Debenedetti (2007) followed up with these participants at 1 year and found the benefits of intensive referral were sustained. The intensive referral group were more likely to attend at least one meeting per week (OR = 1.38), and had greater 12-Step group involvement ($d = 0.23$), as well as high rates of abstinence (OR = 1.61).

Later, Timko et al. (2011) employed a very similar intervention structure, but with a sample of dually-diagnosed individuals seeking outpatient treatment at the Veteran's Administration. Participants were randomized either standard referral, or four sessions of intensive referral to Double Trouble in Recovery—a 12-Step program for individuals with SUD and co-occurring psychiatric conditions. Intensive referral included a peer volunteer from Double Trouble in Recovery joining participants and their counselor in session. Peers gave a brief personal history and arranged to meet participants and attend a meeting together. At 6-month follow-up those receiving intensive referral were more likely to have attended a Double Trouble in Recovery meeting, and had attended more meetings ($d = 0.89$). Similarly, these participants were also more likely to have attended other 12-Step program meetings, and had greater frequency of attendance at these meetings ($d = 0.25$). They also had less past 30-day drug use ($d = 0.30$) and fewer psychiatric symptoms ($d = 0.28$). No differences were observed for alcohol use and notably only 23% of patients in the intensive-referral group actually attended a Double Trouble in Recovery meeting during the 6-month follow-up period compared to 13% in the standard referral group, suggesting about one-fifth of participants receiving intensive referral were driving the observed between group differences.

Manning et al. (2012) sought to determine whether peer referral to 12-Step meetings would increase 12-Step meeting attendance among individuals with SUD undergoing inpatient detoxification ($N = 151$). Patients were randomized to either, (1) introduction and referral to 12-Step by a peer who shared their own recovery experience with the participant, (2) introduction and referral to 12-Step by a doctor, or (3) no introduction or referral (control group). Peers and doctors were instructed to initiate and maintain an open dialogue with participants about their beliefs, concerns, and experiences with 12-Step meetings, and to address any concerns or misconceptions that clients may have held about 12-Step meetings. Together, peer and doctor referral to 12-Step led to increased attendance at 12-Step meetings during inpatient treatment (88 vs. 73%), though peer and doctor groups had similar rates of 12-Step meeting attendance on the inpatient unit (89 and 87%, respectively). Rates of post-discharge meeting attendance, however, were significantly higher in the peer referral group (64%; OR = 3.6) compared to the doctor referral (48%) or no referral groups (33%). Further, participants who attended 12-Step meetings while inpatient were three times as likely to have attended meetings post-discharge than those who did not attend 12-Step meetings while inpatient (59 vs. 20%), and post-discharge meeting attenders reported significantly higher abstinence rates at 3-month follow-up (60.8 vs. 39.2%). Abstinence rates at 3-month follow-up, however, did not differ significantly across intervention groups. Taken together, findings suggest introduction and referral to 12-Step programs for individuals in inpatient detoxification increases 12-Step meeting attendance both during inpatient treatment and after discharge, and that meeting attendance is associated with higher abstinence rates; it is not necessarily important, however, that these referrals/introductions be peer-delivered.

In contrast to the aforementioned studies, which utilized either single session, peer-delivered intervention (Bernstein et al., 2005) or peer support as an addendum to a professional-delivered treatment (Rowe et al., 2007). Tracy et al. (2011) compared a peer-driven treatment that included peer-led groups as well as peer support, to a professional-delivered treatment with peer support in a sample of 96 Veterans Administration inpatients. Study groups included, (1) treatment as usual (TAU) combined with peer-led groups and weekly peer mentorship, (2) TAU combined with a dual recovery intervention involving 8 weeks of clinician-delivered individual and group relapse prevention therapy in addition to peer-led groups and weekly peer mentorship, and (3) TAU only. TAU consisted of standard coping/skills training groups, medication management, and social work support to handle basic needs during inpatient stay. Substance misuse, psychiatric, and medication management support services were also available. Peer mentors were referred by their treating physician/clinician to a compensated work therapy program, and screened by the program coordinator and mentor supervisor from clinical record and interview. 88% of study participants had an alcohol use disorder or other SUD, in addition to psychiatric comorbidity. TAU combined with peer-delivered treatment, and TAU combined with professional-delivered treatment and peer support were both associated with greater post-discharge, outpatient substance use treatment attendance compared to TAU alone (51 and 52% SUD treatment appointment adherence respectively among those receiving peer ministrations vs. 38% for TAU). These two interventions were also associated with greater general medical, and mental health appointment adherence (43 and 48% appointment adherence respectively among those receiving peer ministrations vs. 33% for TAU), as well as greater inpatient substance use treatment accessed ($d$'s = 0.33 and 0.63 respectively vs. TAU only). Taken together, findings suggest that at least in terms of treatment

# Translating to Practice

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# Case Study: Peer Support

Mr. Ramirez is a 24-year-old man who is admitted to the hospital after an accidental overdose.

Per facility protocol he referred to social work for discharge. When preparing Mr. Ramirez for discharge his social Worker considers a range of supports, including peer support recovery services.

**What can this social worker do to increase Mr. Ramirez's chance of attending peer support services?**

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## Translating to Practice

or misconceptions that clients may have held about 12-Step meetings. Together, peer and doctor referral to 12-Step led to increased attendance at 12-Step meetings during inpatient treatment (88 vs. 73%), though peer and doctor groups had similar rates of 12-Step meeting attendance on the inpatient unit (89 and 87%, respectively). Rates of post-discharge meeting attendance, however, were significantly higher in the peer referral group (64%; OR = 3.6) compared to the doctor referral (48%) or no referral groups (33%). Further, participants who attended 12-Step meetings while inpatient were three times as likely to have attended meetings post-discharge than those who did not attend 12-Step meetings while inpatient (59 vs. 20%), and post-discharge meeting attenders reported significantly higher abstinence rates at 3-month follow-up (60.8 vs. 39.2%). Abstinence rates at 3-month follow-

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# Case Study: Peer Support

You are a community nurse who is reviewing the SDOH screen and medical record of Mrs. Jones, a 54 year-old female with a history of social isolation, intimate partner abuse and OUD ( x1 accidental relapse in 2022).

She has previously refused to attend 12-step or other OUD recovery programs.

**How could PSRS help encourage this patient to access OUD recovery programs?**

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study was implemented, speaking to some of the real-world challenges associated with implementation of PRSS, especially in already underserved geographic areas. This observation speaks to the potential utility of peer coaching via telemedicine (Huskamp et al., 2018).

Using government public health, and Medicaid records, Min et al. (2007) retrospectively assessed whether a long-term, peer-mentorship intervention for individuals with SUD and severe co-occurring mental illness has the capacity to reduce rehospitalization rates ($N = 484$). Survival analysis results over a 3-year period indicate that peer-support program participants had longer periods living in the community without rehospitalization, and a lower overall number of rehospitalizations, compared to a sample of comparable controls not engaged in peer-mentorship.

Similarly, Andreas et al. (2010) shared preliminary findings for the Peers Reach Out Supporting Peers to Embrace Recovery (PROSPER) program, which includes peer-run groups, coaching, workshops and seminars, social and recreational activities, and community events ($N = 509$). Peers work closely with program staff and receive extensive training and supervision. Study participants included women and men over the age of 18 who had SUD and histories of incarceration. From baseline to 12-month assessment the authors observed increases in self-efficacy, perceived social support, and quality of life, as well as decreases in perceived stress, though guilt- and shame-based emotions increased over the same period of time.

Work by Armitage et al. (2010) suggests PRSS may also be beneficial to individuals in sustained SUD remission. The Recovery Association Project (RAP), which emphasizes active citizenship and social engagement, is facilitated by individuals in recovery from SUD who had completed at least 15 h each of RAP leadership training ($N = 152$). The authors found retrospectively that 6 months following RAP participation, 86% of their clients reported no past 30-day alcohol or other drugs use, and another 4% indicated reduced use. Further, 95% reported strong willingness to recommend the program to others, 89% found services helpful, and 92% found provided materials helpful.

Using a multi-group prospective design, Deering et al. (2011) sought to better understand the effects of a peer-led, mobile outreach program for female sex workers. Women were surveyed every 6 months over 18 months ($N = 242$). Women were more likely to utilize the peer-led outreach service if they were at higher risk due to factors such as seeing >10 clients per week, working in isolated settings, injecting cocaine, or injecting/smoking methamphetamine in past 6 months. Utilizers of the peer-led service, however, were also more likely to access the intervention's drop-in center, and notably, after statistically controlling for inter-individual differences, past 6-month use of the peer-led outreach program was associated with a 4-fold increase in the likelihood of participants utilizing detoxification and/or inpatient SUD treatment.

In a retrospective single group study, Kelley et al. (2017) explored the effects of the Transitional Recovery and Culture Program, a Montana-based, community-driven, PRSS intervention aimed at improving sobriety rates in a collection of Native American communities in the region, and increasing community awareness of substance use problems and the need to support SUD recovery ($N = 224$). The authors found that participants completing 6-month follow-up (29%) had significant reductions in past 30-day alcohol ($d = -0.78$) and other drug use ($d = -0.64$). Participants were also more likely to have attained housing and employment. Symptoms of anxiety and depression, however, were not significantly changed. The low follow-up rate (29%) for this study, however, suggests the possibly of selection bias; i.e., individuals lost to follow-up were doing worse and are not represented in the results, making intervention look better than it actually was. As such, these results should be interpreted with caution.

Most recently, Scott et al. (2018) piloted an intervention designed to help link individuals actively using opioids to detoxification and/or agonist medication treatment. Peers approached individuals in urban areas identified as high-risk for continued opioid use and overdose, engaged them in a conversation about heroin, and explained they were recruiting for a study that aimed to help people get into treatment. If the individual expressed interest in the study, the peer outreach worker then called study staff to phone-screened the prospective participant for study eligibility. At the study office, participants met with a treatment linkage manager who used an adapted version of the Recovery Management Checkup protocol (Scott and Dennis, 2010) to link individuals to detoxification and/or methadone agonist medication therapy. Over the course of 8 weeks, peer outreach workers identified 88 individuals actively engaged in opioid use. Seventy-two were screened as eligible, and 70 showed to the treatment linkage meeting. Of those showing up to the treatment linkage meeting, eight went to detox, and nearly all (96%) were admitted to methadone treatment, with a median time from initial linkage meeting to treatment admission of 2.6 days. The majority of participants were still in treatment at 30 and 60 days post-intake (69 and 70%, respectively). This study demonstrates the synergistic potential of integrating peer-based approaches and evidence-based SUD interventions. While peers were not necessarily providing treatment *per se*, they served in this instance, as a critical link to treatment and were able to accomplish in the field what may be difficult for a non-peer provider.

Also interested in the benefits peers can confer for individuals with opioid use disorder, Samuels et al. (2018) explored if connecting individuals presenting to emergency department (ED) for opioid overdose would benefit from PRSS provided in the ED, in addition to provision of naloxone, and usual care consisting of medical stabilization and provision of a list of SUD treatment programs in printed discharge instructions ($N = 151$). Using ED electronic medical record review, they contrasted this intervention to provision of naloxone with written and video instructions on use + usual care, and usual care only. Peers were employed by the partner community-based peer recovery organization. Participants were assigned to one of the three treatment groups based on provider and patient discretion. Peers met with participants in the ED and assessed their readiness to seek treatment, identified overdose risk factors, and provided individualized

# Translating to Practice

Using government public health, and Medicaid records, Min et al. (2007) retrospectively assessed whether a long-term, peer-mentorship intervention for individuals with SUD and severe co-occurring mental illness has the capacity to reduce rehospitalization rates ($N = 484$). Survival analysis results over a 3-year period indicate that peer-support program participants had longer periods living in the community without rehospitalization, and a lower overall number of rehospitalizations, compared to a sample of comparable controls not engaged in peer-mentorship.

# Case Study: Peer Support

You are a Community Health Worker evaluating the social needs of a patient.

**The patient is a 59-year-old woman with a history of Opioid Use Disorder (OUD) with x3 accidental overdoses since 2015. The patient has intermittently experienced homelessness since 2023.**

**How could this patient benefit from PRSS?**

**What other services should be implemented alongside PRSS?**

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# Translating to Practice

Similarly, Andreas et al. (2010) shared preliminary findings for the Peers Reach Out Supporting Peers to Embrace Recovery (PROSPER) program, which includes peer-run groups, coaching, workshops and seminars, social and recreational activities, and community events ($N = 509$). Peers work closely with program staff and receive extensive training and supervision. Study participants included women and men over the age of 18 who had SUD and histories of incarceration. From baseline to 12-month assessment the authors observed increases in self-efficacy, perceived social support, and quality of life, as well as decreases in perceived stress, though guilt- and shame-based emotions increased over the same period of time.

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## Translating to Practice

detoxification and/or agonist medication treatment. Peers approached individuals in urban areas identified as high-risk for continued opioid use and overdose, engaged them in a conversation about heroin, and explained they were recruiting for a study that aimed to help people get into treatment. If the individual expressed interest in the study, the peer outreach

# Case Study: Peer Support

## What is the role of PSRS in the following contexts:

1. Clinical setting (broadly)
2. Outpatient
3. Inpatient
4. Social-services)

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# Q & A Session

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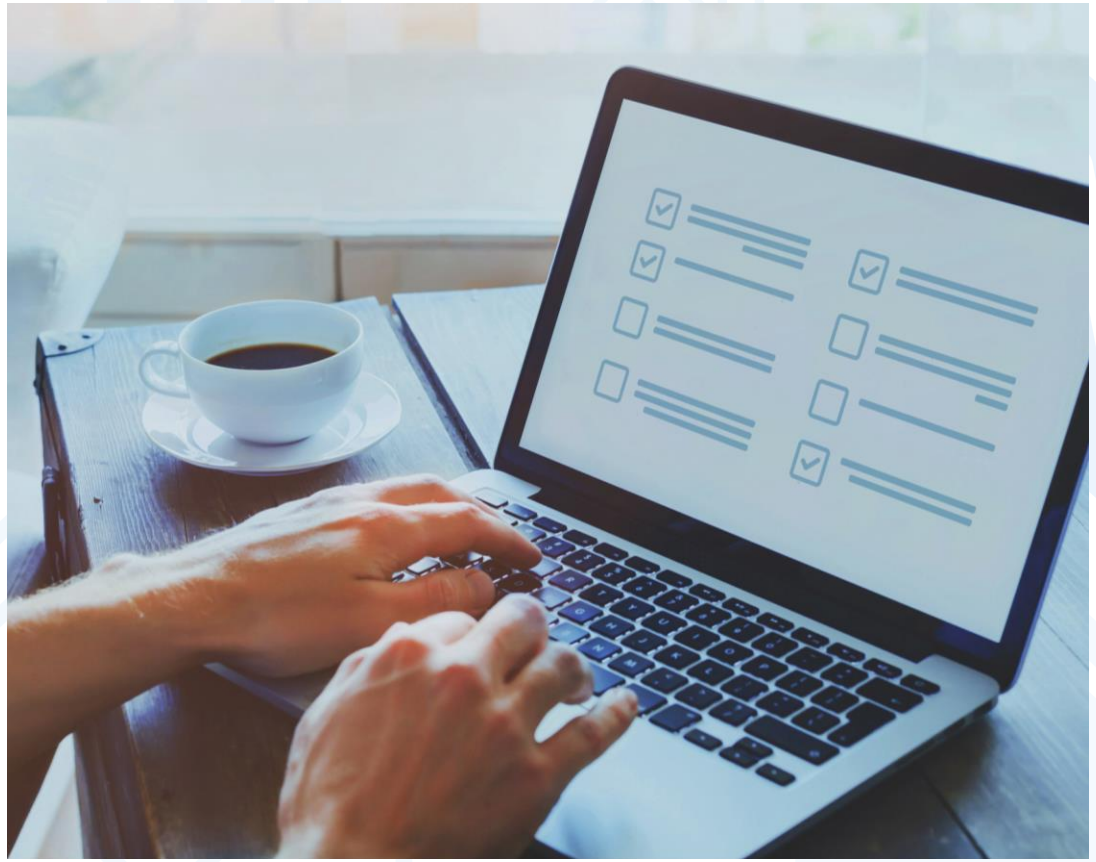

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# Upcoming Trainings

Session 3 02/17/2025 at 2:00 pm EDT

Session 4 02/24/2025 at 2:00 pm EDT

Use the same link to join.

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# Contact Us


**Robert Burns**
Program Director
Bobburns@namgt.com

**Jose Leon, M.D.**
Manager of Clinical Quality
jose.leon@namgt.com

**Kevin Lombardi, M.D., M.P.H.**
Manager of Policy, Research, and Health Promotion
Kevin.lombardi@namgt.com

**Fide Pineda Sandoval, C.H.E.S.**
Training and Technical Assistance Manager
Fide@namgt.com

**Chantel Murray, M.A.**
Manager of Communications
Cmoore@namgt.com

Please contact our team for Training and Technical Support
703-812-8822

**Olajumoke Oladipo, MPH**
Health Communications and Research Analyst
Olajumoke@namgt.com


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# Thank you!

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