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▶ Peer recovery support for individuals with substance use disorders: assessing the evidence.

Reif S., Braude L., Lyman R. et al.

Psychiatric Services: 2014, 65(7), p. 853–861.

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For such a widely implemented and widely supported adjunct to formal treatment, the revelation from this review is how little evidence there is for involving former problem substance users in promoting recovery from similar problems – a lack which may simply reflect the paucity of adequate research.

SUMMARY The "Assessing the Evidence Base" series of reviews was sponsored by the US government's Substance Abuse and Mental Health Services Administration to help inform decisions about which services should be included in public and commercially funded plans.

This last in the series covers peer recovery support services provided by people in recovery from substance use problems to those currently suffering those problems, a resource commonly deployed as part of the treatment of substance use disorders. The primary aim has been to support individuals as they make the life changes necessary to recover from substance use. Peer recovery support providers act as recovery and empowerment catalysts, guiding the recovery process and supporting the individual's goals and decisions.

In general, peer services offer emotional support, information, practical help, and social connection, relying on a common set of core activities that primarily involve education and coaching. Peer providers also commonly identify and help acquire resources clients may need to restructure their lives and further develop life skills, including liaison with formal treatment services or social services or assisting with linkage to medical care, employment support, human services, and other systems of care. More broadly, peer providers serve as advocates for the individual and the recovery community, conduct outreach, and act as role models.

Peer recovery support differs from professional counselling, formal treatment, or mutual-aid sponsorship. However, it may be conducted in parallel with other peer recovery activities or formal treatment, and peer providers may encourage additional recovery activities, such as participation in mutual aid groups.

The reviewers sought English-language research articles and reviews published between 1995 and 2012 which assessed the effectiveness of peer recovery support, including studies with less rigorous methodologies as well as trials which had randomly allocated clients to receive or not receive these services. Excluded were mutual-aid support groups, online peer support, services for smoking cessation, peer support for individuals with developmental disabilities, and studies that did not indicate whether recovery coaches were peers.

They found two randomised trials, four studies with non-randomly allocated comparison groups, and four studies without a comparison group which simply assessed the degree of improvement after the intervention.

Main findings

The two randomised trials found that peer recovery support was associated with positive substance use outcomes, or engagement with treatment which can be expected to lead to positive outcomes. Both from the USA, in one a peer-delivered, one-to-one, brief motivational intervention was offered to out-of-treatment cocaine and heroin users identified through screening at a medical centre. Six months later, compared to patients given only written information and advice, peer support led to fewer patients using those drugs. However, it was unclear whether the peer provider or the motivational approach was the key ingredient.

Conducted at an inpatient unit, another randomised trial recruited patients with significant histories of substance use (mainly alcohol) and psychiatric problems but a poor record of engaging with treatment. Peer recovery support was intended to promote treatment uptake on discharge. Compared to a professionally delivered intervention or treatment as usual, peer support did significantly enhance engagement in post-discharge outpatient treatment.

Of the four studies with non-randomly allocated comparison groups, just one reported outcomes directly related to recovery from substance use problems. It recruited patients who had recently been hospitalised and were suffering substance use and serious mental health problems which led to them being allocated to intensive case management services. Adding peer support to these services significantly delayed readmission to hospital, and meant that by the end of the three-year follow-up, 38% had remained out of hospital compared to 27% of the comparison group not offered peer support.

Remaining studies either had no comparison group or did, but the impact of peer recovery support could not be separated out, or could not reliably be assessed. In some studies too, the sample sizes were very small.

Across all these studies, peer recovery support services have been linked with successful outcomes and other measures, but in a fairly small and greatly varied body of literature. Three studies, including one randomised trial, found peer recovery support associated with improved substance use outcomes. Other associated improvements included rehospitalisation rates, drug use and medical severity, social support, self-efficacy, and quality of life. Several studies, including one randomised trial, found increased engagement in or completion of substance use treatment.

The authors' conclusions

There is some evidence that peer recovery support services can be effective, but it is difficult to reach a cross-cutting conclusion about its effectiveness.

The findings of two randomised trials and one non-randomised study were sufficient to meet minimum criteria for a moderate level of evidence of effectiveness. These and other studies found improved relationships with providers and social supports, increased satisfaction with the treatment experience overall, reduced rates of relapse, and increased retention in treatment.

It is clear that peer support services can provide a valuable way to help clients as they strive to achieve and maintain recovery. Peer providers serve as role models for a life in recovery, which in turn may motivate their clients to sustain their own recovery. They also fill a gap that frequently exists in formal and informal treatment services throughout the continuum of care, and provide a wide variety of non-treatment services that seem to be beneficial in the pathway to recovery and a healthy life in the community.

However, the literature up to 2012 is limited, and methodological weaknesses temper our ability to draw strong conclusions. These

include lack of appropriate comparison groups, lack of measurable outcomes, small samples, a wide variety of populations studied and intended outcomes, and an inability to disaggregate aspects of the peer recovery support service. Further, the varied populations, needs of the populations, and intended outcomes of the peer recovery support service programmes make it very difficult to draw cross-study conclusions. A greater emphasis on rigorous methods is essential to evaluate the effectiveness of peer recovery support.

FINDINGS COMMENTARY The revelation from this review is how little evidence there is for such a widely implemented and widely advocated (for example, in a review for the Scottish government) adjunct to formal treatment. That too was the conclusion of a review conducted by a prominent advocate of peer-based recovery. His findings should, said the reviewer, be considered probationary pending new studies of greater methodological sophistication.

However, the problem may simply be lack of research rather than lack of effectiveness. The research investment has generally gone elsewhere, leaving peer support services short of evidence of effectiveness and findings which could help develop practice standards. Important gaps in the research are studies which could help identify who makes a good peer mentor, and what benefits they derive from mentoring.

Even if peer support has not been shown to be an effective adjunct to treatment, there are other important reasons for considering it. Among these are its empowering philosophy and its potential to help overcome resource limitations (peer supporters may or may not be paid) and provide more extended care congruent with the recovery agenda. Not least too is the chance it gives peer supporters to become seen, and to see themselves, as assets to society and part of the solution rather than part of the problem, and to engage in structured volunteering or employment for which their addiction experience is seen as qualifying them, when they may have little chance of alternative employment. More broadly it is hoped that throwing a positive light on people who have experienced substance use problems and providing visible role models will help instil optimism and erode stigma, creating a more recovery-friendly environment.

One limitation of the review is its considering only relatively modern studies, but extending further back probably would not have altered the conclusions or the tentative way they had to be expressed. For example, predating its 1995 cut-off was a US study at an alcohol treatment clinic. It found trainee alcohol counsellors differed greatly in their record of retaining patients, but whether they had personal experience of alcoholism was not a significant factor.

Though it might have been excluded from the featured review as essentially a study related to mutual-aid groups, a related British study at a specialist inpatient detoxification unit found peer encouragement to attend mutual aid groups after discharge was more effective than encouragement by a doctor, and may have slightly improved abstinence outcomes, but neither to a statistically significant degree.

Thanks for their comments on this entry in draft to David Best of Sheffield Hallam University in England. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

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