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Peer Recovery Support Services Across the Continuum: In Community, Hospital, Corrections, and Treatment and Recovery Agency Settings – A narrative review

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Abstract

In this narrative review, we outline the literature describing the history, training, certification, and role of peer recovery support specialists working with people with substance use disorders at different stages of active use and recovery. We explore the impact of peer recovery support specialists serving people in various settings, including the community, hospitals and emergency departments, jails and prisons, and treatment and recovery agencies; and describes considerations for future expansion of peer recovery support services, including supervision needs, compassion fatigue and burnout, and scope of practice. Finally, we make recommendations to support the broad implementation of peer recovery support services as a sustainable, cohesive, and replicable component of harm reduction and addiction services. We also make recommendations for research to continue to evaluate peer recovery support specialist interventions across settings and outcomes.

Keywords

peer recovery support specialists; mentors; peers; substance use; recovery

Introduction

Peer recovery support services are supports provided across the service continuum by credentialed individuals in long-term recovery from alcohol or other drug-related problems.[1] Titles for people that provide peer recovery support services vary and include peer recovery

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support specialists, peers, peer providers, peer specialists, certified peer specialists, recovery coaches, and peer mentors.[2] In this review, we use the term peer recovery support specialist. The inclusion of peer recovery support specialists is gaining momentum in the United States.[3] Peer recovery support specialists work with clients in all stages of recovery, including consumers of harm reduction services.[4] Peer recovery support specialists can offer strong personal connections and earnest encouragement and hope. Their lived experience may make them more relatable than prescribing clinicians, other medical staff, social workers, and social service staff.[1] The dynamic of shared experience may help to overcome the inherent power differential between clinician and client.[5] Though more evidence is needed, early data suggest that peer recovery support programs may improve substance use and other recovery support outcomes.[6] Implementation challenges may be important to understand and address for successful integration of peer recovery support specialists, especially in healthcare settings. Specifically, the rigid professional structure of hospitals, stigma and discrimination towards people with use disorders, inconsistent staff assignments, and fast-paced work with high patient demand within healthcare settings may make the successful integration of peer recovery support specialists challenging.[7] The purpose of this narrative review is to describe the history of peer recovery support services; outline the types, trainings, and certification processes of peer recovery support specialists; and explore the impacts of peer recovery support specialists in various settings to better understand issues and recommendations for expanding and sustaining interdisciplinary peer recovery support services in addiction medicine.

History of Peer-Delivered Services

Disenfranchised communities have turned to peer-delivered services throughout history to support access to care and advocacy for appropriate treatment.[8] Peer-delivered services have integrated into health care and other community settings to support clinical staff and address individual needs for over 150 years. For example, use of peer-delivered support for persons with mental illness was first noted in the 18th century and gained momentum in inpatient settings throughout the mental health service user movement that began in the 1970s.[9]

Peer-delivered services that address substance use disorder (SUD) emerged through mutual aid entities in the 19th century and solidified a place in SUD approaches in the early 20th century through the establishment of 12-Step Programming.[10] The disability rights movement prompted a paradigm shift across marginalized populations by demanding decision making power in political, cultural, and personal arenas, led by the mantra “Nothing About Us Without Us”.[11] Peer recovery support services aligned with the disability rights movement, becoming a catalyst for empowerment, inclusivity, and social justice in SUD treatment.[12] The appeal of peer-delivered services to support SUD recovery is rooted in shared experience often characterized by despair, shame, and hopelessness.[1] Peer recovery support specialists are also called on to provide unconditional positive regard and support as determined by a person and their goals. The field of addiction medicine integrates SUD treatment across diverse healthcare settings, with peer recovery support specialists increasingly viewed as an essential part of interdisciplinary SUD treatment teams.

Types of Peer-Delivered Service Providers

Peer-delivered service providers are defined differently across communities and settings that use peer-delivered services. For example, Community Health Workers (CHWs; also called peer navigators, promotoras, natural helpers, doulas, lay health advisers, and frontline workers) are trained health care team members that live within the patient's community or share other social characteristics (e.g., language, race, ethnicity, culture) with patients. CHWs support patients as they navigate the health care systems, provide emotional support, and advocate for policy change.[13]

Like CHWs, peer recovery support specialists may also share geographic and social characteristics with the people they serve, but the key shared characteristic is lived experience with SUD.[1,3,12] Peer recovery support specialists' historic entrance into addiction treatment started with non-professional support roles within traditional community treatment programs.[1] Peer recovery support specialists now work in various settings, including community (e.g., syringe service programs, door-to-door outreach and ride-along with first responders), hospitals and emergency departments, jails and prisons, and treatment and recovery agencies.[6] Peer recovery support specialists across settings share the same primary responsibilities – provide hope, act as an ally and confidant, motivate, model behavior, offer honesty, support decision making, navigate resources, and advocate.

Peer Training and Certification

The initial impetus for peer certification was to meet Medicaid reimbursement requirements and create opportunities for access to other funding mechanisms. This led to most states creating certification policies with limited consideration for national standards or alignment with other states. Most states require peer recovery support specialists to obtain some level of certification. The eligibility requirements vary by state but typically include: 1) minimum amount of time in recovery, 2) passing a criminal background check, 3) completion of training courses, 4) passing a code of ethics review, 5) passing a national examination and 6) completion of continuing education and certification renewal at prescribed intervals. Some states have only one certification process, and others have more than one certification option, which may be led by government-affiliated entities.[14] The minimum amount of time in recovery and training hours varies by state, ranging from one to three years and 40 to 80 hours of training. Job titles also vary and jobs requiring differing tasks and responsibilities often have the same or interchangeable job titles.[2]

As of this publication, 27 states and the District of Columbia offer peer recovery certification adopted from the International Certification and Reciprocity Consortium (IC&RC), which allows limited reciprocity among member states.[14,15] After passing the IC&RC exam, state sanctioned certification boards provide certification and registry status. Certifications typically expire every two years and require continuing education hours and completion of a renewal application. Many states also require peer recovery support specialists to review and sign a code of ethics that outlines the appropriate code of conduct and defines conflicts of interest.

To support national certification recognition, the Association for Addiction Professionals (NAADAC) offers a Nationally Certified Peer Recovery Support Specialist (NCPRSS) certification. The NCPRSS requires a minimum of 2 years in continuous recovery, 200 hours of supervision in voluntary or paid direct peer work, completion of 60 continuing education credits, and passing the NCPRSS exam. Peer recovery support specialists become eligible for the NCPRSS Certification after being state-certified.[16]

IC&RC, NAADAC, and Mental Health America (MHA) used Developing a Curriculum (DACUM)-style approaches to develop the three psychometric exams for peer certification.[15–17] DACUM is the process of trained facilitators conducting expert worker focus groups to define occupations. The Substance Abuse and Mental Health Service Administration (SAMHSA) also used a DACUM-style approach as part of its Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) project to identify peer recovery support specialist competencies. SAMHSA's core competencies focus on connection to treatment and recovery,[18] which does not align with best practices of harm reduction peer recovery support specialists.

Peer recovery support specialist training differs widely in duration, format, and content by state and organization.[8,19] These differences create confusion about peer recovery support specialists' work scope and qualifications and may reduce acceptance of them as vital team members. Several states provide an online curriculum for peer recovery support specialist certification. SAMHSA and Health Resources and Services Administration (HRSA)'s Center for Integrated Health Solutions technical assistance website collates resources across states to guide robust curriculum development and implementation.

Beyond training and recovery milestone attainment, state and national certification entities require background checks with varying degree of granularity, even within the same state, and are often dictated based on the setting in which the peer recovery support specialist provides services. For example, a peer recovery support specialist working in a hospital or emergency room setting may have different background check requirements than a peer recovery support specialist working in a correctional facility. Peer recovery support specialists might have experienced incarceration or have had other past interactions with the criminal-legal system that human resources departments in healthcare and other settings must navigate to inform hiring decisions.

Peer Recovery Support Specialists Across Settings

Certified peer recovery support specialists provide services to people with alcohol and other substance use disorders across all stages of change. Peer recovery support specialists do not receive certification by setting but often engage in setting-specific trainings. Their role is driven by the model of care and the needs of the people receiving services in each setting.[20] Across settings, challenges to implementation arise, including unclear roles, limited financial support, inconsistent boundaries, philosophic differences between an organization and the peer model, and service area coverage.[1,7,21,22] As one systematic review described, implementation challenges occur across three levels: systemic, organizational, and individual. At the systemic level, challenges include policies that favor

punitive responses to drug use and the stigmatization of drug use, people who use drugs, and people who work with people who use drugs, which can negatively impact support and buy-in for implementing peer recovery support programs. At the organizational level challenges include exclusionary attitudes, policies, and programs; insufficient trainings for peer recovery support specialists; and lived experience not valued in decision making. At the individual level, challenges include fluctuations in availability in peer workforce due to arrest, return to use or fear of return to use, and competing financial interests.[23]

A diverse body of emerging qualitative, quantitative, and mixed-methods studies measure the impact of peer recovery support specialists' work on treatment efficacy and assesses the context and settings in which diverse peer recovery support services can be the most useful and transformative. While emerging findings are promising, few studies include control groups and several studies with control groups show no difference in outcomes among people who worked with peer recovery support specialists and those who did not.[24] Studies assess a range of domains related to people engaging in services, other professionals and health care providers working alongside them, peer recovery support specialists themselves, and systems of care. The following sections focus on defining the role and assessing the effect of peer recovery support specialists serving people within 1) community, 2) hospitals and emergency departments, 3) jails and prisons, and 4) treatment and recovery agencies.

Community

Peer recovery support specialists may use harm reduction, recovery- and person-centered orientation strategies in all settings. Community-based outreach peer recovery support specialists who serve people outside of the context of treatment or correctional settings rely on harm reduction approaches for people with active use to reduce risk of overdose, infectious diseases, and other harms of use. Examples include working within syringe service programs, conducting street outreach, or engaging in post-overdose outreach (sometimes in cooperation with first responders or public health staff) in the community. Peer recovery support specialists in the community might work with local service organizations to identify street outreach locations, visit the homes of people who agree to contact following emergency medical services, or facilitate mobile or fixed syringe exchange.[23,25,26]

Harm reduction peer recovery support specialists encourage positive change based on people's goals, which often focuses on safer use of substances and decrease in use, but may or may not include abstinence or linkage to treatment.[21] Peer recovery support specialists in community settings assist with people's daily life needs, such as accessing food, housing, identification documents, and health care. They may provide a variety of harm reduction services, such as naloxone education and distribution,[5] fentanyl education and testing strip distribution, access to and disposal of sterile syringes and other injection equipment, and HIV and hepatitis C testing, and linkage to care. Peer recovery support specialists grounded in a harm reduction lens may also engage in dynamic outreach to vulnerable communities (e.g., people experiencing homelessness).[27] Some harm reduction agencies have peer educators who use drugs to provide harm reduction education and tools, though they are not credentialed recovery support specialists.[23]

Preliminary studies exploring peer recovery support services in community settings demonstrate positive impacts. In one qualitative study, peer recovery support specialists in syringe service programs provided knowledge for reducing risky use behavior.[28] In two other qualitative studies, participants using supervised consumption facilities reported peer recovery support specialists make people feel safe, both physically (e.g., comfort and trust in case of an overdose) and socially (e.g., lack of perceived power differential)[5] and encourage communication with people related to SUD treatment and other social and health-related needs.[29] In a randomized control trial, peer recovery support specialists in harm reduction agencies increased access and engagement with HCV treatment.[30] People who use drugs (PWUD) express strong preferences for peer recovery support specialists over clinicians in medical settings due to prior negative healthcare experiences.[5]

Hospital and Emergency Departments

Peer recovery support specialists may be fully integrated or co-located in hospitals, emergency departments, or other health care settings where they connect people to medications for opioid use disorder (MOUD), intensive outpatient or residential SUD treatment, social services, or harm reduction resources. Peer recovery support specialists in health care settings are members of an interdisciplinary care team, available to provide support to people during treatment of medical and surgical complications of SUD (e.g., non-fatal overdose, car accident, serious bacterial infections). Peer recovery support specialists in health care settings use their lived experience and knowledge of SUD to translate information and provide context between health care providers and people with SUD,[31] which can be beneficial for both groups.[32]

Integrating peer recovery support specialists with medical treatment may help overcome historical mutual distrust between health care workers and people with SUD. For hospitalized patients, peer recovery support specialists may offer a trusted voice through a lens of lived experience at a time of heightened motivation for change, easing the stress of hospitalization and assisting the patient in articulating treatment goals.[33] Peer recovery support specialists can also relieve health care providers' stress by facilitating patient-provider communication, offering treatment insights beyond many providers' life experiences and professional training, and assisting with conflict de-escalation. Moreover, peer recovery support specialists can facilitate culture change within healthcare systems through knowledge sharing, modeling of less hierarchical patient interactions, and exemplifying that people with SUD can successfully maintain recovery and serve as valued treatment team members.[32] Peer recovery support specialists can thus change the way medical staff react to people with SUD, which has the potential to reduce stigma and mistrust across groups and address inherent power imbalances within the healthcare system.[31] Health care settings present unique challenges for integrating peer recovery support specialists, including the rigid professional structure of hospitals, stigma and discrimination towards people with use disorders, inconsistent staff assignments, fast-paced work with high patient demand, and intensity of caring for sick patients.[7] As a result of these challenges in healthcare settings, peer recovery support specialists may experience discomfort and discrimination and tension with healthcare staff, patients, and family

members, which can lead to stress and burnout that may impact and peer recovery support specialist's recovery goals. [7,31]

Emerging studies demonstrate promising outcomes for peer recovery support services following emergency medical services calls. In one exploratory program evaluation, PWUD receiving peer recovery support services in the emergency department had high levels of engagement with peer recovery support specialists following emergency department visits.[12] Another evaluation of peer recovery support specialists connecting with overdose survivors in emergency rooms, survivors reported high rates of engagement with peer recovery support specialists and engaged in overdose prevention education, naloxone training and distribution, and peer recovery counseling services in follow-up surveys.[25] A randomized pilot trial examining the impact of peer recovery support specialists follow up in the community after an overdose found that those assigned to peer services engaged in MOUD and received more days of treatment than a control group.[34] In another observational, retrospective cohort study, the median number of days to MOUD initiation following the emergency department event was shorter when a person interacted with a peer recovery support specialist than when they received treatment as usual from health care staff.[35] Patients in these settings describe peer recovery support specialists as trustworthy, making hospitals more tolerable for patients and rebuilding trust in the health care system. Peer recovery support specialists also report benefitting from gaining professional experience in a formal hospital environment.[31] Peer recovery support specialists can be successfully integrated in healthcare settings. However, successful integration may be impacted by many factors within the unique system which can lead to mixed results or results that suggest integration of peer recovery support specialists had no impact on patient outcomes.[7,24]

Jails and Prisons

Peer recovery support specialists serving people within and following release from jails and prisons have a unique responsibility to support community reentry and adherence to community corrections requirements. Release from incarceration can be overwhelming as people navigate housing and employment; reestablish relationships with children, family, and friends; and have more decision-making opportunities. Peer recovery support specialists in jails and prisons typically have personal experience with incarceration and use that experience to motivate and build rapport with people.[8] Specifically, they connect people to social services, link them to community treatment and recovery services, and help those on supervision meet community corrections requirements.[36] Peer recovery support specialists may conduct reach-in visits with people incarcerated close to release, during which they provide encouragement and plan for supports needed before and after release.[37] At release, peer recovery support specialists can be available to provide transportation to a parole or probation officer, housing, or to pick up food or clothing. They may also be used to facilitate entry into treatment post-release and support engagement in recovery services in the months following release from incarceration.[38]

A narrative review of interventions to support people with criminal-legal involvement rate peer recovery support specialist interventions as promising.[39] In one mixed methods study, those who work with peer recovery support specialists expressed satisfaction with the

support and increased predicted life satisfaction.[40] A randomized trial demonstrated that people recently released from prison matched with a peer health worker had decreased rates of emergency department utilization compared to people who received expedited primary care.[41] An administrative data analysis found receipt of peer support was associated with decreased substance use and recidivism.[42] In a mixed methods study evaluating a peer support program after release from incarceration, participants reported increased self-efficacy, perceived social support, positive relations with family and friends, improved quality of life, and decreased stress.[43]

Treatment and Recovery Agencies

Poor retention in treatment is a major barrier to long term recovery. Peer recovery support specialists within treatment and recovery agencies may help people stay engaged and motivated to achieve their treatment and recovery goals and connect to wraparound services that improve treatment retention. In some agencies, peer recovery support specialists are integrated within case management teams[8] and support planning for addressing non-clinical needs. In treatment and recovery agency settings, peer recovery support specialists draw on their own experiences to support people and share the additional benefit of making connections to other recovery communities, such as attending mutual-aid groups together.[20]

Recovery Community Centers (RCCs), also referred to as Recovery Community Organizations (RCOs), are a relatively new type of recovery organization that provides credentialed recovery services across the care continuum. Many RCCs are in areas of high need to reduce access barriers. RCCs have historical roots in the design of 12-step clubs and mental health living room community centers. RCCs typically offer peer recovery support services, MOUD support, mutual-help group meetings, and linkages to programs and services. Since RCCs have a more formal path to services built into their model,[44] peer recovery support specialists in these settings can provide wraparound support, including harm reduction services, while maintaining a distinct role outside the more prescribed model of treatment agencies.[4]

Two systematic reviews, which included studies using various methods including randomized control trials, quasi-experimental studies, and program evaluations examining peer recovery support specialists in treatment and recovery agencies demonstrated positive SUD outcomes, including decreased use and increased abstinence; recovery-related outcomes such as increased housing stability, number of primary care visits, and recovery capital domains; decreased hospital, emergency room, and detoxification utilization; decreased criminal charges; and reduced reports of anxiety and tension. While these findings are promising, it is important to note that the reviewed studies have several limitations, including lack of comparison groups, unclear reporting on the magnitude of the findings, inconsistent definitions of services, and heterogenous study populations.[6,22] Furthermore, this literature also includes studies that demonstrate no impact or negative impact of peer recovery support services and unclear effects because peer recovery support services are often a part of a multidimensional approach.[22]

Important Considerations

Many challenges may arise when attempting to implement peer recovery support services. To mitigate challenges, individuals and organizations should pay special attention to the following important considerations: formalized approaches to supervision, strategies for addressing compassion fatigue and burnout, sustainable reimbursement for services, adequate wages, and clear role definition.

Supervision

Appropriate and formal supervision of peer recovery support specialists is critical for supporting workforce expansion. However, supervision structures and the relationship between peer support staff and other treatment staff is infrequently discussed in the literature. Peer recovery support specialists may encounter many challenges in their work, including unclear roles, expectations, and boundaries; power imbalances; stress; maintenance of their own recovery; and difficult behaviors from people they serve.[27] Peer recovery support specialists may benefit from structured supervision with a focus on self-care and regular check-ins related to their own recovery needs.[31]

Current supervision for peer recovery support specialists is often insufficient.[23] In a national survey of mental health peer support specialists, 74% of participants reported less than 2 to 10 hours per month of training, supervision, or mentorship.[2] Supervision models vary, but successful program models describe frequent check-ins (e.g., weekly) with a supervisor to review caseloads and interactions.[43,45] Special focus should be on organizational readiness that includes commitment to regular recovery-oriented and trauma-informed supervision by knowledgeable supervisors with experience working with people in recovery.[8]

Compassion Fatigue and Burnout

Peer recovery support specialists provide direct services to vulnerable people while balancing their own recovery needs. The work of peer recovery support specialists can be demanding, especially during an overdose epidemic. Unaddressed emotional stress and vicarious trauma can lead to burnout.[46] Peer recovery support specialists may experience stigma and discrimination at work from co-workers, which can increase emotional distress and burnout.[2,19] Emotional stress, burnout, stigma, and discrimination need to be addressed at a systems level to support peer recovery support specialists in the workplace and fully integrate them as team members.[31]

Reimbursement for Peer Services

The Centers for Medicare & Medicaid Services (CMS) authorized states to bill Medicaid for peer provider services if a statewide training and certification process were established and peers received supervision by an appropriate mental health professional.[19] As of 2019, 38 states cover some level of peer support services in the context of a SUD or healthcare treatment episode for PWUD that are Medicaid beneficiaries.[47] However, interviews with state policymakers, directors of training and certification bodies, peer recovery support specialists, and other staff in mental health and substance use treatment and recovery organizations across four states, identified many challenges with CMS billing for peer

recovery support services.[19] Interviewees reported that a complex billing structure coupled with some peer recovery support specialists' lack of experience with technology and billing led to inaccurate reporting and financial penalties. Some peer recovery support specialists reported that the burden of CMS reporting hindered their relationships with people they were serving. Finally, CMS funding requirements of an initial clinical assessment and diagnosis do not fully align with recovery-centered approaches to care that resist diagnosis and labeling people as disordered, which has led some peer-run organizations to forgo CMS funding to avoid clinical supervision requirements that compromise their philosophies.[19]

Even in states with some CMS-covered peer recovery support services, funding for and billing of peer recovery support services can be complicated and may not fully cover all services provided by peer recovery support specialists. Critically, community-based peer support services outside the context of a SUD or healthcare treatment episode—such as those provided through community outreach or harm reduction services-- are typically not billable to CMS. Often, states and organizations fund peer recovery support services using complicated blended funding structures to support sustainability of services. Funding for peer recovery support services may come from SAMHSA grants (e.g., block grants) or state or federal drug court funds.[8] However, like CMS funding, there may be restrictions on what peer recovery support services can be covered.

Wages and Role Definition

On average, peer recovery support specialists report low wages (estimated mean hourly wage between $10 - $20 per hour) and many report part-time employment with limited opportunity for career advancement.[2,8,19] They may feel underappreciated due to low financial compensation to meet the job's high emotional strain and high demand to understand the complex needs of the people they serve.

Peer recovery support specialists also may need to navigate vague role definitions and frequent requests to take on responsibilities beyond their level of training. Peer recovery support specialists may be asked to serve as care managers and research assistants. In SUDs treatment settings, peer recovery support specialists can be asked to do more case management, group facilitation, and advocacy as funding decreases. As their role in healthcare systems expands, they are at risk of being viewed as less costly, non-union service providers to fill the role of hospital social workers and care managers. In addition, peer recovery support specialists may not fully understand expectations for communication about patient needs and interactions across roles within healthcare settings.

Recommendations

The peer recovery support specialist workforce is expanding due to high need and promising results. This narrative review suggests several steps to support the expansion of peer recovery support services, including training and certification standards across settings, supervision regulations, professional development opportunities, and ongoing advocacy. More rigorous evaluation of peer recovery support specialist interventions across settings and recommendation topics is also needed, including examining the level of effectiveness

of peer recovery support specialists across cultural, geographic, and socioeconomic backgrounds and effectiveness of peer recovery support specialists with active use.

Training and Certification Standards

Nationally defined peer recovery support specialist competencies, trainings, and certification exams should be promoted to encourage states to implement, train, and credential a robust workforce. A comprehensive federal competency analysis would help define scope of practice, roles, minimum certification standards, content for exams, and models of supervision. A federal competency TAP (Technical Assistance Publication) similar to TAP 21 for Addiction Counselors[48], would significantly support the direction of standards, trainings, and testing for peer recovery support specialists. Competencies defining peer recovery support specialist need to be developed in partnership with those in recovery to address concerns that national standards will not be recovery-centered or responsive to local differences.

Training and certification processes should be tailored by service setting to increase relevancy of information and impact of services. Even in states with the most robust training, certification, and oversight standards have gaps in relevant topic areas. For example, frequently overlooked topics in peer recovery support specialist certification curricula include MOUD, harm reduction, testing and treatment for infectious disease (e.g., Hepatitis C and HIV), use of de-stigmatizing language, setting boundaries, self-care, vicarious trauma, interfacing with the criminal-legal and healthcare systems and health and human services, pain science, and working with people with co-occurring diagnoses, including a SUD and chronic and persistent pain diagnoses and SUD and severe and persistent mental illness diagnoses.

Stringent background checks can limit job opportunities for peer recovery support specialists and reduce the potential workforce. Criminal background checks should include shorter look-back periods for minor offenses that might restrict an otherwise qualified peer recovery support specialist candidate from working. People from communities of color have disproportion rates of arrests, convictions, and incarcerations. Barring peer recovery support specialists with criminal records perpetuates lack of diversity in treatment settings.

Supervision Regulations

Given that some peer-run organizations forgo Medicaid funding to avoid CMS clinical supervision requirements that compromise their recovery-driven philosophies,[19] grounding formalized supervision models in recovery-centered approaches rather than billing-centered approaches is vital. Supervision models for peer recovery support specialists need to be recovery-oriented and comprehensive so peer recovery support specialists are supported and have opportunities to grow professionally and demonstrate their value. Like all burgeoning fields, strong supervision is important for molding the future of the work. The “Substance Use Disorder Peer Supervision Competencies”[49] provide a strong framework for organizations to follow. Access to Remote supervision using phone and video conferencing to provide continued support outside an office setting is encouraged.[50]

Professional Development Opportunities and Other Workplace Benefits

Professional development opportunities need to deliver content knowledge related to the complex needs of people with SUD, address topics to support the recovery needs of peer recovery support specialists, and provide context specific support to help peer recovery support specialists navigate complex systems (e.g., healthcare). Professional development opportunities need to also address compassion fatigue and self-care. Improved funding structures that include adequate benefits and full-time work are needed to encourage peer recovery support specialists to engage in self-care efforts (e.g., meditation, exercise) to decrease burnout and turnover.

Ongoing Advocacy

Ongoing advocacy is needed to continue nurturing the field and to address stigma and discrimination. Peer recovery support specialists are valuable, integral members of care teams and should not be treated as token colleagues with different professional standards. Standardized trainings, certifications, supervision, and professional development processes should not burden peer recovery support specialists. These structures should be designed to support people in recovery interested in helping others to develop and continuously improve competencies that match the passion and helper mentality of mutual-aid groups.

Conclusion

Peer recovery support specialists may have the ability, through their lived experiences and skills, to support marginalized populations with SUD in ways that complement the efforts of addiction medicine and other SUD treatment providers across diverse settings. As the field continues to expand and research grows, standardization and shared best practices, including ways to mitigate implementation challenges, can support the broad implementation and sustainability of peer recovery support services as a cohesive and replicable component of addiction-related services.

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