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Peer-Delivered Recovery Support Services for Addictions in the United States: A Systematic Review

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ABSTRACT

This systematic review identifies, appraises, and summarizes the evidence on the effectiveness of peer-delivered recovery support services for people in recovery from alcohol and drug addiction. Nine studies met criteria for inclusion in the review. They were assessed for quality and outcomes including substance use and recovery-related factors. Despite significant methodological limitations found in the included studies, the body of evidence suggests salutary effects on participants. Current limitations and recommendations for future research are discussed.

1. Introduction

Historically drug and alcohol addiction has been addressed through intense professional services during acute episodes. While effective in significantly reducing substance use, relapse rates are generally high (Project MATCH Research Group, 1998; Simpson, Joe, & Broome, 2002; Timko, Moos, Finney, & Lesar, 2000). This is not surprising as science suggests that addiction is a chronic condition for many (McLellan, Lewis, O'Brien, & Kleber, 2000). One of the hallmarks of chronic conditions is that they have no cure. However, remission can be attained and the symptoms arrested. Based on this science-based conceptualization of addiction, the Institute of Medicine and leading addiction researchers have called for a shift in the treatment of substance use disorders from the prevalent acute care model to a continuum of care model akin to that used in other chronic conditions (Humphreys & Tucker, 2002; Institute of Medicine, 2005; McLellan et al., 2000; White, Boyle, Loveland, & Corrington, 2005).

At the same time, the behavioral health field is moving toward recovery-oriented approaches to treatment and care for those with mental and substance use disorders. This approach is based on a holistic definition of recovery as a self-directed process of change through which individuals improve their health and wellbeing and strive to achieve their full potential (SAMHSA, 2011). Recovery-oriented approaches involve a multi-system, person-centered continuum of care where a comprehensive menu of coordinated services and supports is tailored to individuals' recovery stage, needs and chosen recovery pathway; the goal is to promote abstinence and a better quality of life (Clark, 2007, 2008).

As health care and in particular, addiction services, are adopting a recovery oriented, chronic care approach, there is a growing emphasis on formally incorporating various forms of peer support in the menu of addiction recovery support services. Peer-based recovery support services are defined as the process of giving and receiving nonprofessional, non-clinical assistance to achieve long-term recovery from substance use disorders. This support is provided by peers, also known as recovery coaches, who have lived experience and experiential knowledge (Borkman, 1999) to assist others in initiating and maintaining recovery and in enhancing the quality of personal and family life. Peer-based recovery support services are distinct from mutual aid modalities of peer support in several ways.

The former, peer-based recovery services, are delivered through formal structures and specialized roles (White, 2009) and aim to provide services across a range of domains that support an individual's recovery. These services are delivered in various forms (Laudet & Humphreys, 2013) including one-on-one services delivered by a peer recovery coach, group settings as implemented in recovery housing, and most recently, the growing numbers of collegiate recovery programs (CRPs) offered in academic settings (Laudet, Harris, Kimball, Winters & Moberg,

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2014). Furthermore, peer recovery coaches may work as volunteers or as paid service workers (Kaplan, 2008). They work in a range of settings, including recovery community centers where educational, advocacy, and sober social activities are organized, in churches and other faith-based institutions, recovery homes/sober housing, jails and prisons, probation and parole programs, drug courts, HIV/AIDS and other health and social service centers, and addiction and mental health treatment agencies (Faces & Voices of Recovery, 2010).

In contrast, mutual aid modalities of peer support are typically provided in the context of 12-step groups, such as Alcoholics Anonymous, the most well known form of peer support. Mutual aid is informal, does not require training, and is deeply rooted in bi-directional relationships of mutual support. Typically, mutual aid presents a single pathway for recovery as defined by the mutual aid group model. Although an important form of peer support, this review is focused on peer-based recovery support services and excludes the extensive literature on mutual aid modalities of peer support.

However, the literature synthesizing knowledge on the effectiveness of peer-based recovery support services for substance use recovery is limited. As peer-based recovery support services have been increasingly integrated into formal models of recovery support services, it is critical that we understand their effectiveness. An expert panel described the lack of a systematic knowledge base on peer (and other) recovery supports and concluded that it was imperative to develop a comprehensive evidence base (Faces and Voices of Recovery, 2010). The most recent literature (Reif et al., 2014) examined peer oriented recovery services for people with addictions and concluded that current knowledge supports the usefulness of this approach, but also noted that methodological weaknesses exist that preclude reaching definitive conclusions. This systematic review included U.S. and international studies (Reif et al., 2014). In contrast, our review focuses solely on U.S. studies, and unlike Reif et al.'s review (2014), we exclude cross-sectional correlational studies (studies based on a single time point). The current review both complements and extends the information in Reif et al.'s systematic review by including unpublished grey literature. We also follow a more rigorous design based on established PRISMA standards.

The purpose of this systematic review is to identify, appraise, and summarize the evidence of the effectiveness of peer-delivered recovery support services for individuals in recovery from addictions using strict scientific criteria. We conclude by presenting recommendations for future research.

2. Methods

Three electronic reference databases (PubMed, PsychInfo, and Web of Science) were searched using full-text, keywords, and Medical Subject Headings (MeSH)/Thesaurus headings terms. Search terms included the following: 1) peer involvement; 2) alcohol or drug addiction; 3) known types of peer led recovery interventions; and 4) the outcome of recovery (See Appendix A for full list of search terms). To locate other eligible articles not identified in the electronic database, such as technical reports and research not yet published, we contacted experts in the recovery and addiction fields, combed the websites of organizations known to conduct research in the field, and searched Google and Google Scholar. We also identified other peer-reviewed literature that was not indexed in the reference database search through reference lists of review articles. Our literature search followed the Centre for Reviews and Dissemination (CRD) guidelines (2009).

The systematic review included primary empirical quantitative studies published in English between 1998 and 2014. The start date for the search (1998) aligns with the year the Recovery Community Services Program was launched, marking a milestone for recognizing the importance of the role of peers in delivering recovery support services as an adjunct to treatment (Kaplan, Nugent, Baker, Clark & Veysey, 2010). Articles needed to investigate the effectiveness of peer-support interventions for addictions recovery while meeting study design and population, intervention, comparison, and outcome (PICO) criteria (Sackett, Richardson, Rosenberg, & Haynes, 1997). Quantitative studies (including mixed-methods) that used a randomized, experimental, quasi-experimental or controlled observational (e.g., cohort analytic, case–control, cohort, interrupted time series) design were eligible for inclusion; cross-sectional studies were excluded. Based on expert opinion on estimating treatment effect (Sim & Lewis, 2012) and preliminary review of the literature, studies conducted among samples of fewer than 50 participants were also excluded. Included studies focused on people in recovery from addiction from alcohol and/or drugs. Studies on tobacco or nicotine addiction were excluded, as were studies that focused on outcomes for peer support workers and volunteers. Any intervention delivered by peers, recovery coaches, or other peer recovery support providers to help people in recovery from addiction was included. Studies that focused on mutual aid models of peer support were excluded, as were studies of peer interventions aimed at facilitating participation in mutual aid groups. Interventions that did not include peer support and did not support recovery from addiction were excluded. Intervention types including telephone-based peer support, recovery programs, recovery centers, peer-run drop in centers, and access to recovery programs were included.

Studies were required to include a comparison group or multiple time points comparing the same group (i.e., single group cross sectional designs were excluded). Single site studies with no control group or comparison data were excluded. Study selection was guided by a holistic definition of recovery as a process of change through which individuals improve their health and well-being, live a self-directed life, and strive to achieve their full potential (SAMHSA, 2011). The primary outcome of interest was substance use. The secondary outcomes of interest were other recovery-related outcomes, such as housing status, health, mental health, criminal justice status, quality of life, and service utilization.

Articles that were primarily commentaries, discussions, editorials, policy analyses, or reviews were excluded, as were newspaper and magazine articles, and book chapters. Dissertations were excluded because of the difficulty of obtaining complete copies. Studies conducted before 1998 were excluded as were studies conducted outside of the United States. Studies that did not specify whether recovery coaches were peers were excluded.

The reporting of this systematic review conforms to recommendations from the Preferred Reporting Items for Systematic Reviews and Meta-Analyses statement (PRISMA) (Moher, Liberati, Tetzlaff, Altman, & The PRISMA Group, 2009) and the CRD Guidance for Undertaking Reviews (Centre for Reviews and Dissemination, 2009). The protocol of this systematic review has been registered with the PROSPERO register at CRD#42014007120.

3. Results

3.1. Literature Search Results

The reference database searches yielded 1,221 studies (see Fig. 1). Additionally, 39 studies not indexed in searched reference databases were identified in the grey literature, which included technical reports and unpublished manuscripts. After removing duplicates, the remaining 1,104 studies were screened for eligibility. One independent reviewer (EB) screened a random sample of 10.4 percent (N = 110) abstracts of all identified publications, using a pre-piloted form consisting of the eligibility criteria (described above). A second reviewer (NG) also screened the same sample. Given a 'very good' degree of concordance (kappa = 0.83, 95 percent CI: 0.72, 1.00) between the two reviewers' ratings, each reviewer then completed a review of half of the remaining abstracts (Altman, 1991). A total of 991 articles were excluded. Full texts of the remaining 113 potentially eligible articles (i.e., those passing the abstract/title level of screening) were retrieved and screened by three reviewers (N = 113) (EB, MR, NG) independently using the eligibility criteria. Nine were deemed to meet the inclusion criteria and are included in the review. Reasons for exclusion at the full-text level are described in Appendix B.