Measuring Outcomes of Peer Recovery Support Services

Literature Review

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Introduction

Purpose

The Virginia Department of Behavioral Health and Developmental Services (DBHDS) is committed to supporting implementation of effective recovery services for individuals experiencing mental health or substance use disorders. To fulfil this commitment, DBHDS is seeking to expand and enhance recovery services delivered by substance use and mental health peer recovery specialists ("peers"), as well as generate and implement more standardized, outcome-focused metrics for individuals receiving services from peers. Peers are individuals providing recovery services who have lived experience with substance use and/or mental health disorders and are in recovery (Myrick & del Vecchio, 2016). To guide this expansion and ensure effective peer recovery support services, a targeted review of the peer recovery services literature was conducted to provide:

- An overview of recovery and peer support within the field of behavioral health services;
- A current definition of peers and a description of the recovery support services they provide;
- A focused repository of salient substance use and mental health recovery outcomes associated with peer recovery support services;
- Suggestions for selecting measures/assessments of peer recovery support services-related outcomes; and
- Recommendations to guide peer recovery service provision, evaluation, and outcomes measurement.

Summary of Review

The literature on outcomes and effectiveness of peer recovery support services in mental health and substance use disorder systems is nascent but growing. There is a greater body of research about peers in the field of mental health than in substance use. Generally, there is a lack of uniformity in the definitions of peers in the literature (O'Hagan, Cyr, McKee & Priest, 2010). There is also high variability and ambiguity about the roles that peers play and the scope of services they provide (Rogers, Kash-MacDonald & Brucker, 2009). Furthermore, measuring recovery tends to include such a wide variety of outcomes (e.g., symptom abstinence, sense of well-being, quality of life, social engagement, evidence of employment or enrollment in education, level of justice-system involvement, etc.) that there is lack of consensus among recovery scholars, administrators, and practitioners about what outcomes are the most salient to measuring both recovery and the efficacy of peers in supporting recovery efforts (Blash, Chan & Chapman, 2015). Despite the variance in definition and conceptualization, research supports the efficacy of peers across roles, settings, and implementations. **This review aims to take the next step of identifying a cohesive and appropriate set of recovery outcomes that will broaden and solidify the promising base of literature.**

This literature review begins by situating the peer role into the context of recovery from mental health and substance use disorders by briefly describing the history of the advancement of peers in recovery fields. This context is followed by a more in-depth look at (1) how peers are defined by the literature, (2) the specifics of their role and fundamentals underlying their practice, and (3)

considerations regarding the standardization of peers. The review then outlines common recovery outcomes typically measured for consumers with mental health or substance use disorders who receive peer recovery support services. The outcomes reviewed were categorized into two overarching domains. The review also briefly describes considerations for families and peers who deliver services, and stigma regarding disorders. Finally, recommendations of instruments used to measure recovery outcomes are provided.

Methods

This review synthesizes findings from expert-refereed health journals; national, state, or otherwise accredited peer recovery organizations; and from organizations outside of the traditional commercial or academic publishing channels (i.e., grey literature). Information related to substance use and mental health recovery was narrowed by including peer recovery-related search terms; the most recently published articles were prioritized for synthesis and generally articles were considered if they had been published within the last ten years.

The review also includes a comparison of peer-specific recovery outcome measurement tools and/or assessments. An initial scan of the literature identified peer-specific instruments commonly used within both mental health and substance use fields and the recovery outcomes measured by their constructs. Instruments were appraised on the quality of their psychometric properties (i.e., validity and reliability), whether the measures were applicable to recovery within both mental health and substance use fields, language clarity and literacy level of the measure, and approximate length of time to complete the measurement tool or assessment.

Terminology

In order to convey information succinctly, the terms "peer" and "consumer" are used throughout this review. "Peer" refers to individuals with lived experience who deliver recovery services; "consumer" refers to individuals who receive those services from a peer. Additionally, in order to subvert the effects of stigma, individuals should not be definitively characterized by the mental health and/or substance use disorders they are experiencing (APA, 2020) but rather recognized as whole, multi-faceted individuals (Yanos et al., 2010). Therefore, this review uses person-first (e.g., a person living with a substance use disorder) versus disorder-first language (e.g., a substance abuser or drug addict) to communicate that people are not defined by their disease (White House Office of National Drug Control Policy, 2016). Nonetheless, disorder-first terms were often found to be used in both the mental health and substance use disorder literatures.

Overview of Recovery & Peer Support within Substance Use & Mental Health Disorders

Substance use and mental health disorders have been described by health professionals, national health agencies, and researchers as chronic conditions that require long-term approaches to treatment and ongoing maintenance of recovery, (McLellan, 2002; McKay, 2005). However, historical models of care for these disorders focus on primary, short-term treatment models, such as medication, symptom reduction, and inpatient clinical settings (Hebert et al., 2008). Typically, the goals of these primary models are to reduce hospitalizations and costs to consumers and providers (Davidson & White, 2007). Additionally, structural limitations such as downsizing and frequent changes in funding sources have resulted in the provision of short-lived, acute care (White, Boyle & Loveland, 2002). The fundamental and structural mismatches between the nature of disorders and type of intervention result in ineffective care, poor treatment and recovery outcomes, premature discharges, or the unintended diversion of consumers into inappropriate care, such as the criminal justice system (Hartwell, 2004; Amering & Schmolke, 2009; Zipursky & Agid, 2015).

Additionally, traditional treatment services tend to emphasize the treatment provider's diagnosis and downplay the social, historical, and environmental factors affecting the consumer (Rufer, 2007; Carlat, 2010). The result is a characteristic imbalance of power whereby knowledge and agency in treatment is perceived to reside with the service provider and not with the consumer (Rufer, 2007; Deegan, 2007). Furthermore, a focus on symptoms and diagnosis can cause consumers to adopt a perception that the disorder they have been diagnosed with defines their identity and existence, leading to decreased hope and self-esteem, which may interfere with treatment (Yanos et al., 2010).

In the last two decades, national mandates and service provider communities have supported the adoption of a recovery orientation (New Freedom Commission on Mental Health, 2003; Davidson et al., 2005). The Substance Abuse and Mental Health Services Administration's (SAMHSA) working definition of recovery as, "a process of self-directed change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential" (SAMHSA, 2012), has been widely accepted among researchers and practitioners. However, some aspects of recovery complicate defining its essential characteristics, rendering the concept of recovery more difficult to measure. For example, recovery processes emphasize and give meaning to the subjective experiences of individuals in recovery (White, 2007; Temesgen, Chien & Bressington, 2019). While recovery may be conceptualized differently by professional, paraprofessional, and peer service providers (El-Guebaly, 2012), **shared core values of the recovery model include self-determination, empowerment or choice, community integration, hope, strengths, self-help, and self-efficacy** (Onken et al., 2002). Each of these values have emerged as a remedy to the shortcomings of traditional treatment-focused services for individuals experiencing mental health and substance use disorders.

Recovery Model Core Values

- Self-determination
- Empowerment or choice
- Community integration
- Hope
- Strengths
- Self-help
- Self-efficacy

Peer Recovery Support in Substance Use & Mental Health Fields

In both the mental health and substance use health arenas, peers are highly adaptable and have the potential to make contributions to consumers' recovery (SAMHSA, 2020b). This section provides a general overview of the way peers typically engage with and support consumers with substance use disorder, mental health challenges, or who encounter co-occurring disorders.

Substance Use Disorders

Substance use disorders span a range of progressive physiological and behavioral conditions associated with ongoing use of alcohol, tobacco, or illicit drugs. Consequences of experiencing a substance use disorder include impairments such as health problems or disabilities; failures to meet major responsibilities at work, school, or home; and/or financial or legal troubles (SAMHSA, 2020a). Being in recovery from a substance use disorder involves voluntarily adopting positive lifestyle changes and values that contribute to health and social functioning, and mitigating substance use and associated symptoms (NIDA, 2020). The process of recovery reflects the chronic nature of substance use disorders. Instead of focusing on remaining abstinent, recovery practitioners and individuals in recovery focus on symptom management and living a productive or meaningful life (Laudet, 2007). Examples of recovery-oriented treatment for individuals experiencing a substance use disorder include long-term outpatient care, recovery housing, mutual aid groups (e.g. 12 step), as well as peer support models.

In the substance use arena, peers engage in giving and receiving non-clinical recovery assistance to achieve long-term recovery from substance use disorder (Laudet & Humphreys, 2013). **Through sharing their experiential knowledge, peers support consumers in initiating and maintaining recovery and enhancing the quality of their personal, family, and social lives** (White, 2009). Substance use services have progressively shifted towards recovery-oriented systems of care and, as a result, peers and peer recovery services have been incorporated into various forms of support that are tailored to consumers' recovery stages, needs, and goals (Clark, 2008).

Mental Health Disorders

Mental health disorders encompass a wide range of cognitive, behavioral, and mood disorders that interfere with a person's ability to function in their daily life, maintain positive relationships with others, or cope with routine daily activities (Kessler, Chiu, Demler, & Walters, 2005). The consequences of mental health disorders are significant, impacting the diagnosed individual (e.g., decreased quality of life and social problems) as well as the communities that surround them (e.g., lowered productivity, increased poverty, and potential justice systems involvement) (Lund et al., 2011). Mental health recovery involves healthy development in essential life domains, such as housing, social relationships, and employment (Drake & Whitley, 2014), making autonomy and choice in care essential (Slade et al., 2014).

Peers in mental health settings act as recovery role models to help consumers engage with and develop personal recovery plans designed to promote hope, empowerment, personal responsibility, and social inclusion (Repper & Carter, 2011). Peers support consumers with skill building activities and case management based on consumer-driven goals.

Specifically, peers aid in the development of independence and autonomy (Ochocka, Nelson, Janzen & Trainor, 2006). Eiken and Campbell (2008) identified three activities typically performed by peers in the mental health field, which may overlap in practice: (1) providing education on the development of coping and problem-solving strategies to facilitate a consumer's self-management of their experience with a disorder; (2) serving as part of an interdisciplinary care team; and (3) offering traditional activities such as case management or referral to various support services.

Co-Occurring Disorders

Significant relationships exist between mental health and substance use disorders (Drake, Mueser, Brunette & McHugo, 2004; Flynn & Brown, 2008). According to SAMHSA, individuals who experience at least one mental health disorder and at least one substance use disorder simultaneously are considered as meeting the criteria for experiencing a co-occurring disorder (SAMHSA, 2005). **Those experiencing co-occurring disorders are at risk for more complicated physical, psychological, and social consequences than those with a single diagnosis.** For example, symptomatology for one disorder can dilute or exacerbate that of another (Carter, Fisher & Isaac, 2013), and rates of relapse are higher for individuals experiencing co-occurring disorders (Schmidt, Hesse & Lykke, 2011).

Barriers to successfully accessing treatment are also more salient for these individuals, such as non-participation due to perceived stigma (Powell, Kurtz, Garvin & Hill, 1996), and likelihood of being incarcerated, homeless, or otherwise separated from society (Drake et al, 1991). Thus, peer approaches in recovery services may be of considerable benefit for individuals experiencing co-occurring disorders, as they supplement traditional or professional service delivery modes (Carter, Fisher & Isaac, 2013).

Overview of Peer Recovery Support Services

Definitions

As with the definition of recovery, the concepts of peers and the services they provide can have varied definitions and terminologies (Davidson, Bellamy, Guy & Miller, 2012). The use of a single term for peer has been viewed as problematic by some, concerned that the term 'peer' may become an identity or one-word label, like consumer, client, or patient (Faulkner & Kalathil, 2012). Some argue that the term 'peer' refers to any person or group with whom one can relate based on some shared experience, irrespective of any training the individual has had to provide recovery support sessions. In this review, the term **'peer' refers to trained persons providing recovery services who have lived experienced with a substance use and/or mental health disorder and are currently in recovery** (Myrick & del Vecchio, 2016). Other terms for peers and the services they provide may include:

Terms for peers	Terms for peer recovery support services
• Peer coaches • Peer workers • Peer specialists • Peer recovery specialists • Forensic support specialists • Counselors with lived experience • Recovery friends • Peer Bridger • Experts by experience	• Consumer-run services • Peer support services • Peer-based services • Peer-led services • Peer-run support • Peer-to-peer support • Peer-centered care • Peer participatory processes

Peer recovery support services are distinguished from professional treatment and mutual aid societies (White, 2009). Professional substance use or mental health treatment services are provided by individuals with formal training in a clinical setting. Mutual aid societies (e.g., Alcoholics Anonymous) are communities connected by a particular recovery fellowship with its own beliefs and practices (White, 2009). Peers are credentialed to support consumer recovery based on their own lived experience rather than formal training and education (Davidson et al., 1999). Though they also receive training and certification, peers' expertise primarily lies in their experience living with a disorder, receiving treatment, and engaging in the recovery process. In this way peers are the personification of the values underlying the recovery-orientation.

The Mechanisms of Peer Support

One-to-one peer support relationships are associated with mutually positive benefits to both consumers and the peer delivering services (Repper & Carter, 2011). **Generally, the peer support approach assumes that people who have similar experiences can better relate to, and effectively establish rapport with, consumers. Consequently, this may offer more authentic empathy and validation in the support relationship** (Mead & MacNeil, 2006). Peer support may also enhance consumer engagement and retention in services. Through modeling of

behaviors (Bandura, 2001), peers serve as an example for consumers so they can envision their own recovery success and develop a sense of hope (Davidson et al., 2012). Consumers can also make realistic comparisons between themselves and peers on recovery behaviors, providing frames of reference for their own recovery goals and progress (Mead & Filson, 2017). Solomon (2004) identified other theoretical mechanisms in which peers and peer support services aid consumers in their recovery such as social support (Sarason et al., 1983), experiential knowledge transfer (Borkman, 1990), and creating self-efficacy to combat stigma (Moran et al., 2012).

Peer Competencies

In 2007, the Centers for Medicare and Medicaid Services specified that peers who provide services funded by Medicaid must complete training and certification as defined by the state in which they are delivered (CMS, 2007). While not all peer recovery support services are billed to Medicaid, most states require peers to complete a training and certification program before providing recovery support services to consumers. Due to the various settings, tasks, job titles, and services provided at the state level, training and certifications vary across and sometimes within states, and there are multiple national certifications for peer recovery support services that are accepted to different extents by each state (Cronise, Teixeira, Rogers & Harrington, 2016). Generally, the treatment and recovery fields are moving toward developing more clearly defined roles and responsibilities for peers offering recovery support services. In 2015, SAMHSA identified core competencies for peer support workers in behavioral health (SAMHSA, 2018), though states can vary in the ways and extent these competencies are integrated into peer training and/or certification.

SAMHSA Core Competencies for Peer Workers

Engages peers (i.e., consumers) in collaborative and caring relationships

Provides Support

Shares lived experiences of recovery

Personalizes peer support

Supports recovery planning

Links to resources, services, and supports

Provides information about skills related to health, wellness, and recovery

Helps peers (i.e., consumers) to manage crises

Values communication

Supports collaboration and teamwork

Promotes leadership and advocacy

Promotes growth and development

Peer Support Structure within the Workforce

There is also significant variation in the way peers provide recovery support services to consumers. Peers may be paid employees or volunteers, and their services may be implemented at various stages of treatment delivery (Solomon, 2004). Peers may serve as counselors, educators, advocates, or general supporters to help and empower persons in recovery meet the needs of daily living (Gates &

Akabas, 2007). Peers' working relationships with treatment providers generally fall into one of following three models (Hebert et al., 2008):

- **Peer-run or operated services:** Treatment or recovery services that are planned, administered, and evaluated by persons with lived experience with disorders. Examples: mutual support groups, drop-in centers, crisis services, mentorship, and education.
- **Peer partnerships:** Services that are delivered by peers but managed wholly or in part by clinical treatment staff. Peer partnerships are programs that are not free-standing legal entities, and the fiduciary responsibility lies with the non-peer organization.
- **Peer employees:** Individuals who identify as having mental illness who are hired into unique peer positions or who are employed to serve traditional mental health positions. Examples: peer counselors, peer support specialists, peer volunteers.

This review focuses on the peer employee model which most often refers to peer roles such as "peer support specialist," "certified peer specialist," or "certified peer support specialist" (Salzer, 2010).

Efficacy & Stigma in the Peer Support Role

Efficacy of Peer Support

Most published studies generally indicate that the implementation of peers provides positive outcomes for consumers of mental health and substance use recovery services (Reif et al., 2014). In early efficacy studies findings regularly showed, with moderate strength, that there were **no differences in the effectiveness of achieving consumer outcomes when delivered by peers compared to when delivered by clinical staff** (White, 2009; Chinman et al., 2014; Rowe et al., 2007, SAMHSA, 2011). The efficacy of peers in promoting positive recovery outcomes is noted in studies that use a variety of research methodologies, including randomized controlled trials (Tracy, Burton, Nich & Rounsaville, 2011); quasi-experimental studies (Min, Whitecraft, Rothbard & Salzer, 2007); qualitative studies (Moran, Russinova, Gidugu & Gagne, 2013); meta-analyses (Lloyd-Evans et al., 2014); ethnographic studies (Austin, Ramakrishnan & Hopper, 2014); and landscape analyses (Blash, Chan & Chapman, 2015).

Across several types of peer recovery support service delivery, Chinman and colleagues (2014) found peer recovery support services to be consistently effective at improving such outcomes as:

- ↓ Reduced inpatient service use
- ↑ Improved consumer relationships with providers
- ↑ Better consumer engagement with care
- ↑ Higher levels of consumer empowerment
- ↑ Higher levels of consumer activation (willingness/ability to independently manage their health and care)
- ↑ Higher levels of consumer hopefulness for recovery

While most of the literature endorses the benefits and efficacy of peer recovery services, some scholars and practitioners are circumspect about utilizing peers to support treatment and recovery efforts. Multiple studies challenge the methodological rigor of other studies concluding the efficacy of peer recovery support services, stating they lacked appropriate comparison groups or outcomes, did not randomize consumers to peer or comparison services, and had insufficient sample sizes (Reif et al., 2014). There are also anecdotal concerns around the implementation of peers precisely because of their lived experience with mental health and/or substance use histories and lack of traditional clinical education (Brown et al., 2014; Chinman et al., 2008). Many of these concerns have been characterized as misconceptions or myths borne out of stigma and are not supported by the peer services efficacy literature, however some peer services efficacy studies may be prone to methodological bias in the interpretation of outcomes (Pitt et al., 2013).

Navigating Stigma

Stigma involves implicit and explicit beliefs and stereotypes that can lead to prejudice and discrimination against those in recovery from substance use or mental health disorders. Stigma can be held by the public towards people in recovery or can be internalized by those in recovery themselves (Corrigan, 2006). Stigma can negatively affect the motivation, relationships, and treatment engagement of those who are in recovery (Corrigan, Larson & Ruesch, 2009).

Furthermore, stigma can negatively affect one's self-image in ways that are more harmful than the disorder one is experiencing (Livingston & Boyd, 2010). Peers themselves encounter stigma in their role as service providers with lived experience of a disorder.

Although research supports the efficacy of the peer role in supporting individuals experiencing behavioral health challenges, stigma manifests in nuanced, yet critical, ways for both consumers and for peers. Social stigma, prejudice, and discrimination are significant barriers to access, engagement, and success with treatment and recovery, especially for individuals experiencing mental health and substance use disorders (Barry, McGinty, Pescosolido, & Goldman, 2014). Clinical care providers themselves may perpetuate stigma (Kelly & Westerhoff, 2010) by reinforcing traditional consumer-provider hierarchies (Henderson et al., 2014) and the "illness-identity" paradigm (Yanos et al., 2010).

Recovery orientations in mental health and substance use disorder services are fundamentally based on respect, empowerment, and support relationships with social networks and communities (Jensen & Wadkins, 2007). Peer support services are a promising method of reducing barriers to mental health recovery due to stigma (Repper & Carter, 2011). Peers challenge stigma that recovery consumers experience through disclosure about problems related to experiencing disorders, thereby undermining the shame implicated in the internalization of stigma (Faulkner & Basset, 2012). Peers can also help consumers gain insight and develop ideas for action to address problems related to stigma through sharing their experiences, general support, and rehearsing various ways to handle their stigma encounters (Corrigan et al., 2016). More generally, **peer contact plays an important role in the maintenance or regaining of positive self-preceptions for persons in recovery (e.g. self-esteem and social inclusion), which can counter the effects of stigma** (Verhaeghe, Bracke & Bruynooghe, 2008; Krawczyk et al., 2018).

Though peers may help challenge stigma and barriers for the consumers they support, peers also encounter stigma themselves. Some fear that peers are more prone to relapse regarding disorder symptoms, which may threaten their ability to perform in an employment setting (Brown et al., 2014; Chinman et al., 2008). There has also been concern expressed that peers may cause harm to consumers as a result of their lack of professional education (Morris, Banning, Mumby & Morris, 2015). On the whole, the adverse outcomes associated with peer services that are documented affect the peers themselves rather than the consumers of their services. **As a function of their non-traditional role in service agencies, peers may encounter challenges due to not feeling accepted by other clinicians, differential treatment due to their peer status, or added stress** (Salzer, 2002; Moll, Holmes, Geronimo & Sherman, 2009). Peer service teams have been found to have high turnover and absenteeism (Paulson et al., 1999). Taking into account the effects of systemic and/or organizational stigma, these findings may be attributed to stigma and discrimination peers experience in work settings rather than characteristics of peers themselves.

Standardization of the Peer Role & Services

Standardizing peer recovery support services across various types of programs, organizations, agencies, consumers, and peer roles (i.e., identification or development of a main set of values and/or principles in order to guide how peers should operate) presents numerous challenges. First, there are many pathways to recovery (Davidson & White, 2007). Each consumer's experience with their disorder and their biological, psychological, and social characteristics make recovery goals and the process itself highly individualized (Temesgen, Chien & Bressington, 2019). Second, **many of the most valuable aspects of peer recovery support services are the same features that interfere with standardization.** For example, the central aspect of peer services is the peer's lived experience, which further individualizes the content and methods of their services. Some scholars argue that standardization should be treated with caution, as it may send the message that peer support is something that can be definitively mastered, rather than practices evolving organically from peers' experiential knowledge (Gillard et al., 2017; McCranie, 2010).

As with scholars concerns over formalizing the peer role and "over-professionalizing" the natural and spontaneous peer relationship process (Faulkner & Kalathil, 2012), there are also risks in not formalizing the role. Peers employed in large bureaucratic organizations who have an indistinct definition of their role are at risk for exploitation in their work. Standardization elements such as job descriptions, competencies, and measured outcomes provide safeguards as well as risks (Repper et al., 2013).

Despite such challenges to standardization, scholars and practitioners have nonetheless documented many outcomes related to peer recovery services, both for consumers of services and for peers themselves. A goal of this review is to provide recommendations for measurable outcomes for peer recovery services. In the following sections, such outcomes are categorized, defined, and descriptions of how peers facilitate these outcomes are provided.

A review of the literature confirmed that there is inherent variability in how peer-facilitated recovery outcomes are measured (Whitley & Drake, 2010; Blash, Chan & Chapman, 2015). Recovery processes may affect all aspects of an individual (e.g., biological, psychological, social), but as with all outcome measurement, it is not feasible to address all aspects of recovery. A realistic balance must be reached to identify the most important areas to focus on. Recommendations for standardization, measurement, and their feasibility are also ultimately contingent on the varying characteristics of organizations and communities in which peer recovery support services are implemented (Carlson, Rapp & McDiarmid, 2001). This may be especially true for organizations such as Virginia's community services boards, that address unique community needs, have different organizational goals and missions, and vary in their capacity to implement peer recovery support services.

Peer-Specific Recovery Outcomes

Outcomes traditionally valued in the U.S. mental health and substance use systems are those related to reduction of symptoms and improvement in functioning. These outcomes are ultimately compatible with recovery, but models of recovery as an outcome challenge those which focus heavily on symptoms and functioning (Corrigan et al., 2004). Recovery is not just the absence of symptoms (Roberts & Boardman, 2013); it has been conceptualized as the achievement of outcomes across several health dimensions or domains (Whitley & Drake, 2010). The holistic nature of recovery outcomes, and the fact that substance use and mental health disorders impact nearly all aspects of individuals' lives, have led scholars and health researchers to varying conclusions on which domains should receive the most attention and focus (Whitley & Drake, 2010). For example, some practitioners assert the importance of clinical and physical health domains (e.g., reduction of symptoms; Davidson & Roe, 2007), while others argue that quality of life domains are more essential to, and representative of, the concept recovery (e.g., empowerment, self-direction; SAMHSA, 2009a).

This section offers a set of key outcomes associated with peer recovery support services categorized within broad recovery domains. **Most consumer outcomes associated with peer recovery support services involve the development of skills and abilities that facilitate consumer recovery.** In general, these outcomes are placed into one of three recovery domains: cognitive, clinical, and social. This review focused on the most salient *peer-specific* recovery domains for consumers receiving peer recovery support services, which were categorized as 1) personal skill building and 2) community skill building.

Domain: Personal Skill Building

Outcomes in the Personal Skill Building domain address internal perspectives and practices that individuals can learn and cultivate to support their recovery process. This domain spans cognitive, emotional, and behavioral aspects of recovery. The six outcomes covered in this section include:

Outcome: Relapse Resiliency

What is it? Within the field of substance use disorder, a relapse is generally well-known as when an abstinent individual returns to using substances (SAMHSA, 2004). In the area of mental health disorders, a relapse indicates that a person's symptoms have returned, and their functioning is decreased, often to the point where hospitalization or more intensive treatment is required (NIH, 2007). **Relapse is a normal part of recovery; thus, *relapse resiliency* focuses on the re-establishment of healthy coping mechanisms after relapse has occurred** (Harris, Smock & Tabor Wilkes, 2011).

Why is it important to recovery? Recovery means more than just individuals maintaining sobriety, or an absence of disorder symptoms (Laudet, 2007; Whitley & Drake, 2010). However, returning to substance use or a return of mental health symptoms are significant factors for individuals in their process of recovery (NIH, 2007). Relapse is conceptualized differently in recovery and treatment. In treatment, a primary goal is to prevent consumers from relapsing altogether, whereas in recovery consumer relapse is considered a normative experience (Volkow, 2011; White & Kurtz, 2006). The process of recovery can involve the increased presence of physiological and/or psychological stressors which can trigger relapse (Brady & Sonne, 1999). The coping skills developed as a result of building relapse resiliency can aid in reducing such stressors, thereby mitigating circumstances contributing to relapse.

How are peers associated with this outcome? The presence of at least one caring and supportive relationship is an important factor in fostering recovery resilience (Masten, 2001). By definition, the peer role embodies the spirit of resiliency. In addition to educating consumers on skills to prevent or recover from relapse and connecting them to resources (Hebert et al., 2008), peer-consumer relationships promote the use of healthy coping skills to overcome trauma and stress that lead to relapse (Harris, Smock & Tabor Wilkes, 2011). Peers' knowledge of and experience with the stages of the recovery process may also help

consumers engage in self-monitoring to recognize where and when relapse is likely to occur (White, Boyle & Loveland, 2004). Additionally, peer demonstration and modeling of skills especially emphasize that resiliency is attainable in recovery.

Outcome: Beliefs and Values Essential to Recovery

What is it? Individuals' beliefs, assumptions, and perceptions essential to recovery are influenced by community and cultural norms, as well as by the recovery services they receive (SAMHSA, 2012). Some view the values of individual choice and personal responsibility as essential to recovery (Gottstein, 2003; Craig, 2008), whereas others emphasize that recovery is more heavily influenced by social and external circumstances (Slade, 2012). Regardless, **it is important to consider how individual beliefs and values inform and guide behavior** (Fazio, 1986), including participation in the recovery process (Boisvert, 2008).

Why is it important to recovery? Embarking on a journey of recovery involves a comprehensive change in nearly all aspects of one's life (Lapsley, Nikora & Black, 2002), which can necessitate adopting and practicing new underlying beliefs and values (DeLeon, 2000). Individuals who are resistant to adopting new recovery-oriented beliefs and values are at risk for unsuccessful adherence to the recovery process (O'Donnell & Shaw, 2016).

How are peers associated with this outcome? The nature of peer recovery support services is person-centered, which enables the examination of consumers' own beliefs and values to create meaning in their recovery lives (Davidson et al., 1999; Moran et al., 2013). Through their relationships with consumers, peers serve as socializing agents who transmit recovery-oriented beliefs and values (Cook, Jonikas & Razzano, 1995; Rogers, Kash-MacDonald & Brucker, 2009). As a function of the authenticity of lived experience surrounding their role, peers are able to effectively transmit these beliefs and values (White & Evans, 2013).

Outcome: Self-Management of Disorder

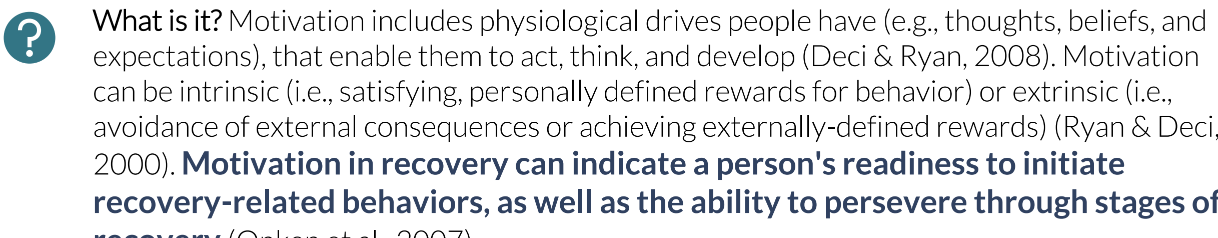
What is it? Self-management refers to **an individual's capacity to manage the disorder they experience inclusive of its associated health behaviors** (Hibbard et al., 2004). **Self-management may encompass skills such as managing symptoms, problem solving, setting personal goals, and developing support systems** (Lawn et al., 2007; SAMHSA, 2009b). Some self-management strategies related to mental health include writing down or talking about problems, enlisting the help of friends, exercising, and self-advocacy (Cook et al., 2009; Copeland, 2002). Self-management also encompasses a person's ability to state their preferences and act as an advocate regarding their own care (Copeland, 2002). Clinicians may also refer to self-management as patient activation (Hibbard & Greene, 2013).

Why is it important to recovery? A central tenet of the recovery-orientation perspective is that substance use and severe mental health disorders cannot be cured. Because a disorder is considered a life-long condition, the concept of self-management is a critical factor of the recovery process and, from this orientation, an ultimate goal of recovery is sustained self-management of a disorder (DuPont, Compton & McLellan, 2015). Self-management is related to outcomes including self-agency (Deegan, 2004), self-determination, and thriving (Cook & Jonikas, 2002). Though achieving self-management is an essential component to the

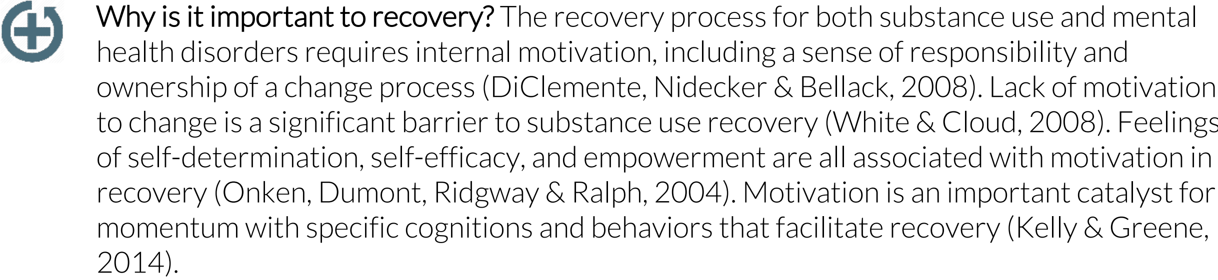
recovery process, it must be balanced with social engagement and improved social functioning within a recovery community (Mead & Copeland, 2000).

How are peers associated with this outcome? Peers can provide consumers with personal examples to illustrate key concepts of self-management (Valente et al., 2007). Furthermore, peers can help consumers navigate the balance between self-management and integration with social groups, for example, by facilitating connections with self-supportive peer groups (Iemmi et al., 2015; Cook, Jonikas & Razzano, 1995). Though self-management direction can be delivered by both peers and clinicians, delivery via peers costs less and peers appear to be particularly well-poised to promote self-management given their authentic lived experience and modeled recovery success (Johnson et al., 2018; Cook et al., 2009). Peers are also effective in increasing consumer self-advocacy, which facilitates self-management (Pickett et al., 2012).

Outcome: Motivation



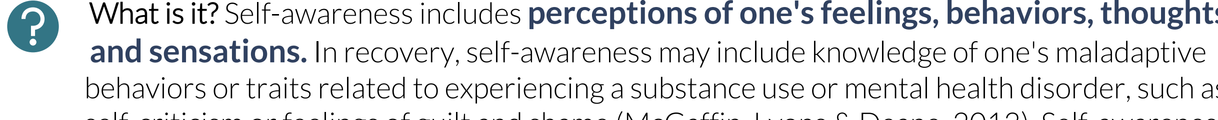
What is it? Motivation includes physiological drives people have (e.g., thoughts, beliefs, and expectations), that enable them to act, think, and develop (Deci & Ryan, 2008). Motivation can be intrinsic (i.e., satisfying, personally defined rewards for behavior) or extrinsic (i.e., avoidance of external consequences or achieving externally-defined rewards) (Ryan & Deci, 2000). **Motivation in recovery can indicate a person's readiness to initiate recovery-related behaviors, as well as the ability to persevere through stages of recovery** (Onken et al., 2007).



Why is it important to recovery? The recovery process for both substance use and mental health disorders requires internal motivation, including a sense of responsibility and ownership of a change process (DiClemente, Nidecker & Bellack, 2008). Lack of motivation to change is a significant barrier to substance use recovery (White & Cloud, 2008). Feelings of self-determination, self-efficacy, and empowerment are all associated with motivation in recovery (Onken, Dumont, Ridgway & Ralph, 2004). Motivation is an important catalyst for momentum with specific cognitions and behaviors that facilitate recovery (Kelly & Greene, 2014).

How are peers associated with this outcome? Peers may help consumers identify barriers to motivation that may not be exposed in the traditional clinician-consumer interaction. For example, the authentic peer-consumer relationship may enable consumers to describe sensitive aspects of their personal recovery story related to motivation that might otherwise be kept hidden (Fukui, Davidson, Holter & Rapo, 2010). Peers, along with friends and family, and others in recovery help support the belief that recovery is possible, which in turn drives intrinsic motivation in recovering consumers (Onken et al., 2004).

Outcome: Self-Awareness



What is it? Self-awareness includes **perceptions of one's feelings, behaviors, thoughts, and sensations.** In recovery, self-awareness may include knowledge of one's maladaptive behaviors or traits related to experiencing a substance use or mental health disorder, such as self-criticism or feelings of guilt and shame (McGaffin, Lyons & Deane, 2013). Self-awareness

may also include a view of one's self-concept, including self-esteem, self-advocacy, or a sense of control (Davidson & Strauss, 1992; Mancini, Hardiman & Lawson, 2005).

Why is it important to recovery? One's recovery process is rooted in their individual experience (Stickley & Wright, 2011), and the self is considered a cornerstone of recovery (Onken et al., 2007). The process of recovery involves developing an awareness of how experience with a disorder has influenced and shaped one's life circumstances, cultivating the desire to alter these circumstances, and generating a sense of agency about the ability to effectively recover (Onken, et al., 2002). In addition to lifestyle changes, there are many internal changes in self-awareness that assist recovery, such as revising one's sense of self as an active and responsible agent in recovery (Davidson & Strauss, 1992). Recovery practitioners characterize a sense of one's self narrative as equally important as other personal attributes, like a person's physical health, financial assets, and community supports (White & Cloud, 2008). Developing self-awareness is critical in early phases of recovery (Laithwaite & Gumley, 2007; Andresen, Caputi & Oades, 2006) to enable consumers to adopt an orientation toward achieving recovery goals.

How are peers associated with this outcome? The ability to accurately gauge one's sense of self can be compromised by problems related to experiencing a disorder (DiClemente, Nidecker & Bellack, 2008). Peer support encourages consumers to reestablish personal priorities and to rebuild their sense of self and purpose. Through the peer-consumer relationship, peers help consumers develop a new sense of self (Mead, Hilton & Curtis, 2001). Looking at other peers as positive role models empowers consumers to grow within and beyond what has happened and to find a new sense of self, meaning, value, and purpose in life (Basset, Faulkner, Repper & Stamou, 2010; Schon, 2010). Peers may also assist in developing self-awareness around consumers' strengths that can aid recovery, and weaknesses or triggers that impede recovery (Davidson et al., 2010).

Outcome: Hope

What is it? Hope is a feeling, belief, or expectation that something will come to pass. **In the context of recovery, hope means that one can face, endure, and overcome adversity and achieve recovery goals** (Jacobson & Greenley, 2001).

Why is it important to recovery? Recovery is fundamentally moving from one state of functioning to another (SAMHSA, 2012), and therefore inherently involves obstacles including frustration, difficulty, and relapse (Gumley & Schwannauer, 2006). Persevering through the process of recovery requires positive belief and expectation (hope), and a desire to achieve recovery goals (Onken et al., 2007). Hope is consistently described as central to recovery (Onken et al., 2007), particularly as a catalyst to initiate recovery as a means of changing one's life in positive directions (Onken et al., 2002; Andresen, Oades & Caputi, 2003).

How are peers associated with this outcome? The belief that people who have faced, endured, and overcome adversity while experiencing a disorder inspire hope for people in recovery has its roots in the very beginning of the peer services movement (Davidson, Chinman, Sells & Rowe, 2006; McCranie, 2010). Peers support recovery by instilling hope and hopefulness through the transfer of experiential knowledge to consumers through modeling their own recovery (Anthony, 1993; Verhaeghe, Bracke & Bruynooghe, 2008).

Domain: Community Skill Building

Outcomes in the Community Skill Building domain foster connections between consumers and external supports, including other individuals, treatment services, organizations, and communities. Using these skills, consumers develop professional and social relationships that bolster recovery. The four outcomes covered in this section include:

Outcome: Engagement in Services

What is it? Engagement in services is a general term used here to describe **when a person in recovery has intentions or initiates behaviors to access clinical services or is actively involved in the treatment process.** In the recovery literature, a similar concept is referred to as treatment/patient engagement (Hibbard & Greene, 2013).

Why is it important to recovery? Consumers typically initiate recovery after engaging in formalized treatment (Laudet, 2007); treatment has been found to be a significant predictor of entry into recovery (Scott, Foss & Dennis, 2005). As a function of the treatment/recovery process, individuals may need to access a broad range of services, some of which may involve clinical settings (Laudet & White, 2010; Volkow, 2011). Individuals experiencing substance use or mental health disorders are often difficult to engage in such services (i.e., dropping out of treatment) (MacBeth, Gumley, Schwannauer & Fisher, 2013). Inadequate engagement may lead to greater rates of relapse, worsened symptoms, hospitalization, and diminished connection to other health services (Dixon, Holoshitz & Nossel, 2016), all of which can impede recovery.

How are peers associated with this outcome? First, individuals experiencing disorders often feel alienated and/or stigmatized, generating hesitation engaging in services (MacBeth et al., 2013). Peer recovery support services benefit consumers by increasing self-determination, awareness, and self-advocacy (Sells et al., 2006) which may counter the effects of stigma and therefore bolster recovery service engagement (Pfeiffer et al., 2012). Second, scholars suggest that barriers to engagement in services may result from individuals lacking trust in authority figures (Lecomte et al., 2008). Peers may serve as a trusted figure connected to various services that support recovery. Lastly, Sells and colleagues (2006) found that consumer engagement with peers is a critical aspect of initial stages of recovery and treatment.

Outcome: Interpersonal Relationships

What is it? As a recovery-related outcome, **interpersonal relationships involves establishing and maintaining relationships, such as family, friends, social peers, co-workers, and connections to community groups.**

Why is it important to recovery? Many people in recovery find they must discontinue negative or maladaptive relationships in order to successfully navigate the recovery process. Other factors such as unemployment, stigma, and complications with symptoms can interfere with consumers' abilities to maintain relationships (Boydell, Gladstone & Crawford, 2002; Davidson et al., 2001). The importance of social relationships in treatment and recovery is well-established (Baumeister & Leary, 1995; Tew et al., 2012). Relationships facilitate positive benefits such as psychological adjustment and the initiation and maintenance of recovery and abstinence (Terrion, 2013; Cloud & Granfield, 2008).

How are peers associated with this outcome? Peer support is especially salient to the concept of developing social relationships (Mead & MacNeil, 2006). Peer support is often conceptualized as a foundational pro-social, positive recovery relationship that aids consumers in their recovery process (Davidson et al., 2012). Furthermore the peer-consumer relationship is fundamentally based on shared power and mutuality (Watson, 2019), which facilitates a comfortable atmosphere for consumers to practice pro-social behaviors such as disclosing past history, receiving feedback, establishing their personal identity, and acting as part of a community (Moran et al., 2012; Mead & MacNeil, 2006).

Outcome: Perceived Community Affiliation

What is it? Perceived community affiliation refers to **general feelings of connectedness with others and membership within specific groups.** The literature also describes community affiliations as the ability to influence, integrate and fulfill one's needs, as well as the capacity to exchange emotional connections with others (Stevens et al., 2012). Consumers' community affiliation may also be gauged by the length of their stays in community before rehospitalization or crises (Min et al., 2007).

Why is it important to recovery? Those who are initiating recovery are often simultaneously re-entering their community post-treatment, and sometimes post-incarceration (Andreas, Ja & Wilson, 2010; Lyons & Lurigio, 2010). Individuals in recovery who lack a connection to community can experience feelings of isolation and loneliness, which impedes recovery efforts (Young & Ensing, 1999). Many recovery programs adopt the idea that successful recovery cannot happen in isolation and that individuals in recovery must rely on resources and networks to support the recovery process (Miller & Kurtz, 1994).

How are peers associated with this outcome? By drawing upon their lived experience accessing community supports, peers facilitate consumers' connections with their natural communities, as well as the recovery community (CSAT, 2009). Chinman and colleagues (2006) described peer support services as advocating for community integration. For example, regarding recovery from substance use, peers may increase consumers' connections to their community by helping them develop skills necessary to participate in substance-free community events (Min et al., 2007). In the peer-consumer relationship, a

safe space is created for those re-entering the community to develop new skills and ways of behaving that are conducive to a life in recovery (Tracy & Wallace, 2016; Mead & McNeil, 2006).

Outcome: Employment

What is it? Employment typically refers to **having a paid position, but may also include gaining individual skills, job training, job searching, receiving income and/or benefits, and improved social relationships at work or other professional relationships.**

Why is it important to recovery? Research has found that employment and returning to work is linked to beneficial effects on clinical and social functioning for those experiencing mental health (Kukla & Bond, 2009) and substance use disorders (Burns et al., 2009). At a certain stage in the recovery process, steady employment and developing an identity as an employed person may help individuals rely less on mental health services and distance themselves from the identity as a "patient" (McHugo, Drake, Xie & Bond, 2012). Employment provides an avenue for social relationships and community connectedness (Bond, 2004), and can provide meaningful purpose to those who are exploring a life in recovery (Onken et al., 2007; Finch, Catalano, Novaco & Vega, 2003).

How are peers associated with this outcome? Peers can often directly relate to employment challenges that individuals in recovery may experience (Kern et al., 2013). Peers generate optimism that consumers can obtain their individual vocational goals (Wolf, Lawrence, Ryan & Hoge, 2010).

Other Considerations for Peer Outcomes

Outcomes for Peer Service Providers

Peer support services also benefit the peers themselves who are delivering services. Through their work, peers gain and practice recovery skills, increase their knowledge around personal recovery, and experience positive connections by working with other peer providers (Mowbray et al., 1998). **Peers share in the beneficial recovery-related outcomes experienced by the consumers they serve, such as increased hope, self-esteem, and recovery** (Ratzlaff, McDiarmid, Marty & Rapp, 2006). Benefits to peers can be facilitated through peer services training programs as well as through the service relationship with consumers (Salzer et al., 2009). Furthermore, a cycle of enhancement can occur where the effectiveness of the support services peers provide is increased as they successfully navigate their own recovery experience (Money et al., 2011).

Much of the research on beneficial peer outcomes is guided by the helper-therapy principle theorized by Reissman (1965), which asserts that helping others can improve physical and psychological health in the helper including:

- Enhanced sense of competence;
- Feelings of "gaining what you are giving"; and
- Enhanced sense of self from social recognition as a service provider.

Job satisfaction is another important outcome to consider for peers, which is directly related to retention in their role as a peer (Clossey et al., 2018). In general, recovery work in substance use and mental health arenas is characteristically plagued by high voluntary turnover due to the nature of the work (Morse et al., 2012; Knudsen, Ducharme & Roman, 2006). Many of the outcomes in peer work are tied to how seamlessly their role is implemented in an organization, which is typically beset with barriers or issues (Gates & Akabas, 2007). These factors suggest job satisfaction is a critical area of assessment for peers in the way their role is perceived and integrated into an employing organization (Kuhn, Bellinger, Stevens-Manser & Kaufman, 2015).

Peers also encounter challenges in their role as recovery service providers. Peers may experience considerable burnout, as their interactions with consumers involve navigating the expression of their own experience with recovery as well, which can be stressful or intense (Mancini & Lawson, 2009). Additionally, peers may experience stigma and resistance from clinical staff in an organization (Chinman et al., 2008).

Family Outcomes

Recovery services are traditionally focused on the goals, outcomes, and experiences of the individual experiencing a disorder (Ward et al., 2017). Yet, their parents and other family members are also impacted by the recovery process (Wyder & Bland, 2014). **A fundamental aspect of recovery is recognizing, building trust, and relying on sources of social support (Mead & Copeland, 2000), and family is typically a significant support system** (Pernice-Duca, 2010). Members within families often become the "primary carers" of those in recovery, especially when person in recovery is young (Leggatt & Woodhead, 2016).

Families can both facilitate and impede the recovery process for the individual in recovery (Reupert & Maybery, 2011). Family members may experience emotional outcomes such as confusion, guilt, blame, or helplessness as a result of the challenges their loved one has faced (Quinn, Barrowclough & Tarrier, 2003). Distress among family members of those in recovery often stems from the unpredictability associated with having a relative who is experiencing a substance use and/or mental health disorder (Kelly, Fallah-Sohy, Cristello & Bergman, 2017), and feeling unprepared to address and support the associated challenges (Leggatt, 2007). Families of those in recovery may develop intrafamilial conflicts and may retract from social interactions outside of the family. These conflicts and challenges may also impact employment, leading to financial strain (Leggatt, 2007).

Family systems also provide structure and support to those in recovery in numerous ways. They can be a catalyst for rebuilding relationships (both in the family and community), which reduces feelings of alienation and stigma (Tew et al., 2012; Pernice-Duca, 2010). Topor and colleagues (2006) also identified important ways families facilitate recovery. First, family members can signify a continuity that predates the challenges an individual in recovery is facing, which facilitates a more holistic identity of that person beyond the disorder. Second, due to their proximity, family members often facilitate linking their loved one to services, as a result of monitoring their recovery process or symptoms.

Peers can use self-disclosure of their similar experiences to promote engagement of the family in the recovery process (Wisdom et al., 2011). Notably, because of their personal experience, peers often have credibility, especially with parents, and can build trust (Gyamfi et al., 2010). Peers can also provide families members information and education about disorders, emotional support, problem-solving skills, and crisis intervention, which can moderate negative outcomes due to feelings of unpredictability (Leggatt, 2007; Davis, Scheer, Gavazzi & Uppal, 2010; Hoagwood, 2005).

Peer-Specific Outcome Measurement Tools

While reviewing the foundations and practices of peer recovery services, potential instruments for measuring peer recovery support services were identified using a variety of research articles and established mental health and substance use associations, including SAMHSA. Instruments were compiled and ranked based on the extent to which they included and prioritized aspects of recovery and emphasized quality of life in their conceptualization of recovery. Instruments that focused on the symptoms of disorders (e.g., depression, anxiety, or frequency of substance use) or on clinical treatment (i.e., followed the traditional medical model) were ranked lower or excluded. **Measures prioritized for inclusion in this review: (1) favored a holistic person-centered and recovery orientation; (2) could be used in informal, community-based settings; and (3) could be used both as a service provision and measurement tool** to yield information that could directly inform peers' work with an individual consumer. Most importantly, however, instruments were selected based on their level of inclusion and overlap with the 10 recovery outcomes areas identified in the section above.

Specific recovery instruments were then evaluated and ranked according to the following characteristics:

- Scientific validity (e.g., face, convergent, discriminant validity), the degree to which an instrument accurately measures the constructs it was designed to measure
- Reliability (e.g., test-retest, inter-rater, internal consistency), the degree to which an instrument consistently measures what it was designed to measure
- Ease of use for peer specialists (e.g., number of items, time to administer, Flesch-Kincaid readability score)
- Setting-specific appropriateness
- Accessibility (e.g., proprietary restrictions)

Results from this peer outcomes measurement tool ranking process are provided in the following table in no particular order.

Recommended Peer Recovery Instruments

Instrument Description	Content Areas	Recovery Domain	Additional Information	Accessibility
Recovery Process Inventory (RPI) 22 items, approximately 15 minutes	• Hope • Empowerment/self-control • Self-esteem • Self-management • Social relations • Family relations • Housing status • Employment status • Stigma • Spirituality	Personal ☐ Relapse Resiliency ☐ Beliefs/Values Essential to Recovery ☑ Self-Management of Disorder ☑ Motivation ☑ Self-Awareness ☑ Hope Community ☐ Engagement in Services ☑ Interpersonal Relationships ☑ Perceived Community Affiliation ☑ Employment	• Focused on consumer recovery and feelings that treatment staff and services are facilitating recovery • Promotes dialogue between consumers and providers • Appropriate for both mental health and substance use outcome assessment • Has undergone less testing than the RAS (see below) • Conducted via interview • Demonstrates sound psychometric properties	Must get consent by the South Carolina Department of Mental Health to use (developers), no clear scoring guide. Access to instrument: Website Link (page 46)[1] Citation: Jerrell, Cousins & Roberts, 2006
Recovery Assessment Scale (RAS) 41 items, approximately 20 minutes	• Self-confidence • Hope • Willingness to ask for help • Goal & success orientation • Reliance on others • Self- rather than symptom-identity	Personal ☑ Relapse Resiliency ☑ Beliefs/Values Essential to Recovery ☑ Self-Management of Disorder ☑ Motivation ☑ Self-Awareness ☑ Hope Community ☑ Engagement in Services ☑ Interpersonal Relationships ☐ Perceived Community Affiliation ☐ Employment	• Developed as an evaluation measure • Versatile, can be adopted in a variety of settings • Appropriate for both mental health and substance use outcome assessment • Shorter, 24-item instrument available (RAS-Revised) • RAS-DS (RAS Domains and Stages) suitable for use with adolescents • Conducted via interview or self-administration	No copyright nor permission to use required, free to use. Access to instrument: Website Link[2] Citations: Giffort et al., 1995 Hancock et al., 2015 Hancock et al., 2020

[1] https://www.mentalhealth.va.gov/communityproviders/docs/review_recovery_measures.pdf
[2] https://depts.washington.edu/ebpa/sites/default/files/RAS%20-%20double%20sided.pdf

Brief Assessment of Recovery Capital (BARC-10) 10 items, approximately one minute	• Substance use and sobriety • Global psychological health • Global physical health • Civic and community engagement • Social support • Meaningful activities • Housing status • Safety • Risk-taking behavior • Coping & life functioning • Recovery experience	Personal ☐ Relapse Resiliency ☑ Beliefs/Values Essential to Recovery ☐ Self-Management of Disorder ☑ Motivation ☑ Self-Awareness ☐ Hope Community ☑ Engagement in Services ☑ Interpersonal Relationships ☑ Perceived Community Affiliation ☐ Employment	• Longer version (ARC) available with 50 items and 5 subscales. 10-item version is more limited • More appropriate for substance use rather than mental health outcome assessment • Suitable for measuring peer efficacy in a community setting	Public domain. Access to instrument: Website Link[3] Citation: Vilsaint et al., 2017 Kowalski et al., 2020

[3] http://shura.shu.ac.uk/15835/2/Best%20-Development%20and%20validation%20of%20a%20Brief%20Assessment%20of%20Recovery%20Capital%20%28BARC-10%29%20%28Scale%29.pdf

Peer Recovery Literature Review Summary & Recommendations:

Summary

The term peer refers to trained persons providing recovery services who have lived experienced with a substance use and/or mental health disorder and are currently in recovery. The implementation of peers in mental health and substance use recovery services provides benefits to consumers, organizations, and communities. However, there is great variability in peer service processes, consumer pathways to recovery, and organizational structure can present challenges to implementation and standardization. **Successful implementation of peers requires a balance between standardization and variability to maintain the essence of what makes peer recovery support services work.**

The literature on outcomes and effectiveness of peer recovery support services in mental health and substance use disorder systems is nascent but growing. Across several types of peer service delivery, peer recovery support services are consistently effective at improving such outcomes as:

- ↓ Reduced inpatient service use
- ↑ Improved consumer relationships with providers
- ↑ Better consumer engagement with care
- ↑ Higher levels of consumer empowerment
- ↑ Higher levels of consumer activation (i.e., willingness/ability to independently manage their health and care)
- ↑ Higher levels of consumer hopefulness for recovery

This review identified 10 key outcomes associated with peer recovery support services categorized within two broad recovery domains: *personal* skill-building and *community* skill building. These represent domains in which research shows that peers influence the recovery outcomes of the consumers they serve.

There are three promising recovery instruments that adequately measure most or some of the domains and outcomes highlighted in this literature review: the Recovery Process Inventory (RPI), the Recovery Assessment Scale (RAS), and the Brief Assessment of Recovery Capital (BARC-10). These instruments were selected because they approach measuring recovery from a holistic person-centered, quality of life orientation; assess many of the 10 salient recovery outcomes areas prioritized in this literature review; are easy, short, and simple to administer; and can be used both as a service provision and measurement tool by peers, yielding information that could directly inform peers' work with an individual consumer.

Recommendations

Although this literature review identified three potential instruments that may be effectively used to measure recovery outcomes, **the primary recommendation is that peer support services, and their impact on consumers served by them, are measured in some way**. The following recommendations are intended to support agencies in taking initial steps toward this larger goal, including guiding questions to support conversations among agency staff of all backgrounds.

Recommendation: Integrate Peers Throughout the Process

As the subject matter experts, peers should be involved throughout development, implementation, and maintenance of measurement-driven recovery services. The instruments identified above were selected with the intent that they would be administered by peers. Whether these instruments or other data collection processes are used, peers should be adequately trained in the outcomes measurement process from data collection to documenting and tracking data. Developing protocols to be as peer-friendly as possible will aid in the standardization of processes and prevent loss of data.

Guiding Questions:

- What is your agency's readiness and/or capacity to adopt a recovery orientation in the services it provides?
- Which of your agency's peers will be integrated into this process? What strengths will they bring to the team? What support might they need to fully engage?
- Which areas of your agency's outcomes measurement process will benefit most from peer expertise?

Recommendation: Include Recovery Outcome Domains

Efforts to measure consumer and other outcomes of peer support services can prioritize the domains of personal and community skill building, specifically some or all of the recovery outcomes within each of these domains. Capacity to measure specific outcomes in these domains may vary depending on how peers are implemented, types of recovery services, and organizational capacity. The great variability among peers and their services, the consumers of their services, and the settings in which services are delivered reinforces the importance of seeing these recommendations as guidelines, not as rigid rules.

Guiding Questions:

- Which recovery outcomes are most relevant to the peer services your agency provides? Consider any stated goals of your agency's peer programs, how and where these programs are implemented, and the type of consumer they are intended to support.
- Is there a good balance of both domains (i.e., personal and community skill building) in the identified outcomes?
- What input can be gathered from peers on which outcomes and/or domains are most salient?

Recommendation: Capitalize on Existing Information

A review of existing organizational assessments, and/or evaluation protocols should be conducted to determine where overlap exists regarding measurement of outcomes in these domains. Input from peers should be considered in this review of outcome measurement, as should be the incorporation

of outcomes and/or domains in peer training and evaluation efforts. Similarly, review should be conducted across organizations and settings (e.g., community services boards) to ensure outcome measurement accounts for important areas of variability in services.

Guiding Questions:

- Where is your agency already collecting information about recovery outcomes? Consider client forms, intake assessment, symptom inventories, treatment or crisis plans, service notes, quality assurance information, satisfaction surveys, etc.
- Where is this information kept? Who has access to this information?

Recommendation: Prioritize Quality over Quantity

As with any evaluation effort, it is better to collect high quality, accurate information covering a few outcomes than to inconsistently collect an overwhelming or unsustainable amount of outcome data. Although each of the outcomes described in this review could be informative for a peer recovery program, it may not be feasible to measure each of the 10 outcome areas. It is important to prioritize measuring recovery outcomes that most closely relate to the nature of peer recovery support services provided by peers. It is also important to focus on developing a process to consistently collect the prioritized recovery outcomes measures.

Guiding Questions:

- What amount of data collection is truly feasible for your team? Consider the number of questions asked, the frequency at which they are asked, and who will be responsible.
- Imagine your agency and/or peer program one year from now. Does the data collection identified in the previous still seem feasible?
- What is the first step your agency would need to take to develop a consistent, sustainable outcome data collection process? Who in your agency might be an ally or support?

Recommendation: Track Outcomes Consistently and Sustainably

Following the identification of measurable outcomes, effective documentation and tracking of outcomes should be established to ensure data are collected and managed. Developing a system to consistently track recovery outcomes provides peers and the agencies they work within the information and knowledge to demonstrate peer recovery support program efficacy and improve the quality of peer recovery support services across settings, and time points.

Guiding Questions:

- Has your agency attempted to collect outcomes data on a consistent basis in the past?
    - If so, what went well? What challenges came up? How can you address those challenges at this point?
    - If not, what strengths does your agency or department bring to this endeavor? What might get in the way of consistency and sustainability? How will you address those barriers?
- How is information tracked in other departments or areas within your agency? Can existing systems be modified to collect additional information related to recovery outcomes?

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