Voices of Hope: Substance Use Peer Support in a System of Care

Christian Scannell [ID]

Assumption University, Worcester, MA, USA.

ABSTRACT: Peer support in substance use recovery assists individuals who seek long-term recovery by establishing supportive and reciprocal relationships that support the initiation and maintenance of recovery. Prior research has found that peer support workers provide essential services to individuals in recovery, while the experience of the peer and their integration into a system of care has yet to be fully explored. This qualitative study explored the peer worker's experience as a provider of recovery support services in a system of care. Semi-structured interviews were conducted with 10 peer support workers. The interviews were transcribed and analyzed using qualitative data analysis software. Thematic analysis was used to identify themes and patterns inductively from the data. Peer support worker experiences included challenges establishing credibility, frustrations in managing systemic barriers, a lack of understanding as to what the role of peer worker entails by stakeholders, and skepticism from other providers about the value of the position. Positive experiences included a decrease in the perception of stigma about substance use and feeling valued. Supervision played a key role in the success of the peer worker role, with concerns related to supervisors who are not in recovery. This study highlighted improvements in the integration of peer support workers in systems of care and regard for the role by professionals. A widespread understanding of the role and scope of practice is lacking and a need for better support for the role through avenues such as training, and supervision exists.

KEYWORDS: Peer support, recovery, substance misuse, communities of care, hope broker

Introduction

Peer-to-peer support is a phenomenon that can be seen in the behavioral health field throughout history in a multitude of informal roles and increasingly in paid formal roles designed to address prevention, health, health promotion, and intervention support.[1] Peer support has been defined by SAMHSA (Substance Abuse and Mental Health Services Administration) as a system of giving and receiving nonclinical support based upon the principle of shared experiences, responsibility, and cooperation.[2] The application of peer support has been widespread with workers providing support for physical health issues, homelessness, chronic pain, supported employment, mental health, and substance use. Peer support has been empirically associated with positive behavioral health outcomes for individuals in recovery that are equal to or greater than those provided by non-peer professionals.[3,4]

While formal roles for peers in substance use recovery did not appear until the 2000s, informal peer support has had a presence much earlier through self-help programs such as Alcoholics Anonymous (A.A.) and Narcotics Anonymous (N.A.). Peer support workers (PSWs) have been identified as making positive contributions to treatment retention and recovery outcomes of individuals with active substance use both in paid and unpaid roles.[5,6] These improvements include decreased substance use, fewer re-admissions to hospitals, increased participation in aftercare services, and greater connectedness to community resources.[3,4] Turpin and Shier[7] found that peer support provided a unique and different perspective than that of professionals which strengthened traditional service delivery and created an increase in the resources available to individuals in early recovery. Peers that have received this service report increased confidence,[6] increased self-esteem, and a greater understanding of the practical issues of navigating recovery,[7] including increased coping skills, and increased hope that recovery is possible.[8] Bassuk et al[3] conducted a meta-analysis and found that PSW's create a unique working alliance that can improve outcomes in many life domains.

The cornerstone of the peer relationship is the shared lived experience of addiction and recovery. This shared narrative enhances hope that long-term recovery is sustainable and increases motivation for engagement in recovery-based activities.[9-11] The real-world knowledge of addiction and recovery positions PSWs to provide effective psychosocial supports and life skills, to serve as a broker between the community and the individual in early recovery[12] thereby removing many personal and environmental obstacles often experienced in recovery. This role often includes activities such as mentoring, coaching, being a role model, connecting to natural community-based supports and resources, facilitating community reintegration, advocacy, coping skill development, and the encouragement of treatment adherence and completion.[5,13-15] Despite these benefits, PSWs have not experienced a seamless integration into service delivery models or systems of care.

Substance Abuse and Mental Health Services Administration[16] defines recovery-oriented systems of care (ROSC) as "networks of organizations, agencies, and community members that coordinate a wide spectrum of services to prevent, intervene in, and treat substance use problems and disorders" (p. 2, para 1). PSWs are considered recovery support services and are infused throughout the ROSC at the

intervention and treatment phases, to support long-term recovery and prevent relapse thereby decreasing recidivism to formal treatment and offsetting the lack of resources in this system.[16] PSWs can also facilitate early intervention and referrals for individuals experiencing relapse and decreasing the negative impact on the individual and their family.[16]

PSWs are employed in several practice settings most often as either an adjunct to clinical or medical treatment, such as in an emergency room (ER) or primary care office, or in community-based programing.[5] Point of initial contact, location of the PSW, and level of acuity may differ across settings, however, the core roles and functions remain relatively stable with PSWs working in in ER's reporting lengthy follow-up and community-based engagement.

Despite their widespread presence, the integration of PSWs into the field of recovery has been challenging. Many of the difficulties of working in a ROSC are directly tied to the understanding of the PSW role by stakeholders, specifically who peer workers are, what services they can provide, the value of such services, as well as their qualifications and training.[17] The defining qualification of employment, self-identification of personal recovery status[18] (Moran et al[19]), may also perpetuate existing stigma and create inequities in employment status[20] as well as a lack of credibility in the role of peer worker.[21] PSWs have reported a lack of equality between themselves and their non-peer colleagues,[22] concerns related to being accepted by coworkers,[23] as well as feelings of stigma and discrimination from leadership.[24,25] This negative view of PSWs by non-peer staff may be related to the lack of role clarity and lack of information available about the benefits of this service.

While the employment of PSWs in the substance abuse field continues to rapidly expand, existing literature focuses on the mental health field creating generalizations that may not consider the unique attributes of substance abuse recovery. Although evidence exists regarding the benefits to the consumer receiving the support, it is not clear how providing these services is experienced by the PSW.[3,4] Given the increased visibility of PSWs in formal roles and across practice settings, it is crucial to explore their experiences in a ROSC and their perspectives on how this role is integrated into existing service delivery models.[11,14] This study concentrated on PSWs who were paid to deliver nonclinical support to people in recovery in emergency care and community-based settings.

Method

To understand the gap in the current literature, this qualitative study used in depth semi-structured interviews to explore PSWs experiences as part of a system of care. The selection of participants was done utilizing a criterion sampling approach to identify PSWs living in Massachusetts (MA) who were actively providing paid peer support to individuals seeking substance use recovery. Snowball referral sampling was also utilized to ensure an adequate number of participants to reach

saturation. The current study was approved by the Walden University Institutional Review Board.

Participants

The participants for the study were 10 PSWs from MA (7 male, 3 female) all working in programs through a ROSC with 4 in emergency care settings and 6 in community-based settings. These two practice settings are the most common places that PSWs are employed in MA at the time of the study. Peer workers whose agencies were community-based had offices in the community yet all reported working with acute care patients, seeing patients in emergency rooms, and providing ongoing care to individuals who live in the community they serve. These peers received referrals for services from hospitals, community providers such as probation or child welfare programs, other PSWs, and individual's support.

The PSWs working in emergency rooms had offices within the hospital and met with individuals on medical floors as well as in the ER, these connections were made either via referral from a medical provider or proactively by searching hospital admissions for diagnostic codes. All the participants reported at least 12 months of stable recovery and employment as a peer worker for a minimum of 6 months. The length of time in this role ranged from 10 months to 20 years.

Procedure

Participants were recruited via social medial platforms including Facebook and LinkedIn and via emails sent to the state certification body with a description of the study and contact information for interested participants. In addition, once the interviews began, participants were asked to pass on information about the study to other peer support workers that may be interested. Three respondents were recruited via snowball referral sampling.

Once contact was made from an interested participant and eligibility was determined, participants were asked to opt into the study and informed consent was obtained. All participants were reminded of their right to withdraw from the study at any time and their right to withhold any information that they did not feel comfortable sharing. Participants were offered to have interviews conducted in person, via video platforms such as Zoom or Skype, or via the telephone. The interviews consisted of a brief study overview, review of informed consent, a 60-minute in depth semi-structured interview, and a debrief including how the data would be stored and used in the context of the research study. A semi-structured interview guide was utilized to explore the experiences of PSWs in their role and within a system of care. Interview questions were developed from themes in the literature and conceptual frameworks and included questions related to how they view and experience their recovery, role as a PSW, practice, setting, helping others, and connection to personal recovery.

Participants were provided with a $20.00 Amazon gift card as a thank you for participating in the study. All participants were provided with a summary of their interview transcript to review that included the overall themes generated from the study, for member checking purposes, and feedback was elicited regarding accuracy, clarifications, and additional information for inclusion. Interviews were audio recorded and stored with field notes on a password protected laptop.

Data analysis

Thematic Analysis was used to inductively analyze the transcripts and identify themes across the participant experiences. The 6-phase thematic analysis was implemented as recommended by Clarke and Braun.[26] This method was chosen due to its reflexive and recursive approach which allowed for the meaning of the PSWs experiences to be captured and utilized to identify themes across the data.[26,27] Data analysis began by familiarization with the data through a careful review of each verbatim transcript while listening to the audio recording.[28] This allowed for immersion in the data and ensuring the accuracy of the transcript. Next, initial codes were generated inductively from each transcript and patterns in the data were linked to preliminary categories. Transcripts were initially hand-coded individually before being uploaded into NVivo 12 for further analysis this allowed for the coding of the data at 2 different points. A comparison of the 2 allowed for the establishment of reliability in the coding process. Overall, 75 codes were established during this phase of analysis before the search for themes began.

Theme identification began by clustering the codes and corresponding data into meaningful groupings.[29] The codes were then explored through the lens of the research question and candidate themes were generated. The themes were then reviewed and revised, ensuring that the themes worked in relation to the data and the research question.[29] Following this, themes were named and defined to ensure that they were distinct and quotes that clearly illustrated the themes were selected to incorporate into the findings.

Results

From the transcripts, 4 distinct themes were apparent: establishing credibility, managing systemic barriers, scope of practice, and the importance of ongoing supervision. PSWs shared that while initially the role was met with skepticism by other professionals, they have experienced a shift in this view, and a resulting decrease in stigma surrounding substance use. Further, PSWs noted that ongoing supervision for this role is crucial with some of the peer workers expressing concern that many supervisors are not in recovery. Some of the PSWs interviewed work in acute hospital settings on interdisciplinary teams with doctors, social workers, nurses, etc. while other workers are employed in community agencies as a standalone service, to enhance existing services provided by the organization or to provide support services by referral to ER settings. Regardless of the practice setting, all of the PSWs explained that their role is situated within a system of care with the goal of enhancing engagement in treatment and recovery-based activities.

Establishing credibility

Several of the PSWs interviewed explained that in their work environment peer support often did not previously exist, making the position new, exposing them to skepticism, and taking time for clinical providers to appreciate the value of the shared lived experience (P3, P5, P6, P8). "We were the new kids on the block. It wasn't always so easy" (P5). "There were a lot of counselors who were just saying it's stupid, it's a paid sponsor, so we were up against that" (P3). The peers recognized that the role was new to providers "I think it's just an adjustment to have somebody who is open about their lived experience on their team" (P8). They recognized that the acute care approaches intervention

> "from a clinical standpoint. And to be fair, we're mostly in a clinical environment, and we're not clinicians. . .now four years later we're still trying to get it to work in the ED, it's not as smooth sailing as we would like it to be." (P4)

Yet for some PSWs they saw a shift in how their role was viewed by others over time. PSWs expressed pride in being able to see such a transformation in the way in which lived experience is valued (P3, P4, P5, P6). "I think it's being honored more now because people are seeing the effects that we have in the field. So we're getting more respect" (P9).

> I've watched it change over the past 10 years. Early on, you almost felt like you were a kid that was allowed by his father to go out and use the lawnmower for the first time, but you knew your father was lurking right around the corner. (P6)

P4 also saw a significant shift in perspective in the years of work as a PSW.

> They can hear what we are saying, they trust what we say, I don't think in the beginning it was this way, but now because they see what we can contribute and how uniquely helpful we are to people.

Others explained that it is rewarding to have medical professionals ask their opinion, recognizing their lived experience as an expertise rather than seeing a lack of credentials (P5, P6, P9). "My favorite part is reducing that stigma; warm handshakes with doctors that say hey what do you think? And they value my opinion" (P5). P6 also shared that there is a recognition of the ability of PSWs to "keep their patients engaged with them. . .they've started to understand the peer-to-peer relationship can provide a lot."

Some of the PSWs shared that they continue to experience distrust from practitioners (P4). "They're not really sure about

us (P4)." P5 expressed that the lack of understanding of the role may be creating a fear reaction that PSW's are trying to take the jobs of existing practitioners or that the role may replace formal treatment providers. P5 also expressed that it may be that changing cultures can still be challenging. "A lot of people are kind of stoic and stuck in their old ways when we're just trying to help. That can be difficult."

Yet despite the skepticism, the PSWs believe that they can often serve as a bridge between individuals who are in active addiction and their practitioners. "They took a Hippocratic oath to treat people fairly, kindly. But sometimes people in the throes of addiction are not so nice" (P5). PSWs, through their shared lived experience, believe that they can be more tolerant and empathic during these times, taking the behaviors for what they are rather than personalizing or evaluating the whole person based on a low point in their lives (P5, P6). P5 expressed that the presence of a peer in stable recovery can serve as a reminder for practitioners that relapse is a part of addiction and may decrease the negative perception of individuals who represent for treatment repeatedly.

> I just try to remind them that I wasn't a one and done. I didn't just go to treatment once and then like here I am. No, like I was a mess, I was in and out and that is a valuable part of our collaboration.

P6 shared that one of the rewarding aspects is seeing a change in practitioners from when he was struggling with his own addiction.

> I remember a lot of how I got treated when I was out there running and gunning and I was hitting the emergency rooms and putting up with aversion from doctors and nurses and people who didn't want to deal with ya and in wearing out PCPs. This movement has brought somebody into the mix that is helping people understand a little bit. Seeing attitudes change in PCP offices and in the mental health field has been a good part of it.

PSWs interviewed shared that this also helps in bridging relationships between patients and providers and helping patients to see that the relationship does not need to be adversarial. P8 shared that the lived experience often includes difficult relationships between providers and individuals with substance use issues and that this is a place where a PSW can build a bridge.

> A lot of people broke my trust, especially in the medical field. So I think that the more I show people that I'm just another human being definitely like makes the connection better, which keeps them coming back to treatment with their providers.

Managing systemic barriers

Many of the PSWs interviewed expressed that a barrier to being effective in their role is directly related to systematic challenges (P3, P8, P9).

> Whether it's the child welfare system, the Department of Transitional Assistance and Housing, there's just a lot of systems that I

really feel like are not built to support these people. . .I think that's been the hardest part of my job. I can do the best possible work that I can but if they're engulfed in these systems that aren't working for them, then sometimes it can feel like is my work even worth it. (P8)

P3 experiences the system as outdated and controlled by insurance. "We can make the best plans in the world, but the system lets people down a lot. A lot of times people just can't get housing, transportation, jobs, psychiatrists. There's such an extreme shortage." P9 shared that working in an emergency room can create challenges for individuals who are trying to get into detox or treatment programs. "Once they know they're in the hospital now, the alarms go off. Do they have medication? Are they physically healthy?" P10 also shared significant barriers related to aftercare services and gaps that can exist between when one service begins and another ends. "We're trying to get health insurances to extend their stay until beds become available but once health insurance cuts you off, you have to leave."

P3 explained that traditional recovery programs, while beneficial, can add to the systemic barriers without appropriate community-based follow-up.

> We try to fix people within this highly controlled environment, and it doesn't work. They say go home and repeat the things we taught you in this little box and it's just unrealistic, it's not practical, we need to connect them to recovery community organizations.

P3 shared that peer support in the community allows individuals to receive services that are integrated into the environment that they live in, allowing for connection to naturally occurring resources. "We need to be out in the community, meeting them in their space, outside of the bounds of institutions" (P3).

PSWs talked about the disparities that exists for individuals needing treatment based on access to health insurance and the quality of the insurance policy (P1, P2, P3, P4, P7, P9). Some peer workers struggled with not being able to help all individuals seeking help due to insurance restrictions (P7). They explained that it creates barriers for individuals seeking recovery and inequality in the type of treatment that is received leading to decreased long-term recovery and increased recidivism rates (P3, P4, P9, P10). P9 shared his experience of

> continually sending somebody for a spin dry, I call it, five to seven-day detox and then they hit the street and we're wondering why we don't have such a high success rate? Well it takes a lot longer than that to change anything. . .I mean getting the drugs and alcohol out of your body is a beautiful thing for a week, but then what?. . .If folks aren't off the streets long enough to heal their spirit and mental health, they continually fall, go to detox, come back to the ER.

PSWs recognized that working in an emergency room or acute care environments such as a detox can be a challenging environment for participant engagement and that it is most effective when combined with community-based follow-up (P1, P3, P8). "To get them when they're in their most vulnerable point, like the emergency department is wicked important but I

think it's an opportunistic intervention, the real success is from longer term relationships." P3 also shared that this is not always a feasible option due to funding limitations for peer support "Nobody wants to pay coaches to be with someone for three months or six months or a year." P1 shared that there were significant differences between getting individuals to engage in the hospital "four out of every 10 maybe would go" and when engaging in community-based follow up after discharge "the follow up process was very successful; we were able to get 75 to 80 percent to go to at least one or two meetings." Although both settings were viewed as integral parts of recovery support at the intervention and treatment phases in a ROSC.

Scope of practice

Most the PSWs interviewed repeatedly used the phrase "stay in your lane" to describe the need to recognize the scope of practice of a PSW and where they fit into the larger system of care (P5, P6, P7). P6 shared "Our job is to remove barriers and advocate. . .You don't mess with people's meds. We're not fixing their trauma, we can't. We can be sensitive to it" (P6). P7 explains that it involves not steering people toward one choice or another but rather guiding them toward healthier options. "We just try to guide them into making a choice that will be more healthy that the choice they were previously making and help people look into things they're willing to do."

While the role of PSW operates within a system of care and often within a community organization that has many types of programs, the PSW's interviewed expressed concern over expectations that do not mesh with the informal nature of the intervention (P3, P7, P8). P7 shard that outside agencies can be unclear on what the role of a PSW is and expect things from the service that are outside of the intention of the role.

> Sometimes we work with different probation departments and their people would test positive for marijuana, they don't understand the role that we're providing. We don't say you can't smoke marijuana, we may try to say if you smoke a joint, you're gonna test positive and you're gonna violate. . .we try to influence them into adhering to the stipulations that they have.

Others explained that there is increased pressure for measurable outcomes from grant funders and insurance companies who are looking for a return on their investment (P3, P4, P5, P8). Yet these demands were reported by the PSWs to contradict how they perceive their role and the informal nature of the relationship (P3, P6, P8).

> I get it on their end, they want outcomes to show that the money is worth spending. . .It's really hard to quantify like quality of life. It's really hard to quantify, I show up for my appointments. It's really hard to quantify I have a better relationship with my daughter. (P3)

While the PSWs understood the desire to have measurable outcomes, they reported a lack of connection between improved functioning and quantifiable measurements (P3, P6, P8).

> A lot of times it's something as simple as you've had a recoveree who didn't come out of his hours or wash his hair for 6 months and now he's coming out of his house with clean hair, going to the doctors, and coming to meet you for coffee. Your measurables are different with everybody. And the rest of it is just like looking at a person with your own eyes and seeing that, you know what? This guy is way better than he was last year. (P6)

P6 shared his belief that if they are afforded the time to build relationships with individuals struggling with addiction that the outcomes would become obvious. "You will see that your patients are doing better, you have to grow to trust the process" (P6). While the PSW's advocated for increased latitude in their role, they expressed concern that this is not possible due to the cost of this service and systematic expectations including reporting to stakeholders and demands for measurable outcomes (P3, P5, P7, P9).

Supervision

Supervision was described as an avenue for PSW's to have support for the peer role and to receive guidance around the more challenging aspects of the role (P1, P3, P6, P7, P8). Many PSWs enter the field as a natural extension to their personal recovery, through informal channels, without previous work experience, which was a concern raised by all the participants. P1 and P6 shared that this is a first job for many PSWs and identified a need to include job readiness skills in initial and ongoing trainings. P1 also explained that many of the skills that necessary in the role of PSW are learned through performing the work, making supervision during decision making an important piece of success in this role. "The only way to really teach this stuff is on the job. Yes, you should do the training but when it's the first time in somebody's life that they've ever even tried to do this, they need supervision" (P1). P6 also shared that supervision is crucial due to the acute nature the individuals they serve "you're going to have clients who have SI/HI, you need to be careful about the fact that you're a mandate reporter, you need to seek supervision over anything you see that doesn't sit right with you."

Some of the PSWs shared that their supervisors did not have a history of substance use or had never worked as a PSW (P1, P3, P6, P8). They expressed concern about whether this is an effective supervision model for a role built upon shared lived experience and shared that this often led to another level of their role being misunderstood or undervalued (P3, P6, P8). They observed individuals with clinical backgrounds attempting to transfer the skills to supervision of PSWs and shared that it appeared disconnected from the nonclinical and informal nature of peer support. In particular, they identified a lack of understanding of the lived experience, recovery processes, the delicate balance of maintaining boundaries and personal disclosure, and not having the deeper level of understanding recovery experiences that they were looking for (P1, P3, P6, P8). The need for self-advocacy from the peers for supervision

and ongoing support and training was identified as a critical aspect of long-term success.

Discussion

Themes identified from the qualitative interviews highlight both challenges and successes for the integration of PSWs into a ROSC. Important experiences of the role expressed by PSWs were challenges in establishing credibility of the role and the value of the service that can be provided, frustrations in managing systemic barriers to client success, ensuring appropriate scope of practice, and access to ongoing and supportive supervision by an individual in recovery that understands the peer role. PSWs shared that while initially the role was met with skepticism, many have experienced a shift to greater acceptance. Consistent with previous research, PSWs shared that the shared lived experience allowed them to serve as a bridge between providers and individuals in recovery[4] decreasing the existence of mistrust, and demonstrating that recovery is possible. PSWs found themselves to be able to model for both providers and individuals what recovery can look like and normalize the experience of relapse.

Previous research identified concerns about using the shared lived experience as the cornerstone of the helping relationship and the potential to perpetuate stigma related to substance use.[20,21] However, PSWs in the current study found that despite initial difficulty in establishing credibility, the perception of the peer role and its unique placement in a ROSC, became more widely recognized, leading to trust and respect for how it can enhance traditional services. The PSWs shared that the increased regard from providers coupled with the visible improvements in the individuals that they supported demonstrated the strength of this role. Yet the visible successes did not mitigate concerns related to demands for outcome measurement and fidelity to the nonclinical and informal nature of the intervention voiced by PSWs, with PSWs reporting challenges with operationalizing quality of life outcomes, and the need for continued attention to how success is measured in substance abuse recovery.

PSWs experienced benefits of the role including increased confidence, improvements in self-esteem, and a greater sense of control over their recovery and illness.[11,25] PSWs identified feeling proud when they are regarding as having something to offer and reported a visible decrease in stigma in the systems in which they worked. The PSWs shared that they found providers seeking out their advice when working with individuals in recovery, being asked to participate on task forces, and being integrated into service delivery options offered to individuals in early recovery. These improvements may be related to the increased visibility and understanding of how this role can increase engagement and outcomes. Despite these improvements, concerns exist regarding how this role is conceptualized by stakeholders and the appropriateness of expectations that are held. Specific items like reporting to child welfare, probation offices, clinicians, and other stakeholders should be

clarified and an understanding of the scope of practice enhanced. Future research into the ways peers have been successfully integrated into systems of care may help to solidify the understanding of these roles on a larger scale.

Supervision was a construct that all PSWs expressed as being critical to the sustainability of this role and a major asset in understanding the boundaries between nonclinical peer role and a clinical professional. Concerns were raised regarding the availability and quality of supervision, having supervisors who were in recovery or at least first-hand experience with substance use, and the need for PSWs to be strong advocates for what they require from supervision. This is consistent with previous studies that suggested the need for safeguards to ensure that harm does not come to the peer worker from the intensity of the role[30] (Tracy et al[31]). As many PSWs enter the field without previous work experience, support from supervisors who have firsthand knowledge of the way the PSW role may create stress for personal recovery, challenges due to acuity of patients, and typical boundary concerns that may arise is critical to ensuring success for the PSW. Further research may be needed to investigate best practices for supervision in peer-to-peer models, the impact that this has on longevity in the role, and success as a PSW.

Although the findings of this study contribute to the literature regarding the integration of PSW's into a system of care and identify clear challenges and benefits experienced by the PSW, there are some limitations that should be considered. PSWs in this study were from Massachusetts, a state that has a formal training academy and is developing a credentialing process for PSWs. It is recommended that similar studies be conducted in other geographic areas to understand potential differences if the model is less developed. While saturation appears to be reached, further investigation with a larger sample may have revealed additional findings due to the small sample size of the present study. While caution is necessary regarding generalization of the findings, the present study highlights some important items for consideration when integrating PSW's into a system of care.

While the PSWs in the present study had an average of 6 years of employment as a peer support worker, their actual span of experiences was 10 months to 20 years of employment. There were no discrepancies that stood out in their experiences related to length of employment, however, future studies that utilize a longitudinal approach to explore the experiences of the peer support worker over the course of their employment may identify if their subjective experiences of their role changes over time.

PSW in the substance abuse field is a growing and increasingly visible intervention that has yet to be fully operationalized and lacks widespread understanding as to the nature of the intervention. PSWs in the current study have experienced an increase in acceptance from coworkers and providers but continue to report inconsistencies in integration into the ROSC and expectations from stakeholders that are inconsistent with the nonclinical nature of the intervention. A more widespread

understanding of the PSW role may assist in the development of reporting strategies, supervision, and implementation into the ROSC that is more consistent and that accentuates the informal nature of the PSW role.

Author contribution

CS Project conceptualization and design, recruitment, data collection, data analysis and interpretation, writing of all drafts and revisions.

Ethical Approval/Patient Consent

Informed consent was obtained from all study participants. This study was approved by the Walden University Institutional Review Board.

ORCID iD

Christian Scannell (iD) https://orcid.org/0000-0003-1589-8231

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