Peer supports may facilitate re-integration and substance use disorder recovery following incarceration

Rates of substance use disorder are high among incarcerated individuals and there are insufficient supports in place to facilitate effective community re-integration following incarceration. In this study, researchers described and pilot tested an innovative peer support intervention for individuals with substance use disorder following release from incarceration. The results provide insights into interventions that might improve outcomes for these individuals post-incarceration, but research with more rigorous tests of their effectiveness are needed to inform practice and policy.

WHAT PROBLEM DOES THIS STUDY ADDRESS?

Incarceration rates in the US are the highest worldwide, and the prevalence of substance use disorder among incarcerated and recently released individuals is exceptionally high.

Readjustment to community life following incarceration is a challenge for many individuals with substance use disorder and may require social support as well as assistance with housing, employment, education, and accessing other community supports to promote readjustment and recovery. Peer support specialists who are trained to provide support; mentoring; and employment, housing, and treatment planning assistance might provide added value to individuals post-incarceration and provide care that complements existing services (e.g., outpatient treatment, case management). While peer support models are being delivered in both community and clinical care systems across the U.S., there are few studies that evaluate the effectiveness of peer supports in the context of outpatient substance use treatment and case management. Also, while these models are promising, existing studies have generally not been designed to examine whether these services improve substance use and other recovery outcomes. This study provided outcome data of a pilot randomized clinical trial, comparing their peer support and voucher program to treatment as usual within an outpatient clinic offering outpatient substance use disorder treatment and case management. This study provides an important building block toward developing a better understanding of the value of peer supports in the recovery process, both overall and for individuals post-incarceration specifically.

HOW WAS THIS STUDY CONDUCTED?

This study was a randomized pilot trial of 100 previously incarcerated individuals comparing substance use treatment as usual or treatment as usual plus a peer support intervention on recovery outcomes including self-efficacy, treatment motivation, and substance use. Eligibility specified individuals over 18, current substance use disorder diagnosis (how diagnosis was determined is not reported in the study), at least 1 felony or 5 misdemeanors, and release from prison or jail within 3 months of study enrollment. Recruitment into the study took place within the Public Advocates in Community Re-Entry (PACE) program, a non-profit and community-based program for previously incarcerated individuals in Indiana, and spanned October 2017-December 2018. The researchers conducted interviews with clients at baseline (i.e., the day participants first

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enrolled in services at PACE, which could have been at any point from one day to three months after release), and again at 6- and 12-months following baseline. Participants in the study received $60 for each interview (up to $180 total) and were entered into a raffle for 1 of 2 $100 gift cards at each assessment wave.

The peer support intervention – Substance Use Programming for Person-Oriented Recovery and Treatment (SUPPORT) – is based on a peer service model and designed to pair peer support workers, who are current or former clients of the PACE program, with a current client to support recovery and facilitate community reintegration following incarceration.

The peer support workers were certified by the state as "peer recovery coaches" to provide mentoring, facilitate support groups, and provide employment and housing assistance. The peer support intervention also engaged participants with recovery-oriented treatment planning consistent with client goals and provided vouchers to pay for recovery-oriented services. Clients assigned to the SUPPORT treatment condition received 12 months of individualized peer support and $700 in vouchers to cover an undefined group of "recovery support services" that were not covered by the program including housing, employment, treatment, transportation, childcare, education, or after care planning services.

Clients in the treatment as usual condition had access to the same standard of care that all individuals receive in the PACE program, including substance use counseling and case management services, but did not receive individualized peer support or vouchers.

In this pilot study, the researchers measured several outcomes that they considered to be mechanisms of action of their intervention, and primary study outcomes. The mechanisms of interest in this study included self-determination, treatment motivation, and general self-efficacy. Their primary outcomes included self-reported substance use and abstinence (e.g., nicotine, alcohol, sedatives, tranquilizers, opioids, stimulants, cannabis, hallucinogens, inhalants), motivation to change substance use behavior, and quality of life.

Participants in the study were 39 (SD = 10.4) on average, predominantly male (58%) and white (60%), followed by black (36%) and multiracial (4%). Participants were also predominantly straight/heterosexual (92%) with 8% reporting gay/lesbian, bisexual, or "unsure" identities. The vast majority (88%) were unemployed, 35% reported completing a college education, 45% held high school diplomas or equivalencies, and 20% reported lower than a high school education. The authors did not report on the types of substance use disorders or other relevant psychiatric or medical diagnoses of their sample.

> Peer supports can fill a gap that often exists in both formal and informal treatment for individuals with substance use disorder, and during the critical readjustment phase following incarceration. They can help the client by focusing on recovery first and by helping to rebuild and redefine the individual's community and life while also helping them access necessary occupational, housing, financial, and social supports.

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WHAT DID THIS STUDY FIND?

Attrition rates among the participants in the study was high, with over half leaving the study before 6 months, and more than 2 out of 3 leaving before 12 months.

A total of 77 out of 100 participants left the study. Three participants died during the study period and the remainder were recorded as "lost to follow up," which included re-incarcerated or leaving the program. Participants with higher treatment motivation and who had longer delays between their release from incarceration and treatment admission were less likely to drop out. That is, counter to what might be expected, shorter time lags between release and treatment admission were associated with a higher likelihood of dropout. All data from 6-month and 12-month follow-ups summarized below reflect just the sub-set of 23 individuals who completed these assessments.

The authors noted improvements on self-reported substance use but no significant differences between treatment groups.

Total abstinence from alcohol and other drugs increased in the peer support groups from 70% to 84%, but decreased in treatment as usual from 74% to 59% between baseline and the 6-month follow-up. While these, of course, reflect descriptive differences, they were not statistically significant. Participants in both groups maintained high rates of abstinence but reported decreases between the 6-month and 12-month follow-ups (down to 77% for SUPPORT and 59% of individuals in the treatment as usual condition).

Both groups generally improved on other recovery-related measures, with inconsistent differences between groups.

The peer support group reported positive changes in self-efficacy (their confidence in their ability to accomplish things they set out to do) whereas participants in the treatment as usual group reported positive changes in their perceived choices, or their feelings about the degree to which they have choices about how to behave. The two groups were statistically similar, however, on each of these outcomes at both follow-ups.

WHAT ARE THE IMPLICATIONS OF THE STUDY FINDINGS?

The authors describe outcomes of a pilot randomized clinical trial evaluating changes in substance use and other recovery-related outcomes among recently incarcerated individuals engaged in a substance use treatment and case management program. Half of participants were assigned to receive individualized peer support and vouchers for 12 months in addition to treatment as usual, whereas the remainder of participants only received treatment as usual.

While the authors reported that individuals in both groups reported similar improvements on substance use and recovery-related outcomes (e.g., self-efficacy) over time, follow-up rates were 28% and 37% in the SUPPORT and treatment as usual conditions, respectively, and the improvements reported only included individuals who completed follow-ups.

It is possible individuals dropped out of the study because they were not doing as well, making it difficult to determine how the sample overall, and for each group, fared over the 1-year follow-up period. As such, while the peer support intervention described here remains a promising approach to assist individuals with substance use disorder after incarceration, more research is needed to examine the effectiveness of this and other similar peer support interventions. While the authors did not report feasibility and acceptability data from the participants, the study helps support proof-of-concept and is a demonstration of the implementation of a peer support and voucher intervention for individuals with substance use disorder recently released from incarceration.

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As mentioned above, there was a very high level of drop out from the study, suggesting that greater attention may be needed to keep similar clients and participants engaged in treatment and research, respectively. The authors further found that dropout was highest among individuals with lower levels of treatment motivation and who initiated treatment sooner rather than later following their release from incarceration. The latter and somewhat counter-intuitive finding might relate to the possibility that the participants who were most likely to stay in the study and in treatment had less immediate need for treatment following their release, were more stable by the time they entered treatment, or had more support and resources available to them after their release from incarceration. If so, these individuals might have characteristics or resources that promote treatment engagement and study continuation relative to those who started treatment earlier. In contrast, individuals who started treatment earlier might have been more severe, may have required more intensive treatment or resources, and might also have more closely resembled those who never sought treatment in the first place (e.g., higher level of ambivalence).

LIMITATIONS

BOTTOM LINE

Outpatient treatment, case management, and potentially peer support represent promising intervention strategies for individuals with substance use disorder in the weeks and months following release from incarceration. While receiving additional peer support on top of outpatient treatment, descriptively, was associated with improved substance use outcomes, the high drop-out rates from the study make it too difficult to draw conclusions. While interventions that leverage peer recovery support specialists are promising, more effort and support is needed to increase sustained treatment and research participation in the future to reduce attrition and increase the rigor of tests of their effectiveness. This study provides important information on the challenges of studying this population that can inform future research.

- ***For individuals and families seeking recovery***: Individuals face a variety of stressors as they re-adjust to daily living following release from incarceration. Common obstacles pertain to employment, housing, medical and mental health concerns, lack of finances or social supports, and limited means of accessing effective treatments. For individuals and families, substance use disorder treatment and case management that helps to improve housing, employment, education, and recovery prospects appears to be highly beneficial. While peer recovery supports are promising, more research is needed before we can confidently say these services are likely to help.
- ***For treatment professionals and treatment systems***: Clients face a variety of obstacles as they readjust to life following release from incarceration and may need added support and assistance to obtain and maintain housing, employment, training, and to achieve and maintain substance use disorder recovery. The authors of this study describe outpatient treatment and case management options that may be efficacious, as well as a model for delivering a peer support intervention to supplement usual care. While participants in both conditions in this study improved similarly, there may be benefit from implementing peer support specialists to supplement usual care, given peers' ability to lead by example, provide information, and to support clients in recovery beyond that which is typically provided in outpatient care clinics.
- ***For scientists***: The authors of this study did not detect significant between group differences which might relate to insufficient statistical power. Prior to the execution of the study, the authors projected they needed 80 participants to achieve 80% power. They later indicated they may have been underpowered (largely due to high levels of attrition) and estimated that 304 participants would be needed to detect between-group differences. Replication of this kind and magnitude could be beneficial to evaluate the statistical significance of their

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results, which included small and moderate effect size differences between groups in the absence of statistical significance. As the authors point out, there is a dearth of rigorous research on this topic; replication may benefit from careful attention to research design, with preference for randomized clinical trials to evaluate the efficacy of peer support interventions. Future research might also benefit from examining the use of peer recovery support specialists specifically to facilitate adherence to medications for substance use disorder (e.g., buprenorphine). Despite the obvious limitations of the findings, this study nonetheless provides important information on the challenges of studying this population that can inform future research protocols.

- ***For policy makers***: The number of individuals incarcerated in the U.S. is higher than anywhere else in the world, and rates of substance use disorder and substance-related deaths among incarcerated and recently released individuals are exceptionally high. Engaging these individuals in therapy, offering case management, and potentially peer support may provide critical support during the post-incarceration readjustment phase. However, research in this area remains underdeveloped and increased funding and support could increase the development, implementation, and evaluation of novel intervention strategies to engage these individuals in care and retain them in treatment to facilitate readjustment and recovery from substance use disorder.

CITATIONS

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A systematic review of the effectiveness and cost-effectiveness of peer education and peer support in prisons

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Abstract

Background: Prisoners experience significantly worse health than the general population. This review examines the effectiveness and cost-effectiveness of peer interventions in prison settings.

Methods: A mixed methods systematic review of effectiveness and cost-effectiveness studies, including qualitative and quantitative synthesis was conducted. In addition to grey literature identified and searches of websites, nineteen electronic databases were searched from 1985 to 2012.
Study selection criteria were:
Population: Prisoners resident in adult prisons and children resident in Young Offender Institutions (YOIs).
Intervention: Peer-based interventions.
Comparators: Review questions 3 and 4 compared peer and professionally led approaches.
Outcomes: Prisoner health or determinants of health; organisational/process outcomes; views of prison populations.
Study designs: Quantitative, qualitative and mixed method evaluations.

Results: Fifty-seven studies were included in the effectiveness review and one study in the cost-effectiveness review; most were of poor methodological quality. Evidence suggested that peer education interventions are effective at reducing risky behaviours, and that peer support services are acceptable within the prison environment and have a positive effect on recipients, practically or emotionally. Consistent evidence from many, predominantly qualitative, studies, suggested that being a peer deliverer was associated with positive effects. There was little evidence on cost-effectiveness of peer-based interventions.

Conclusions: There is consistent evidence from a large number of studies that being a peer worker is associated with positive health; peer support services are also an acceptable source of help within the prison environment and can have a positive effect on recipients. Research into cost-effectiveness is sparse.

Systematic review registration: PROSPERO ref: CRD42012002349.

Keywords: Systematic review, Prisoners, Prisons, Peer interventions, Peer education, Peer support, Health promotion, Health inequalities

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Background

Offender health is a priority for the Department of Health in England and Wales [1] because ill health is more prevalent in prisoners than the general population [2], and prisoners experience significant health inequalities associated with multi-faceted social problems. [3,4] In December 2013, the prison population of England and Wales was 85,429 [5] - high by European standards [6] - with a relative increase in prisoners aged over 50 years [7]. The global prison population has also grown exponentially in all five continents, to a reported 10 million [8]. Imprisonment can produce adverse health impacts, particularly in mental health [9,10]; in 2012, for example, there were 23,158 self-harm incidents in prisons, affecting approximately 6,761 individuals. Younger prisoners, female prisoners and prisoners in the early stages of custody were most likely to self-harm. Suicides are reported to be 102.6 per 100,000 prisoners, compared with 10–12 per 100,000 in the general population [11]. Evidence shows that prisoners engage in riskier health behaviours, such as drug and alcohol misuse [4] and smoking [12]. Inequalities in long term conditions also exist; with over a quarter of newly sentenced prisoners reporting a long-standing physical disorder or disability [13]. Evidence suggests that women prisoners [13,14] and older prisoners [7] have greater physical health needs.

Since 2006, the NHS has had responsibility for prison healthcare in England and Wales, with a duty to provide services equivalent to those in the community and, since April 1st 2013, NHS England took responsibility and oversight for commissioning all health services (with the exception of some emergency care, ambulance services, out of hours and 111 services) for people in prisons in England through 'Health and Justice' commissioning teams. [15] While many offenders experience barriers accessing health services outside of prison [16], prison health services can potentially improve prisoners' physical and mental health [17]. NHS England have a clear remit for commissioning health promotion in prison, supported by the Ministry of Justice who are responsible for wider health promotion through non-clinical service provision, such as exercise promotion delivered by qualified prison gym staff [15].

Peer-based interventions, where prisoners provide education, support or advice to other prisoners, can contribute to achieving health and social goals within the prison environment and beyond [18]. A 2002 survey estimated that seven percent of prisoners played peer support roles [19]. Justifications include: ability of peers to connect with other prisoners [20] and to have social influence with vulnerable populations resistant to professional advice [21,22]; direct benefits for the peer deliverers themselves [20,23]; wider benefits for the prison system including effective use of resources [24,25]; expanding the range of health services in the criminal justice system [26].

There is evidence of peer interventions operating across prisons globally, ranging from HIV/AIDS programmes in Mozambique and Siberia [27,28] to peer-led emotional support schemes in Israeli prisons [29]. Nevertheless, recent commentators have argued that the emphasis placed on health promotion intervention varies significantly across the world's prison systems. The WHO's health-promoting prison philosophy, for example, is less well developed in resource-poor regions, like sub-Saharan Africa [30]. This is reiterated in recent reviews which have shown that most published accounts of peer interventions come from prison systems in the UK, US, Canada and Australia [31].

Peer support is an established feature of prison life in England and Wales, for example the Listeners scheme, developed by the Samaritans and first launched in 1991 at HMP Swansea [32] as part of a suicide prevention strategy, now operates across most prisons in England and Wales. Other peer–based interventions in English and Welsh prisons address substance misuse, violence reduction, support for new prisoners, translation services, housing and employment advice and mentoring schemes [23] and, more recently, health trainer schemes [26].

There is an extensive evidence base on peer roles for improving access to healthcare services and removing barriers to health in the general population [33,34], but more needs to be known about the effectiveness of these interventions in prison settings, especially given their prominence [19,23,35]. The international literature on effectiveness of different types of prison-based peer education and support has not been systematically reviewed. One literature review of prison-based peer education schemes noted the dearth of evidence demonstrating effectiveness, despite positive impacts reported by some studies [22], while a recent systematic review of peer health promotion concluded that peer education could impact positively on attitudes, knowledge and behaviours of sexual health and HIV prevention, but there was little research on other health issues [31]. Studies of peer support for suicide prevention/self-harm [20,24] report benefits of peer-delivered emotional support, such as decreased prevalence of suicide [36,37]. Peer-based interventions might be more cost-effective than professionally-delivered ones [22]. The cost-effectiveness of peer interventions promoting behavioural change has been assessed in a variety of settings and populations with mixed results [38-40], but to date there has been no systematic review of the cost-effectiveness of peer interventions on health in prison settings. This study thus addresses a knowledge gap by synthesising evidence on a range of peer-based interventions in prison settings and their effectiveness and cost-effectiveness [41].

Methods

Objectives

The study used standard systematic review methodology to appraise evidence on effectiveness and cost-effectiveness [42-44] with input from experts in the field, in the form of steering and advisory groups. A full study protocol was developed and peer-reviewed by the study Steering and Advisory Groups prior to publication on PROSPERO (ref: CRD42012002349 http://www.crd.york.ac.uk/prospero/display_record.asp?ID=CRD42012002349).

The main research question was:

What is the effectiveness and cost effectiveness of peer-based interventions to maintain and improve health in prisons and young offender institutions (YOIs)?

This led to four review questions:

1. What are the effects of peer-based interventions on prisoner health and the determinants of prisoner health?
2. What are the positive and negative impacts of delivering peer-based interventions on health services within prison settings?
3. How do the effects of peer-based approaches compare to those of professionally-led approaches?
4. What is the cost and cost effectiveness of peer-based interventions in prison settings?

This paper reports the findings for review questions 1, 3 and 4; review question 2 will be explored in a separate paper.

Data sources

Sources searched for papers published from 1985 to 2012, with no language restrictions: MEDLINE; PsycINFO; CINAHL; EMBASE: International Bibliography of the Social Sciences (IBSS); ASSIA; Web of Science, Social Science Citation Index; National Criminal Justice Reference Service Abstracts; Social Services Abstracts; Sociological Abstracts; DARE; TRoPHI; DoPHER; Health Evidence Canada; ORB Social Policy Database; Social Care Online; Academic Search Complete; Cochrane and Campbell Collaboration Databases. Electronic contents lists of key journals (Journal of Correctional Health Care, Health Education & Behavior, Criminal Justice and Behavior) were also searched.

Search terms drew on results from a previous systematic scoping review on lay roles in public health [45], with further search terms identified in consultation with the project steering group.

Additional databases for the cost-effectiveness review were NHS EED and REPEC (IDEAS). Other databases were searched using an adaptation of the economics search filters developed by the NHS Centre for Reviews and Dissemination combined with the search terms used in the effectiveness literature search strategy.

Search strategies are available from the authors on request.

Unpublished (grey) literature was identified from contacts with experts, conference and dissertation abstracts, reference lists of key papers, hand searches of relevant book chapters, and searches of relevant websites. Contacts made with national and international experts included: Offender Health Research Networks (OHRNs); Prison and Offender Research in Social Care and Health (PORSCH); Samaritans (Listeners scheme); Volunteering England; National Offender Management Service (NOMS); PCTs (health trainers); Prison Officers' Association (POA); Action for Prisoners Families; CLINKS; Prison Governors' Association.

Practitioners and academics with expertise were contacted through academic and practice mailing lists.

Study selection

Two reviewers independently selected studies for inclusion. Any disagreements were resolved by discussion, and a third reviewer if necessary.

Eligibility criteria

Population: Prisoners resident in prisons and children in YOIs in any country, all ages, male and female.

Intervention: Any peer-based intervention, including peer education, peer support, peer mentoring, befriending, peer counselling and self-help groups, operating within prisons and YOIs in any country. 'Peer' includes prisoners and ex-prisoners delivering interventions to serving prisoners.

Comparators: For Review Questions 3 and 4, studies comparing peer and professionally-led approaches to the same health or social problem. For all other questions, studies with any or no comparator (or usual care).

Outcomes: Studies reporting any effects of peer-based interventions on prisoner health or determinants of health within the prison setting. For review question 4, papers reporting resource use/cost and/or outcome comparisons of peer-based interventions with standard care.

Study designs: Quantitative, qualitative and mixed method evaluations.

Data extraction

Data were extracted onto piloted electronic forms by one reviewer and checked for accuracy by a second, with reference to a third reviewer if necessary. Data extraction fields included: Bibliographic detail; Population details; Setting/institution details; Intervention details; health or social issue; method of delivery; Outcomes.

Additional data extracted from cost-effectiveness studies were: type of economic evaluation; the basis of costing; source of cost data; cost year and discounting;

summary of effectiveness and costs; cost-effectiveness/utility; sensitivity analysis and conclusions as reported by the authors.

Detailed extraction of quantitative data took place into Microsoft Word tables and RevMan 5.0.

Detailed extraction of qualitative data took place into NVivo 9 software, using text conversion of pdf files to import the whole paper. Coding was then applied to methodological and other potential sources of variation (such as population, intervention and settings), as well as results, to allow data to be assembled in the most appropriate way [46-48].

Study authors were contacted for additional or missing information, where needed.

Validity assessment

Appropriate validity assessment criteria were developed based on published checklists [44,49]. Data from grey literature were assessed using the same criteria. Two reviewers assessed each study for validity using piloted forms. Disagreements were resolved by discussion and a third reviewer if necessary. No papers were excluded on the basis of the validity assessment.

Each validity assessment form required the reviewer to make an overall assessment of internal validity and of relevance, based on the completed checklists. These were: 1–3 for internal validity (where 1 = good internal validity and 3 = poor internal validity), and a-c for relevance (where a = highly relevant and c = not very relevant).

The quality of cost-effectiveness papers were assessed using a modified version of the Drummond et al. checklist [50]. For papers reporting economic evaluations alongside clinical trials, this was supplemented with reference to the Good Practice Guidance produced by the ISPOR Task Force on Economic Evaluations alongside Clinical Trials [51]. For papers reporting cost-effectiveness models, the checklist was supplemented with reference to the checklist proposed by Drummond et al. [50] and the Good Practice Guidance [51].

Data synthesis

Quantitative data was synthesised by two reviewers. Where data were suitable for statistical meta-analysis, studies were combined using a fixed effect model to give relative risks with 95% CIs for binary outcomes and weighted or standardised mean differences with 95% CIs for continuous outcomes. Statistical heterogeneity was examined using the χ^2 and I^2 statistics, with a χ^2 p-value of >0.1 or an I^2 value of >50% indicating statistical heterogeneity, in which case, reasons for the heterogeneity would be investigated, and a random effects model would be used.

A thematic synthesis of qualitative studies was undertaken to combine evidence [46] using QSR NVIVO software to manage the data and ensure a transparent process.

A mixed method systematic review design similar to that used by the EPPI-Centre [46] was then used to combine qualitative and quantitative data. For Review Question 1, studies were grouped according to intervention mode and then type of outcome. For Review Questions 1 and 3, qualitative themes on outcomes for peer deliverers and recipients were mapped to quantitative results grouped by intervention mode and then type of outcome [52].

Due to lack of detail given in the included studies, it was not possible to look at the modifying effects of type of institution, prisoner pathway or gender differences.

For the cost-effectiveness review, data were synthesised through a narrative review with tabulation of results of all included studies.

Results

The effectiveness literature search identified 15,320 potentially relevant papers (Figure 1). 14,963 articles were excluded at the title and abstract screening stage, and 357 articles were obtained and screened in full. 237 papers were subsequently excluded, and we were unable to obtain a further 63 potentially relevant articles, leaving 57 studies included in the review.

Searches for the cost or cost-effectiveness analysis of prison-based peer-interventions identified 1158 titles and abstracts (Figure 2). Twenty six full-text papers were retrieved for assessment. From these, one eligible study was identified, 25 studies were excluded on methodological grounds as none reported costs or cost-effectiveness.

A list of excluded studies is available in the full report [41].

The effectiveness review included 57 studies [19,21,23-29,32,36,37,53-98], and one study was included in the review of cost-effectiveness [99,100] (Table 1). Twenty were carried out in the UK (Table 2). Peer education was the most studied intervention mode, followed by peer support (Table 3). Twenty studies looked at HIV/AIDS/Hepatitis C or other blood borne virus or STI prevention [21,25,27,28,55,60,63,65,66,68,69,75,78,84,85,87,89,93,97,98], 12 at general health and/ or hygiene,(25, 32, 38, 40, 119, 127, 133, 136, 140, 148, 149, 157, 159) eight at general emotional support,(146, 151–156, 161) and seven at prevention of suicide or self-harm. [20,24,32,36,56,61,86] (Table 4)

Overall, the internal validity of included studies was quite poor, with only five studies judged to be of good quality [53-57], 18 of moderate quality [23,29,32,58-72] and 32 poor quality [19,21,25,27,28,36,73-98]. Five were

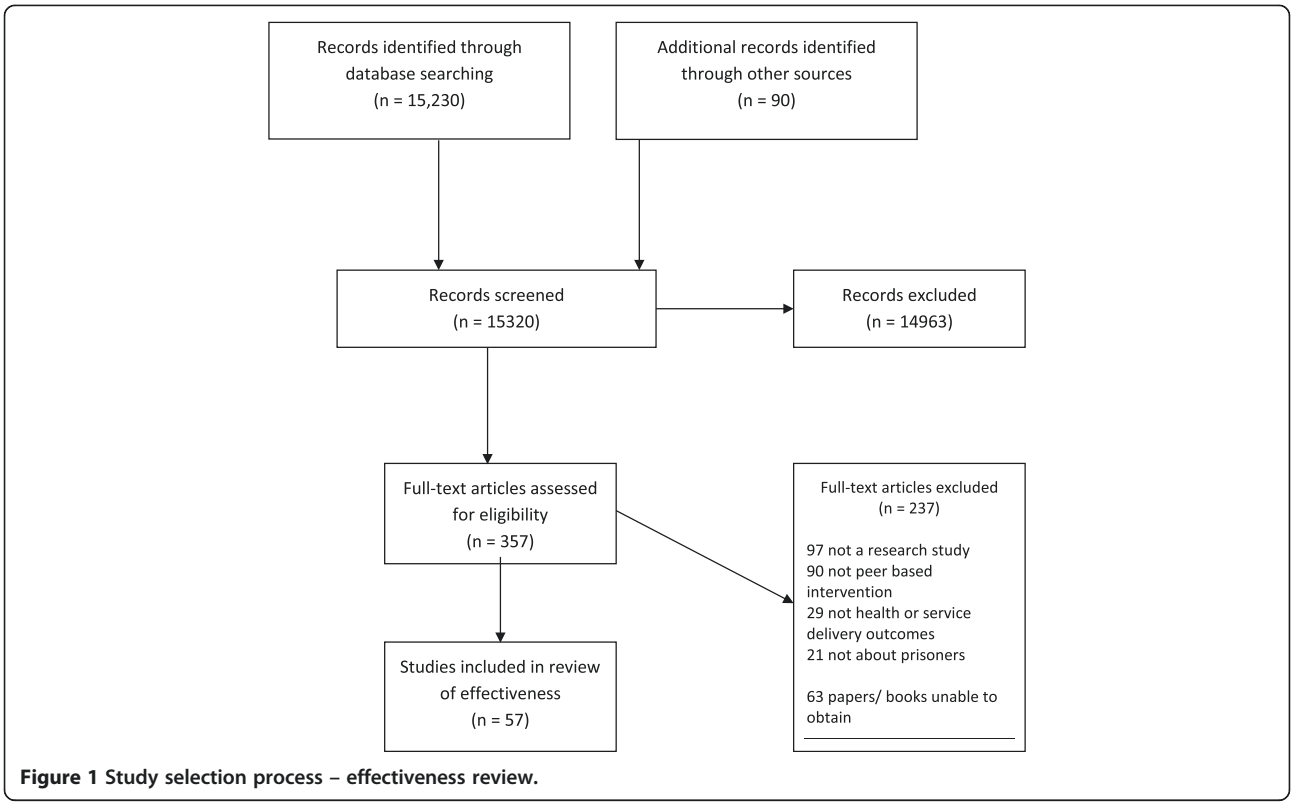

Figure 1 Study selection process – effectiveness review.

judged to be highly relevant [53,54,56,57,59], with 27 of some relevance [19,21,23,28,29,32,55,58,60,61,63-68,70,71,75,79,81,84,86,92,95-97] and 22 not very relevant [25,27,36,62,69,72-74,76-78,80,82,83,85,87-91,93,98].

The main issues affecting internal validity were small sample size, lack of comparators and/or lack of adjustment for potential confounding factors, poor reporting of study methodology and poor reporting of results, limiting meta-analysis of quantitative studies, or meta-ethnography of qualitative studies. Only two studies defined "peer".

A typology of interventions was developed with working definitions for the major intervention modes (Table 5).

Review Question 1: What are the effects of peer-based interventions on prisoner health?

Fifty-one studies were relevant to review question 1 [19,21,25,27-29,32,36,53-64,66-77,79-84,86-98], eighteen had a quantitative design [21,25,27-29,60,63,66,69,71,83,84,86,88,89,92,93,98], three of these were RCTs [25,63,84]. Fourteen studies had a qualitative design [32,53,55-57,61,62,67,70,74-77,87,107] and 15 were mixed methods [19,36,54,58,59,68,72,79-81,90,94-97]. Four studies had an unclear design [64,73,82,91]. Seventeen were UK studies [19,32,53,56,57,59,61,62,67,73,74,88,89,91,92,94] and 17 were from the USA [21,25,55,60,63,64,66,68,71,77,83,84,86,87,90,93,98]. The predominant intervention type was peer education (19 studies) [21,25,27-29,55,60,63,66,68,69,76,84,88-90,93,97,98].

Findings are presented in Table 6.

Peer education

Ten included studies [28,66,68,69,84,88,90,93,97,98] reported the effects of peer education on prisoner knowledge. There was no standard outcome measure used. Statistically significant improvements favouring peer education were seen in the number of correct answers to 22 of the 43 questions asked, while negative effects of peer education were seen in the answers to one of the 43 questions asked. The responses to the remaining 20 questions showed no evidence of effect of the intervention. Risk ratios ranged from 0.43 (95% CI: 0.33, 0.56, 1 study n = 949) - in favour of peer education to 3.06 (95% CI: 1.91, 4.91, 1 study, n = 200) - against peer education (Figure 3). Qualitative evidence suggested that peer educators improved their own knowledge of health issues as a result of their training [55,68,76].

Findings were equivocal for the effects of peer education on behaviour change intentions and health beliefs. Consistent evidence indicated that peer education reduced risky behaviours: not using a condom at first intercourse after release from prison (pooled RR 0.73, 95% CI: 0.61, 0.88, 2 studies, n = 400); injecting drugs after release from prison (pooled RR 0.66, 95% CI: 0.53, 0.82, 2 studies, n = 400); injected in past 4 weeks (RR

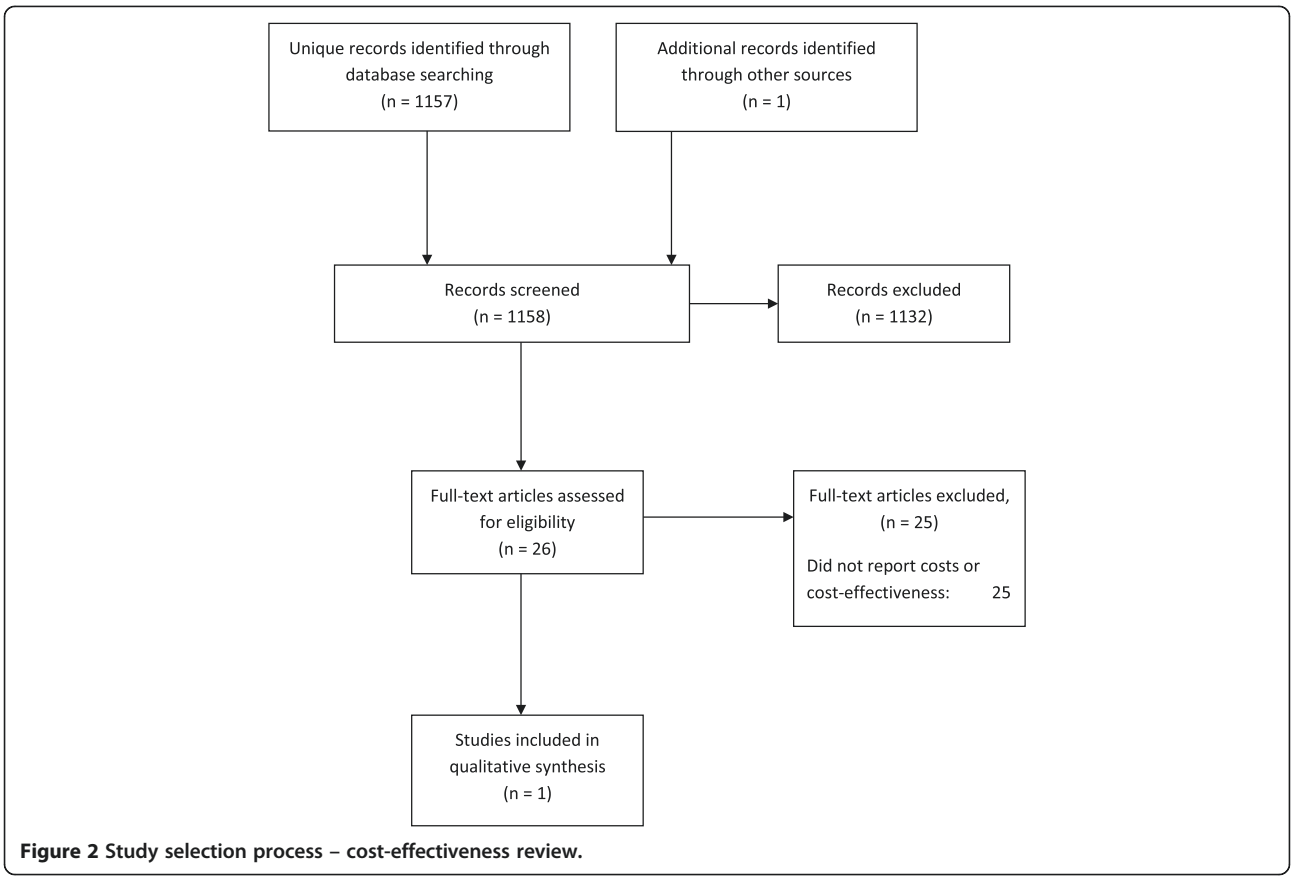

Figure 2 Study selection process – cost-effectiveness review.

0.11, 95% CI: 0.01, 0.85, 1 study, n = 241); sharing injection equipment after release from prison (pooled RR 0.33, 95% CI: 0.20, 0.54, 2 studies, n = 400); peer educators never having had an HIV test (RR 0.31, 95% CI: 0.12, 0.78, 1 study, n = 847) (see Figure 2). Weak evidence indicated an association between peer health education programmes and uptake of screening/HIV testing in prisons [87,89].

Peer support

Six included studies reported the effects of peer support interventions on prisoners [58,79-81,95,96]. These all reported on the Canadian Peer Support Team (PST) program and used similar evaluation designs and outcome measures. The PST Program is a model that has been developed and delivered across a number of Canadian prisons. It is specifically targeted at women prisoners and is based on a holistic, women-centred approach to health care that aims to be culturally sensitive and to develop the women's autonomy and self-esteem. Three studies used the Rosenberg self-esteem scale to measure prisoners' self-esteem [58,80,95] and found no statistically significant effect (pooled WMD 1.51, 95% CI: −0.84, 3.86, 3 studies, n = 83), although there was substantial heterogeneity (I^2 = 81%). Strong qualitative evidence related to improvements in the peer deliverers' self-esteem, self-worth and confidence as a result of the role [53,58,79-81,96]. The sense of being trusted by the prison authorities was reported to enable peer deliverers to regain their self-respect [23,79]. The notion that peers became more empowered consequentially was alluded to [58,79,80,95,96]. Peer support was reported to have helped prisoners either practically, emotionally, or both [58] and could be particularly beneficial for prisoners during the early part of their sentence [62]. In several studies [23,58,79,80,96], peer deliverers gained better self-awareness and perspective on their life as well as developing the skills to deal with their own health and offending issues. One study [23] suggested that the experience of being a peer support worker could reduce the likelihood of re-offending.

The demands placed on peer support workers/counsellors by other prisoners gave individuals a sense of purpose in prison [23,53,94] and this was beneficial for combatting boredom while serving the prison sentence [23,53]. However, there were indications that the role could be challenging and onerous and the burden of care of supporting many prisoners could be problematic [53].

Table 1 Included Studies

Study	Country	Study design	Health topics	Nature of intervention/ scheme	Population/setting	Individual outcomes	Service, delivery or organisation outcomes	Validity score*
Ashton 2010 [75]	Canada	Qualitative	HIV/AIDS and HCV (& other infectious diseases)	Peer support	"Healing Lodge" – a small (28 bed) minimum/medium security prison for Aboriginal women, incorporating Aboriginal healing practices, meaningfulness and cultural-connection. Most women are serving sentences of 3 years or less.	Strengths of programme listed. Staff perceptions.	Not reported	3b
Betts-Symond 2011 [76]	Ireland	Qualitative	Health, hygiene and cleanliness	Peer education	700 prisoners in Wheatfield prison, Dublin Ireland (medium-high security male prison) and their immediate family members	Personal development and changed outlook of the volunteers; results presented under 6 themes: Environment, behaviours, capabilities, beliefs and values, identity & goals.	Relationship between operational health services and inmate IRC volunteers.	3c
Blanchette 1998 [58]	Canada	Mixed Qualitative& Quantitative	General emotional/ mental health, psychological support and counselling	Peer support	Women resident in one of four small prisons in Canada: Nova Institution; Etablissement Joliette; Grand Valley Institution; Edmonton Institution.	Self-esteem; Sociometric tests for understanding personal and group dynamics; Perceptions of the prison environment (correctional environment status inventory); Staff and prisoners' views, feelings and ideas about PST (interviews).	Staff and prisoners' awareness and perceptions of the role and functioning of the PST (surveys);	2b
Boothby 2011 [53]	UK	Qualitative	General health/ support	Peer support	Male prison in the UK. The scheme supports prisoners who are new to the prison system.	Insiders perceptions of role and themselves. prisoners' mood; suicide rates	Numbers of prison staff	1a
Boyce 2009 [59]	UK	Mixed	Housing/ resettlement	Peer advisors	Serving prisoners in: 3 category B prisons (male), 1 Youth Offending Institution (male)	skills and self-confidence, work ethic, sense of control over their lives, work experience and qualifications.	Effects on 'professional' time. Staff concerns: potential for bullying or intimidation and breaches of confidentiality.	2a
Brooker & Sirdifield 2007 [54]	UK	Mixed Qualitative & Quantitative	Multiple health issues	Health Trainers	Serving prisoners in 4 adult prison, one Young Offenders Institution and one probation setting	Perceptions of tutors of the Health Trainers re. confidence; knowledge of services; communication skills; ability to assess someone's readiness to change; self-esteem; self-worth. Perceptions of health trainers re. knowledge of health issues and attitude; confidence in sign-posting individuals to services; changing own behaviour.	Perceptions of prison-based trainees re. their role. Perceptions of stakeholders re: -workload for prison PE departments	1a

Table 1 Included Studies *(Continued)*

						Perceptions of health trainer clients; issues discussed; services referred on to.	-training sessions -Raising risk issues - engagement with health services -Change of focus for the gym -Highlighting a lack of health services in some areas -Raising staff awareness of health issues and/ or services available	
Bryan 2006 [60]	USA	Quantitative Pre-test post-test design (one group only).	HIV prevention	Peer education	196 serving prisoners in maximum and minimum security prisons. 90% male, mean age 30.4y.	Knowledge; Perceived risk; Condom attitudes; Condom norms; Condom self-efficacy; Condom intentions; Attitudes for not sharing needles; Norms for not sharing needles; Self-efficacy for not sharing needles; Intentions to not share needles; Peer education attitudes; Peer education norms; Peer education self-efficacy; Peer education intentions; Peer education behaviour.	Not reported	2b
Chen 2006 [29]	Israel	Quantitative Pre & Post	General emotional/ mental health, psychological support and counselling	Peer counselling	93 male repeat offenders in three prisons in Israel. (Two maximum security and one minimum security). Mean age 36 years (SD = 6.35).	Sense of coherence; Meaning in life; Anxiety; Depression; Hostility:	Not reported	2b
Cichowlas & Chen 2010 [77]	USA	Qualitative	General health/ support	Prison hospice volunteers	Ill/dying prisoners at Dixon Hospice in Illinois	Perceptions of peer deliverers	Not reported	3c
Collica 2007 [78]	USA	Quantitative & Qualitative	HIV/AIDS and HCV (& other infectious diseases)	Peer education	All prisoners in USA were covered by the survey.	Facilities were asked to report on: 1. Number of HIV positive inmates in their custody; 2. If they mandated HIV testing; 3. If they provided prison-based peer programming on HIV. If answer to Q3 was YES: Extent of HIV peer education, and other services.	Not reported	3c

Table 1 Included Studies *(Continued)*

						If answer to Q3 was NO: How HIV education was provided and why inmate peers were not used.		
Collica 2010 [55]	USA	Qualitative	HIV/AIDS and HCV (& other infectious diseases)	Peer education	Aimed at women in prison with HIV/AIDS. One maximum and one medium security prison for women	Role of peers	Not reported	1b
Correctional Service of Canada 2009 [79]	Canada	*Quantitative & Qualitative*	General emotional/ mental health, psychological support and counselling	Peer Support	Women prisoners "in distress"	From interviews: predominant mental health issues of women prisoners; how these are addressed in training sessions; benefits to trained peer counsellors	Trust between staff and prisoners	3c quant/ 3b qual
						From survey: whether prisoners value the PST; reasons for asking to see a peer counsellor; benefits to service recipients; helpfulness of peer counsellors; recommendations for improvements	Staff becoming part of peer support team	
							Recommendations for improvements.	
Daigle 2007 [24]	Canada	Not applicable	Suicide/Self harm	Peer support	Canadian prisons (no further details reported).	Not reported	Concerns about recruitment, security and responsibility	N/A
Davies 1994 [32]	UK	Qualitative	Suicide/Self harm	Listeners	HMP Swansea (adult prison)	Attempted suicide rate.	staff time.	2b
						use of the strip cell or care room.	Prison atmosphere.	
						Listeners' perceptions (benefits to Listeners)		
Delveaux & Blanchette 2000 [80]	Canada	*Quantitative & Qualitative*	General emotional/ mental health, psychological support and counselling	Peer support	Small women's prison.Women prisoners, all serving sentences of two or more years and classified as minimum or medium security.	Self esteem; Sociometric tests for understanding personal and group dynamics; Perceptions of the prison environment (correctional environment status inventory)	Staff and prisoners' awareness and perceptions of the role and functioning of the PST (surveys)	3c
						Staff and prisoners' views, feelings and ideas about PST (interviews).		
Dhaliwal & Harrower 2009 [61]	UK	Qualitative	Suicide/Self harm	Listeners	Vulnerable or distressed prisoners, or those at risk of suicide.	Listeners' own experiences, the impact on them as individuals, skills and/or benefits acquired.	Presents findings in relation to what the prison service can do to support the scheme.	2b
Dolan 2004 [27]	Russia	Quantitative: pre and post	HIV/AIDS and HCV (& other	Peer education	Male colony for drug-dependent prisoners in Siberia. Mean age 24 (range 18–30), 63% first time in prison, mean	Whether seen the program booklet?	Access to bleach and condoms	3c

Table 1 Included Studies *(Continued)*

			infectious diseases)		years served 1.2 (SD 0.7), 66% imprisoned for drug related offence.	Whether participated in peer training education? Demographic characteristics; Knowledge of HIV transmission; STI and BBVI status; Drug use; Sexual activity; Tattooing; Access to bleach and condoms.		
Eamon 2012 [81]	Canada	*Quantitative & Qualitative*	General emotional/ mental health, psychological support and counselling	Peer Support	Edmonton Institution for Women population = 65	Satisfaction with/ performance of PST; Hours per week of support provided by PST members; Time to response to inmate calls for peer response; Level of trust in PST members; Suggestions for improvement; Improving relationships.	Suggestions for improvement to number of sessions	3b
Edgar 2011 [23]	UK	*Quantitative & Qualitative:*	Multiple health issues	Peer support/ Listeners	Not stated	Various, including Listeners and other peer roles.	Diverting workload away from staff.	2b
Farrin (undated) [82]	Australia	Review	Multiple health issues	Peer support	*At-risk prisoner* in 8 state prisons	Changes in responsibility, accountability and self-esteem (Syed & Blanchette 2000)	Reports the results from Devilly et al., 2003 on changing attitudes and behaviours; Offender preference	3c
Foster 2011 [56]	UK	Qualitative	Suicide/Self harm	Listeners	Adult category-B local male prison. Operational capacity 1103	Effect on Listeners' personal development; Self-esteem; well-being; relationships. Numbers of potential suicides and incidents of self harm.	Prison environment, burden on prison staff and health care professionals.	1a
Goldstein 2009 [83]	USA	Quantitative	Mental health/ Substance abuse	Peer mentoring	2 correctional facilities. Incarcerated women with current or history of behavioural issues and/ or substance abuse. Age range: 19 to 59 y (mean = 35 y). 15 out of the 32 participants had 5 or more prior incarcerations.	Adherence to outpatient psychiatric treatment, including medication management; Medication compliance, sobriety & symptom reduction; Re-offending; Abstinence in the use of alcohol or illegal drugs or misuse of prescription drugs; Employment or enrolment in an educational program or completion of the application process for disability benefits; Secure treatment, transitional housing or a permanent place to live.	Nor reported	3c
Grinstead 1997 [84]	USA	Quantitative: RCT	HIV	Peer education	Male inmates at large (n = approx. 5600) medium-security state prison. . 45% had history of injection drug use, more than 75% of these reported having shared equipment.	HIV Knowledge; Preference for teacher; Condom use intention; Bleach use intention; HIV antibody use intention; Interested in taking test now.	Not reported	3b
Grinstead 1999 [25]	USA	Quantitative. RCT	HIV prevention	Peer education	Large state prison for men. Mean age 35y, spent more than 9y of life in prison. 90% had just completed a	Risky behaviour at follow up:	Not reported	3c

Table 1 Included Studies *(Continued)*

					sentence of less than 5y and <10% were imprisoned for the first time.	used a condom the first time they had sex since release; used drugs since release; injected drugs since release; shared needles		
Hall & Gabor 2004 [36]	Canada	Mixed quantitative and qualitative.	Suicide prevention	Listeners	Medium security prison with capacity 585. Inmates have committed serious crimes. modal age category 18-29y, followed by 30-39y. Length of sentence ranged from 2 years to life.	personal growth, knowledge of suicide, self-esteem, communication skills, and sense of purpose; support; general program operation; impact of training; personal development	Findings are reported related to program implementation	3c
Hoover & Jurgens 2009 [85]	Moldova	Qualitative	HIV/AIDS and HCV (& other infectious diseases)	Peer outreach	7 prisons (6male prisons and 1 female prisons)	Not reported	Decline in HIV cases	3c
Hunter & Boyce 2009 [57]	UK	Qualitative	Housing/ resettlement	Peer advisors	Prisoners requiring housing advice in 5 prisons in SE England (Three Category B prisons (male), one young offender institution (male) and one female open prison.)	social interaction with others; experience and qualifications to assist post-release; self-confidence.	Views of prisoners and staff re. staff workload and prisoners' use of their time in prison.	1a
Jacobson & Edgar (undated) [62]	UK	Qualitative	General health/ support	Peer support	New arrivals at HMP Edinburgh	Effects on prisoners	Use of staff time	2c
Junker 2005 [86]	USA	Quantitative	Suicide/Self harm	Peer Observers	Those prisoners judged to be suicidal	Not reported.	Number of hours individuals spent on suicide watch post-IOP compared to pre-IOP (i.e. using staff for observations):	3b
Levenson & Farrant 2002 [19]	UK	Quantitative & Qualitative	Multiple health issues	Peer support/ Listeners.	Not stated	Perceptions of role (peer supporters) Self-esteem. finding accommodation and small amounts of money after release	Not reported	3b quant/ 2b qual
Martin 2008 [63]	USA	Quantitative. RCT.	HIV/ HCV prevention	Peer education	3 sites: Delaware, Kentucky and Virginia. N = 343. Mean age 34y. 86% male.	The only outcome reported is condom use during sex.	Not reported	2b
Maull 1991 [64]	USA	Study design unclear	General health/ support	Prison hospice volunteers	Ill prisoners at U.S. Medical Centre for Federal Prisoners in Springfield, Missouri	Effects on volunteers; Effects on prisoners	Retention/attrition of volunteers	2b
McGowan 2006 [87]	USA	Qualitative	HIV counselling	Peer education	Male prisoners in state prisons in California, Mississippi, Rhode Island and Wisconsin. aged between 18 and 29y, incarcerated for at least 90 days, classified as minimum or medium security level, scheduled for release within 14 to 60 days.	Effect son HIV testing: mandatory testing at intake, voluntary testing at medical intake, and voluntary testing during a peer health orientation class.	Not reported	3c

Table 1 Included Studies *(Continued)*

Mentor 2 work [73]	UK	Study design unclear	Unclear	Peer mentoring	Prisoners with mental health problems at HMP Liverpool.	Self-esteem, confidence and motivation; Self-worth; Communication skills, reasoning and reflection skills; Mental health and treatment.	Numbers of volunteers and prisoners being mentored; effects after release.	3c
Munoz-Plaza 2005 [65]	USA	Qualitative	HIV/ AIDS and HCV (& other infectious diseases)	Peer education	A state correctional facility in California. Drug treatment program is located on a medium security prison yard that houses male inmates. age range 20–50 years	Not reported	Not reported	2b
O'Hagan 2011 [88]	UK	Quantitative	Literacy	Peer education	Serving Young Offenderss at 5 YOIs	Literacy: Impact on learners; Impact on mentors	Not reported	3c
Peek 2011 [89]	UK	Quantitative	Infectious disease prevention: screening and vaccination.	Peer education	Male prisoners at HMP High Down Category B male local prison.	Hep B and Hep C awareness and vaccination uptake. Chlamydia awareness and screening.	signposting to healthcare, Effects on nurses utilising their time in the prison. Effects on barriers between nursing staff and prisoners. Prison atmosphere. Changing role/perception of prisoners.	3c
Penn State Erie 2001 [90]	USA	Mixed methods	Parenting	Peer education	Fathers in prison. State Correctional Institute at Albion (SCI Albion), in Erie county. A medium-security institution for men	contact with children per month/year; Anger & Frustration; Knowledge about their child/children; Parental Locus of Control; ICAN Fathering Profile; Total Parenting score Father's Questionnaire: knowledge, attitudes, skills, and behaviors.	Staff awareness and perceptions of programme	3c
Player & Martin 1996 [91]	UK	Study design unclear	Addictions/ substance abuse	Peer counselling	Prisoners with addictions at HMP Downview	drug use; prisoner behaviour	Not reported	3c
Richman 2004 [92]	UK	Quantitative	General emotional/ mental health, psychological support and counselling	Listeners	HMP Manchester	Change in demeanour. Expected effects on release from prison (on Listeners)	Effects on staff – peer worker relationship.	3b
Ross 2006 [66]	USA	Quantitative Pre & Post	HIV/ AIDS and HCV (& other infectious diseases)	Peer Education	36 Texas State prison units. Peer educators and students were predominantly male, aged 34–43 y.	HIV–related knowledge; self–assessed educator skills among peer educators;	impact of the peer education program on HIV testing at participating units	2b

Table 1 Included Studies *(Continued)*

						Diffusion of HIV–related knowledge; HIV–testing behavior and intentions		
Schinkel & Whyte 2012 [67]	UK	Qualitative	Housing/ resettlement	Peer mentoring	Based in Glasgow – prisons not stated. Prisoners serving sentences of between three months and four years. Service offered to eligible prisoners who are returning to Glasgow, Renfrewshire and North Lanarkshire.	Effects on prisoners	Staff perceptions of life coaches' need for support.	2b
Schlapman & Cass 2000 [93]	USA	Quantitative – pre and post	HIV prevention	Peer education	Incarcerated adolescents in North central Indiana juvenile facility.	AIDS knowledge & self reported sexual behaviours.	Not reported	3c
Scott 2004 [68]	USA	Mixed quantitative (pre and post) and qualitative)	HIV prevention	Peer education	Prisoners at 5 Texas prison facilities. A diversity of facilities was selected (small and large, short and long term, male and female prisoners)	HIV related knowledge, attitudes and beliefs among peer educators and students.	Factors affecting implementation, maintenance and overall impact of the program from the perspective of program coordinators, wardens and peer educators.	2b quant/ 2c qual
Sifunda 2008 [69,101]	South Africa	Quantitative Pre & Post	HIV/ AIDS and HCV (& other infectious diseases)	Peer education	4 medium-sized correctional facilities (male) in South Africa. Number housed comparable in size to UK prison..N = 263. Mean age 27 y (range 17–55). Mean period of incarceration = 2 years (range 6 m – 17 y).65% were first time offenders.	Knowledge and beliefs; Attitudes; Sexual communication, social norms about gender relations and sexual violence; Self-efficacy; Intentions	Not reported	2c
Sirdifield 2006 [70]	UK	Qualitative	General health/ support	Health Trainer	All prisoners	Changes in Health Trainers' attitudes and health behaviour. Recognising stress in other prisoners.	demands placed on prison staff and health services as a result of the intervention.	2b
Snow 2002 [37]	UK	Quantitative	Suicide/ self harm	Listeners	5 prisons having a Samaritan supported Listener scheme. All prisons were local type establishments and chosen because of the comparatively high rate of suicide.	Perceived benefit from using the scheme: Approachability of listeners Availability of listeners Use of listener scheme in the future. Reasons for not using the scheme Ways to improve the scheme	Not reported	2b
Stewart 2011 [94]	UK	Quantitative & Qualitative	General health/ support	Peer support	3 UK prisons. Originally for older prisoners but to include those with learning disabilities, mental health problems and prisoners with physical and sensory disabilities.	Effects on prisoner-carers	communication between staff and prisoners. Training and supervision issues. Contribution to the health and social care services within the gaol.	3c

Table 1 Included Studies *(Continued)*

Syed & Blanchette 2000 [95]	Canada	Quantitative & Qualitative	General emotional/ mental health, psychological support and counselling	Peer Support	Small women's prison, n = 78 at time of study. All were serving sentences of minimum 2 years and were rated at 'minimum' or 'medium' security levels. Survey respondents, average age 34.5y (sd = 9.07, range 21–58). Average sentence length 4.39y (range 2 to 15y). Average time spent at Grand Valley = 9 months (SD = 0.62, range = 2 weeks to 2 years).	Self esteem; Sociometric tests for understanding personal and group dynamics; Perceptions of the prison environment (correctional environment status inventory); Staff and prisoners' views, feelings and ideas about PST (interviews).	Staff and prisoners' awareness and perceptions of the role and functioning of the PST (surveys);	3b quant/ 1c qual
Syed & Blanchette 2000 [96]	Canada	Quantitative & Qualitative	General emotional/ mental health, psychological support and counselling	Peer Support	women's prison in Canada. N = 56 at time of study. All were serving sentences of minimum 2 years and were rated at 'minimum' or 'medium' security levels. All women, average age 35.1y (SD = 11.3, range = 21 to 62). Average sentence length 4.7 years (range 2y to life). Mean time served at Joliette = 13.3 m (range 2 m to 2.5y).	Self esteem; Sociometric tests for understanding personal and group dynamics; Perceptions of the prison environment (correctional environment status inventory); Staff and prisoners' views, feelings and ideas about PST (interviews).	Staff and prisoners' awareness and perceptions of the role and functioning of the PST (surveys)	3b quant/ 2b qual
Taylor 1994 [97]	Australia	Quantitative and Qualitative: Pre-post	HIV prevention	Peer education	New South Wales Correctional Centres. 90% of inmates had been in other correctional centres.	Knowledge; attitudes	Awareness of the peer education scheme.	3b
The Learning Ladder Ltd. (undated) [74]	UK	Qualitative.	Mentoring for education/to improve qualifications	Peer mentoring	HM Young Offenders Institution Reading – a small prison holding prisoners between the ages of 18 and 21y.	self-esteem; confidence; attitude to offending behaviour.	Success of scheme.	3c
Vaz 1996 [28]	Mozambique	Quantitative, pre-post	HIV/ STD prevention	Peer education	Largest prison in Mozambique (1900 prisoners incarcerated at time of study). 300 inmates sentenced to 1 year or longer, selected on entry. Mean age 26y.	knowledge around HIV/AIDS ; relationship between knowledge of HIV/AIDS and educational attainment of participants.	Not reported	3b
Walrath 2001 [71]	USA	Quantitative Pre & Post	Violence	Peer training.	Medium all-male security corrections facility in Maryland, USA, housing inmates serving sentences of 3 months or longer. Age range: 18 to 51 y, mean age 30 y. Average sentence 20y, ranging from less than 1 year to life.	Anger; Self esteem; Optimism; Locus of Control; Behaviour	Not reported	2b
Wright & Bronstein 2007 [72,102] *2 papers*	USA	Mixed Qualitative & Quantitative	General health/ support	Prison hospice volunteers	Dying prisoners in 14 prison hospices in the USA	Not reported	Impact of having a hospice (& implicitly, using prisoner volunteers) on prison environment & climate.	2c

Table 1 Included Studies *(Continued)*

Zack 2001 [21]	USA	Quantitative RCT	HIV/AIDS and HCV (& other infectious diseases)	Peer education	Medium-security prison housing approximately 6000 men who stay at the prison for an average of less than two years. Men arriving at and leaving the prison, and women visitors.	Intentions to use condoms and be tested for HIV; Knowledge; HIV/AIDS testing; behaviour	Resistance from staff Institutional lockdowns	3b
Zucker 2006 [98]	USA	Quantitative. One-group pretest - posttest.	Hepatitis C prevention	Peer education	Massachusetts county jail . 25 men who spoke and wrote in English.	Changes in self-reported behaviour, knowledge, relationship with teacher .	Not reported	3c

NOTE: Validity score: 1 = good internal validity, 2 = moderate internal validityand 3 = poor internal validity; a = highly relevant, b = of some relevance, and c = not very relevant.

Table 2 Number of included studies by Country

Country	Number of studies
USA	20
UK	20
Canada	9
Australia	2
Ireland	1
Israel	1
Moldova	1
Russia	1
Mozambique	1
South Africa	1

Table 4 Number of included studies by health topic

Health topic	Number of studies
HIV/AIDS/HCV/BBV prevention	20
General health, hygiene	12
Emotional support	8
Suicide/self harm prevention	7
Employment/housing post release	4
Mental health/substance abuse	2
Improving educational skills	2
Parenting	1
Violence reduction	1

Listeners

Strong qualitative evidence supported individual health gains for those trained as Listeners or befrienders. Trained individuals reported that they were 'giving something back', doing something constructive with their time in prison and being of benefit to the system; this consequently had an effect on individuals' self-esteem, self-worth and confidence [19,23,32,36,56,61]. Moreover, enhanced skills as a result of being a peer deliverer, like listening and communication, were mentioned by two studies [56,61] and there were indications of prisoners feeling able to put these skills into practice on release from the institution [61].

There were some negative health effects reported [32,56,61,92] and these related to the emotional burden of listening to other prisoners' problems and issues.

Two interventions studied in the UK, health trainers and peer mentors, focused on changing behaviours. One study provided weak evidence that mentoring had positive effects on health behaviours, treatment adherence, drug taking and re-offending [83]. Two studies provided moderate evidence that becoming a health trainer positively affected knowledge, attitudinal and behaviour change, self-esteem and development of transferable skills [54,70]. There was little evidence of effects on health trainers' clients; however limited evidence showed that health trainers discussed a range of lifestyle issues with clients and referred them to other services [54,70].

Twenty-one predominantly qualitative studies [19,23, 29,32,36,53-59,61,64,68,72,79-81,96,102] indicated that being a peer worker was associated with positive effects on mental health and its determinants. These findings were consistent across a number of different models including peer education, peer support, Listeners, prison hospice volunteers, health trainers, and Peer Advisors. Skill development, including transferable employment skills, was also mentioned in relation to Peer Advisors [57,59] and health trainers [54]. Negative effects for peer workers related to experiencing a burden of care, particularly in roles involving emotional support [32,56,61,92].

Table 3 Number of included studies by intervention mode

Intervention mode	Number of studies
Peer education	21
Peer support	14
Listeners	6
Peer mentoring	4
Prison hospice volunteers	3
Peer advisors	2
Health trainers	2
Peer counselling	2
Peer outreach	1
Peer observers	1
Peer training	1

Review Question 3: What is the effectiveness of peer delivery compared to professional delivery?

Very few studies compared peer-led to professionally-led interventions. Three of four quantitative studies were about peer education for HIV prevention [21,63,84], two of which were RCTs [63,84]. Consistent evidence from these studies indicated that peer educators are as effective as professional educators in HIV prevention. The fourth was a study of peer observers for suicide watch [86].

Consistent evidence from ten qualitative studies [23,54, 56-59,67,80,95,96] indicated that peer delivery was preferred to professional, with cross cutting themes including peer deliverers demonstrating empathy due to lived experiences, being non-judgemental, being trusted by prisoners and offering more time than staff. Prisoners felt more at ease talking to fellow prisoners and also found them more accessible.

Table 5 Types of peer interventions

Type of peer intervention	Working definition
Peer education	Peer education involves the teaching and communication of health information, values and behaviours between individuals who are of equal social status, or share similar characteristics, or have common experiences [103,104]. Peer education has been widely applied in the prison setting, particularly in relation to HIV prevention and risk reduction. Peer educators typically undertake formal training to equip them with the knowledge and skills to undertake the role.
Peer support	Peer support is the support provided and received by those who share similar attributes or types of experience. Peer support can be an informal process between individuals and/or can be provided through formalised interventions where peer supporters seek to promote health and/or build people's resilience to different stressors [104]. There is a range of different peer support interventions reported in the prison literature. In the UK, the Listeners scheme is a specific peer support intervention focused on prevention of suicide and self-harm.
Prison hospice volunteers	Prison hospice volunteers provide companionship, practical assistance and social support to terminally ill patients. They may be involved in a range of activities as requested by patients including letter writing, reading, accompanying patients to religious services and other parts of prison and sometimes maintain a bedside vigil with dying patients [102].
Mentoring	Mentoring describes the development of a relationship between two individuals where the mentee is able to learn from the mentor, model positive behaviour and gain experience, knowledge or skills [105,106]. Peer mentors, as defined by Finnegan et al., have a similar background or experiences to their mentee ([106]:6). There are a number of peer mentoring schemes in UK prisons focused on education and training, such as The Learning Ladder [74], and on resettlement and prevention of reoffending.
Health trainers	Health trainers are lay public health workers who use a client-centred approach to support individuals around health behaviour change and/or to signpost them to other services, some of which are also free at the point of delivery (Health Trainers England). Prison health trainers receive the standardised training on health promotion, healthy lifestyles and mental health, but adapted for the prison setting and client group.

Review Question 4: What is the cost-effectiveness of peer based interventions in prisons?

Only one study met the inclusion criteria [99,100], focusing on costs rather than health outcomes, and the programme aim was poorly described. The study showed management cost savings in prisons in the short term through the use of a Therapeutic Community (TC) programme, albeit these were a small part of the overall costs. Their findings suggest that TC activities or the existence of the TC environment may help to reduce or control prison management costs.

Discussion

Overall, current evidence is strongest in terms of evaluating effects on peer deliverers, rather than recipients of peer interventions. There is strong evidence that being a peer worker is associated with positive effects on mental health and its determinants, and this is consistent across a number of peer intervention models. Peer education interventions are effective in reducing risky behaviours, and peer support services are acceptable to prisoners and have a positive effect on recipients. There is some evidence that peer educators are as effective as professional educators for HIV prevention outcomes, and strong evidence that peer delivery is preferred to professional delivery. The finding of reduced risk of HIV transmission was in part reflective of the fact that it was the outcome that was most commonly evaluated. Therefore the absence of evidence for other health outcomes should not be misinterpreted as evidence of absence of the effectiveness of peer education for addressing health conditions other than HIV. Research into cost-effectiveness is sparse, with little economic evaluation even into interventions with evidence of effectiveness.

The 58 included studies represent the best available evidence, although their methodological quality was limited. Most did not report an underpinning theoretical model and only two defined 'peer', which leads the reader to make their own assumptions about whether peer deliverers and recipients within prisons are a homogeneous group. The dominance of positive findings in the quantitative data suggests publication bias. Clinical heterogeneity in outcomes and interventions precluded meta-analysis of most outcomes. Studies of interventions delivered by non-professionals, and studies of prison health, are not well indexed in electronic databases and early pilot searches returned impractically large numbers of hits. A more specific search strategy was developed, but this may have lost some sensitivity and therefore some relevant studies may have been missed. The effects of peer interventions on reoffending and other non-health outcomes (such as employment) are not represented in this review, nor are the effects of non-prisoner volunteers on prisoner health, effects of peer interventions in the probation service, or staff-to-staff peer interventions, although there is a body of literature on each of these. 63 studies were unobtainable: 17 were books and another substantial proportion were PhD theses or newspaper or magazine articles. Not all would have met inclusion criteria.

A previous review in this area highlighted a lack of evidence-based literature on the efficacy of prison-based peer-led programmes [22], but this review only searched one database, and included only peer

Table 6 Review Question 1 findings

	Intervention type:						
	Peer Education	**Peer support**	**Listeners**	**Prison hospice volunteers**	**Peer mentoring**	**Health trainers**	**Other**
Knowledge	Ten studies [66,68,69,84,88,90,93,97,98]	Two qualitative studies showed reported increases in knowledge [58,80]. In one of these studies, a number of respondents noted that knowledge acquired from the training was applicable to improving relationships with their children, partners and others in the community [58].	Enhanced skills as a result of being a peer deliverer, like listening and communication, was mentioned by two studies [56,61] and there was indication of prisoners feeling able to put these skills into practice on release from the institution [61].			Two qualitative studies showed increased knowledge on a variety of topics, including: drugs, sexual health, nutrition, alcohol and mental health issues [54].	
	Statistically significantly higher proportion of correct answers to 22/ 43 questions asked in peer education vs control group. RR 0.43 (95% CI: 0.33, 0.56, 1 study n = 949) to 3.06 (95% CI: 1.91, 4.91, 1 study, n = 200).					Improvements were seen in the mean knowledge scores in all areas in one study [54], but it was not possible to ascertain whether these improvements were statistically significant.	
	Knowledge scores: mean difference 0.46 (95% CI: 0.36, 0.56, 2 studies, n = 2494, I^2 = 94%).					Both health trainers and Health Trainer tutors reported that Health Trainers had developed effective communication and listening skills as well as fostering attributes essential for team working and future employment after release from prison [54].	
	Other evidence: peer educators improved their own knowledge [55,68,76]. and [69] information was diffused to those outside the prison, such as family members and children.						
	In the study on literacy [88], > 90% of learners agreed that their reading and communication skills had improved.						
Intentions	Four studies [66,69,84,93]		In one study [37] 61% of those surveyed said they could talk to a Listener about anything that was worrying them. 74% had no problems contacting a Listener when they had requested help.				
	One RCT [84] reported improvements in: interest in		57% of users thought they would seek the				

Table 6 Review Question 1 findings *(Continued)*

	taking HIV test for the first time (RR 1.49, 95% CI: 1.12, 1.97); interest in taking HIV test now (RR 1.82, 95% CI: 1.33, 2.49); condom use intention (RR 1.15, 95% C I: 1.08, 1.22); intention to never use condoms (RR 0.59, 95% CI: 0.48, 0.72). No improvement in intention to use bleach with drug injecting equipment (RR 1.06, 95% CI: 0.97, 1.16). No improvement [67] in intention to take a HIV test (RR 1.24, 95 CI: 0.75, 2.05) and a negative effect on peer educators' intentions (RR 0.62, 95% CI: 0.41, 0.95). A study in South Africa [69] did not show any evidence of a commitment to change their behaviours, $X^2(10, N = 69) = 10.934$, $p = .36$.		help of a Listener if they faced a similar problem in the future.	
Attitudes/ Beliefs	Four studies [68,69,97,98] No changes in one study [68]; in another [97], improvements seen in agreement with all three statements: "HIV positive inmates should be separated" (RR 2.55, 95% CI: 1.94, 3.33); "I feel safe in the same wing as an inmate who is HIV positive" (RR 0.74, 95% CI: 0.68, 0.84);	One study [91] showed that a drug treatment intervention that included the support of trained prison counsellors caused changes in prisoners' reported attitudes to drugs and alcohol. This translated to a self-reported reduction in drug and alcohol use. The one-to-one sessions with trained peer counsellors was regarded as the most "helpful aspect" of the recovery process.		Attitudinal change, often as a result of increased knowledge, was seen primarily in the area of smoking and diet [54,70].. In one study [54], more than 50% of health trainers stated that their attitude had changed in the areas of: healthy eating/ diet; sexual health issues; smoking cessation; exercise; mental health issues. 75% of HTs stated that they would like to get a job as a HT when they are released from prison

Table 6 Review Question 1 findings *(Continued)*

	"I know enough to protect myself from catching HIV/AIDS" (RR 0.54, 95% C: 0.50, 0.59).				
Behaviour	Eleven studies [21,25,27,60,63,66,68,69,87,89,90,98] Positive effects seen: Not using a condom at first intercourse after release from prison (RR 0.73, 95% CI: 0.61, 0.88, 2 studies, n = 400); injecting drugs after release from prison (RR 0.66, 95% CI: 0.53, 0.82, 2 studies, n = 400); injected in past 4 weeks (RR 0.11, 95% CI: 0.01, 0.85, 1 study, n = 241); sharing injection equipment after release from prison (RR 0.33, 95% CI: 0.20, 0.54, 2 studies, n = 400);	In one study [92], 64% of 22 prisoners claimed that friends and family had noticed a difference in their demeanour, finding them more relaxed, responsible, optimistic, able to speak more and more able to listen. 73% agreed that their new responsibilities would allow them to 'adjust better' on release, and 55% agreed that the 'prison authorities' appreciated their work. 77% said there was a difference in how immediate staff interacted with them: being trusted more, staff talking more to them, staff being grateful for the work they do. 86% said that fellow prisoners behaved differently towards them.	In one study [83] At 3 months, 38/44 participants (86%) were receiving outpatient psychiatric services and 40/44 (91%) successfully managing their medications. At 6 months, 36/44 participants (82%) were medication compliant, and 35/44 (80%) demonstrated symptom reduction. 12/44 (27%) had not maintained sobriety at 6 month time point. 17/22 (77%) participants released for at least 12 months had not been rearrested. 16/22 participants who had been released for at least 12 months (73%) were abstinent in use of alcohol or illegal drugs or misuse of prescription drugs.	Health trainers reported eating more fruit and vegetables and one health trainer had given up smoking [54,70]	**Peer training:** One study [71] reported a statistically significantly reduced rate of confrontation post-intervention at 0.432 (CI: 0.319, 0.583, $p < 0.0005$).

Table 6 Review Question 1 findings *(Continued)*

	peer educators never having had an HIV test (RR 0.31, 95% CI: 0.12, 0.78, 1 study, n = 847). In one Russian study [27] the prevalence of tattooing in prison significantly decreased (42% vs 19%, p = 0.03) and of those who were tattooed the proportion using a new needle increased from 23% to 50%. Where behaviour was measured on a scale [60,69,98], positive effects were seen in all three studies. HIV tests in prison [87] was associated with having attended a HIV prevention programme in prison (OR = 2.81, 95% CI: 1.09, 7.24). Chlamydia screening in the under-25 s rose from 13 to 83 in a 6 month period after beginning a peer education intervention, similarly hepatitis C screening increased from 9 to 46, and numbers were also increased for HIV screening and hepatitis B vaccinations [89]. In a study on parenting skills [90] statistically significant improvements in self-reported father/ child contact were seen (mean difference 41.3, 95% CI: 6.47, 76.13).					
Confidence	One study [69] reported no significant differences.	No statistically significant effect of the peer intervention in three studies [58,80,95] (WMD 1.51, 95% CI: −0.84, 3.86, 3 studies, n = 83, I^2 = 81%).	Trained individuals reported that they were 'giving something back', doing something constructive with their time in prison and being of benefit to the system; this consequently had an effect on individuals' self-esteem, self-worth and	Volunteers experience increases in self-esteem and self-worth as a result of the service they provide to others [72,102]. Evidence also suggests prisoners gain an enhanced sense of compassion for other people [72,102] and being	Health trainers seemed most confident in signposting to exercise, smoking cessation and drugs services and least confident in signposting to self-harm, immunisation and dental services [54].	**Peer training:** One study [71] reported s mall but statistically significant negative effects of the intervention on self-esteem (MD −2.15, 95% CI: −4.20, −0.10), measured with the Rosenberg self-esteem scale, and optimism (MD 1.30, 95% CI: −0.83, 3.43),

Table 6 Review Question 1 findings *(Continued)*

			confidence [19,23,32,36,56,61].	prison hospice volunteers allows individuals 'to give something back' [77].		measured with the life orientation text.
		Qualitative evidence suggested improvements in the peer deliverers' self-esteem, self-worth and confidence as a result of the role [53,58,79-81,96].The sense of being trusted by the prison authorities to counsel and support prisoners in distress was reported to enable peer deliverers to regain their self-respect [23,79].The notion that peers became more empowered consequentially was alluded to [58,79,80,95,96].			Qualitative research [54] found that training as a health trainer had been a huge boost to prisoners' confidence, self-esteem and self-worth, reported by key staff. There was also evidence of health trainers bolstering other prisoners' reported self-esteem and confidence through listening and supporting individuals [54].	**Peer outreach:** Qualitative evidence suggested that peer volunteers felt that their role was worthwhile and that they were making a difference to the health of the prison population [85].
						Peer advisers: Two studies reported increased self-esteem and self-confidence, coupled with peer deliverers reporting that they were building a work ethic and a sense of control over their lives [57,59]. The role was perceived by the volunteers to be worthwhile and purposeful as well as enabling social interaction with others and offering 'structure' to the prison day [57]
Mental health	No effect on anger or frustration in the parenting skills study [92], either immediately post-intervention (MD 0.20, 95% CI:	Peer support was reported to have helped prisoners either practically, emotionally, or both	Three studies [32,36,56] reported an impact in reducing depression and anxiety in	In one study, prison volunteers described life enrichment, growth, and coming to terms with their		**Peer training:** One study [71] found no statistically significant effect of the intervention on

Table 6 Review Question 1 findings *(Continued)*

−1.42, 1.82) or at longer follow-up (MD 1.40, −0.03, 2.83).	[58] and in one study it was demonstrated that this type of intervention could be particularly beneficial for prisoners during the early part of their sentence [62]. Those who had used peer support reported using it as an avenue to vent and to overcome feelings of anxiety, loneliness, depression and self-injury [58,79,96] and there were indications that this may be potentially beneficial in preventing suicides in prison [53].	distressed prisoners and improving their mental state. There is anecdotal evidence that suicide and self-harm is reduced as a result of the support offered by peers acting in this role. A fourth study [37] found 44% of users of the Listener scheme reported that they always felt better after confiding in a Listener, while 52% felt better at least 'sometimes'. 84% said they had always found the experience helpful.	own mortality as a result of their involvement [64]. Moreover, the recipients of one of the programmes suggested how the volunteers had supported them and enabled them to overcome states of depression [64].	anger (mean difference −4.01, 95% CI: −9.40, 1.38), measured with the anger expression scale.
		Four studies [32,56,61,92] related the emotional burden of listening to other prisoners' problems and issues. Discussions relating to suicidal intentions and other distressing topics could be particularly burdensome for peer deliverers to manage. There were also reports of peer deliverers experiencing 'burnout' and mental exhaustion as a result of the demands placed on their time by other prisoners [56,92]		**Peer support and counseling:** One study [29] looked at the effects of peer support (Narcotics Anonymous meetings) and counselling (12 step programme), compared to peer support alone (NA meetings only) on mental health, namely coherence, meaning in life, anxiety, depression and hostility. Improvements with the combined interventions were seen in all outcomes: coherence (mean difference −0.31, 95% CI: −0.48, −0.14), meaning in life (MD −0.42, 95% CI: −0.65, −0.19), anxiety (MD

Table 6 Review Question 1 findings *(Continued)*

					−0.42, 95% CI: −0.66, −0.18), depression (MD −0.35, 95% CI: −0.52, −0.18), hostility (MD −0.11, 95% CI: −0.18, −0.04).
Preference	In an American HIV RCT [84], 68% preferred to be taught by an inmate with HIV versus 11% who preferred a HIV/ AIDS educator.				
Additional themes	Qualitative evidence suggested that peer deliverers found the experience personally rewarding, giving their time in prison meaning and purpose [55,68]. In one study, this included improved listening and communication skills as a result of their participation [90]. Other [55research suggested that being a peer educator also enabled the difficulties of prison life to be off-set through the supportive net-work of other trained peer educators.	No statistically significant effect was seen on prisoners' perceptions of the prison environment in the pooled results of 3 studies [58,80,95] One study [79] found that 81% of 35 respondents valued the existence of the Peer Support Team. Another study [81] reported that inmates were very satisfied with the quality of the information delivered by PST members. Expectations of the PST were also well met. Staff reported that PST members were effective in handling crisis interventions, providing services to inmates and serving as role models. In one study [81] PST members estimated that they provided support to others of 3–5 hours per week on average.	16/22 (73%) participants released for at least 12 months were employed, enrolled in an educational program or had completed the application process for disability benefits. 18/22 (82%) participants who had been released for at least 12 months had secured treatment, transitional housing or a permanent place to live.	**Prisoner outcomes:** Issues most likely to be discussed with health trainers were reported in one study [54] to be exercise, weight and healthy eating. **Onward referrals:** Health trainers in one study [54] were most likely to refer clients to gym staff or healthcare staff. Referrals were also made to Counselling, Assessment, Referral, Advice, and Throughcare services (CARATS), counsellor, dentist and optician.	**Peer observers:** One controlled study [86] found a statistically significant decrease ($t(71.55) = 2.14$, $p = 0.036$) in the mean number of hours on watch following the implementation of the Inmate Observer Programme.

Table 6 Review Question 1 findings *(Continued)*

	In several studies [23,58,79,80,96], there was indication of peer deliverers gaining better self-awareness and perspective on their life as well developing the skills to deal with their own health and offending issues. There was limited information on the impact that the role would have on future re-offending. Only in one study [23] was it suggested that the experiences of being a peer support worker would be beneficial in reducing the likelihood of re-offending.		
	The demands placed on peer support worker/counsellors by other prisoners gave individuals a sense of purpose in prison [23,53,94] and this was beneficial for combatting boredom while serving the prison sentence [23,53]. However, there were indications that the role could be challenging and onerous and the burden of care of supporting many prisoners could be problematic [53].		

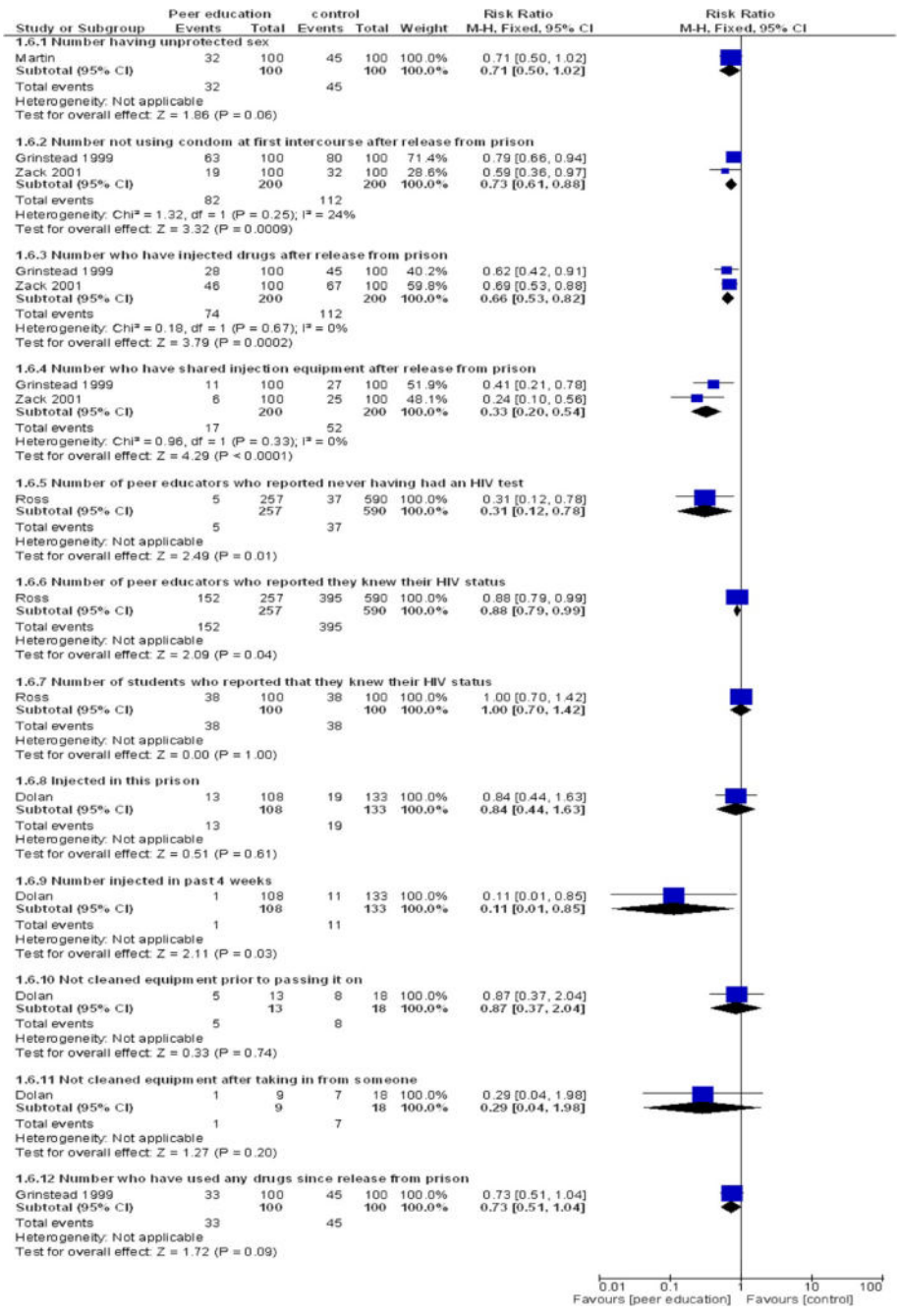

Figure 3 Effects of peer education on behaviour (binary outcomes).

education interventions. Nevertheless, their conclusions concurred with ours, showing prison-based peer education programmes as well tolerated, effective and possibly more cost-effective than professionally led programmes. A 2011 systematic review of peer education for health promotion in prisons [31] searched fewer databases than our review, including only ten studies, and concluded, as does our review, that peer education is effective in reducing risk of HIV transmission.

This is the first systematic review of all the evidence on effectiveness and cost-effectiveness of peer interventions in prisons, a topic that is now of considerable interest to the Department of Health for England and Wales and NHS England. Given that the WHO consensus statement on mental health promotion in prisons argues that activities should be available to help offenders make best use of their time inside, and that the Prison Reform Trust estimates that only 20% of prisoners will

be employed whilst inside (in industrial workshops for example), there is a need to provide meaningful occupation for offenders. Being a peer worker could provide such meaningful occupation [108], moreover peer-based interventions can be considered a valuable mechanism to maintain or improve health and wellbeing in the prison setting. A recent study of peer based interventions in mental health services found that peer workers were able to engage people with services by building relationships based on shared lived experience [109]. The benefits of peer education and support, particularly in those pathways that are concerned with changing behaviour or requiring individual motivation to pursue a healthy lifestyle, have also been seen in other areas such as managing substance misuse and addiction [110,111], and managing long-term conditions (for example, the Expert Patient Programme [112]).

This study has highlighted research gaps and ways in which the evidence base for peer-based interventions in prison settings could be strengthened. This work supports the Health and Justice function in Public Health England who have called for evidence-based guidelines and advice on all aspects of public health in prisons, including health promotion and public health [113]. It is vital that to further inform the evidence base, future studies need to be methodologically robust, sufficiently broad to capture outcomes for different stakeholder groups and assess costs and benefits both within and outside the prison system. Research is needed to explore the impact across the criminal justice system in line with the Department of Health's focus on offender health and understandings of the wider determinants of health in this vulnerable group.

There is also a pressing need for implementation and economic evaluation of a prison based peer educator initiative.

Conclusions

Peer-based interventions can be considered a valuable mechanism to maintain or improve health and wellbeing in the prison setting, with positive effects seen on knowledge and behaviour of peer deliverers and recipients. Peer education is less used in prisons in England and Wales than in the USA, perhaps reflecting more general trends in health promotion; however, the finding that peer education can increase knowledge and reduce risky health behaviours, particularly in relation to HIV prevention, suggests that consideration should be given to whether a peer education component should be introduced into other health behaviour change interventions.

Transparency statement

All authors had full access to all of the data and can take responsibility for the integrity of the data and the accuracy of the data analysis. Dr Bagnall affirms that the manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned have been explained.

Ethics approval statement

The study received approval from the National Offender Management Service (NOMS) National Research Committee (Ref: 165–11) and the research team agreed to conduct the study in compliance with the Terms and Conditions set out by the National Research Committee. The study did not require ethical approval through NRES. Study documentation was reviewed through the Faculty of Health and Social Sciences Research Ethics Committee, Leeds Beckett University.

Data sharing

Full search strategies and lists of included and excluded studies are available from the corresponding author at a.bagnall@leedsbeckett.ac.uk.

Abbreviations

BBV: Blood Borne Viruses; HCV: Hepatits C Virus; CI: Confidence Interval; DARE: Database of Abstracts of Reviews of Effects; DoPHER: Database of Promoting Health Evidence Reviews; EPPI: Evidence for Policy and Practice Information; HIV: Human Immunodeficiency Virus; HMP: Her Majesty's Prison; HSDR: Health Services and Delivery Research; NHS: National Health Service; NHSEED: National Health Service Economic Evaluation Database; NIHR: National Institute for Health Research; NOMS: National Offender Management Service; OHRN: Offender Health Research Network; PCT: Primary Care Trust; POA: Prison Officers Association; PORSCH: Prison and Offender Research in Social Care and Health; RePEc: Research Papers in Economics; WHO: World Health Organisation; YOI: Young Offenders' Institution.

Competing interests

All authors have completed the Unified Competing Interest form at http://www.icmje.org/conflicts-of-interest/ (available on request form the corresponding author) and declare that (1) all authors have support from NIHR HSDR stream for the submitted work (2); No authors have relationships with companies that might have an interest in the submitted work in the previous 3 years (3); their spouses, partners, or children have no financial relationships that may be relevant to the submitted work; and (4) No authors have non-financial interests that may be relevant to the submitted work.

Authors' contributions

AMB was project lead for the systematic review of effectiveness, co-wrote the review protocol, contributed substantially to the design of the review, undertook study selection, data extraction and validity assessment, designed data extraction and validity assessment told, undertook the meta-analysis, synthesis of qualitative and quantitative data, and wrote the paper. She is a guarantor. JS was the Principal Investigator for the study, having overall responsibility for the full report, was instrumental in the design and securing funding, co-wrote the review protocol, contributed to study selection and data synthesis and co-wrote the paper. She is a guarantor. CH was project lead for the review of cost-effectiveness, co-wrote the review protocol and contributed substantially to the design, read and commented on drafts of the paper. JW contributed substantially to the study design and undertook study selection, data extraction, validity assessment, qualitative synthesis, wrote sections of the full report, read and commented on drafts of the paper. KV-C undertook study selection, data extraction, validity assessment, synthesis and wrote up the cost-effectiveness review, read and commented

on drafts of the paper. KK contributed to the design of the study, undertook study selection, data extraction and validity assessment and read and commented on drafts of the paper. GR undertook study selection, data extraction and validity assessment, meta-analysis, and read and commented on drafts of the paper. RD, NW and LH were involved in the design of the study and read and commented on drafts of the paper. All authors read and approved the final manuscript.

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A Webinar-Supporting Document August 2017

Peer Support Roles in Criminal Justice Settings

The term recovery can be defined as "a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential" (SAMHSA, 2012). Peer support is a highly effective way of supporting the recovery of individuals with behavioral health challenges who are involved in the criminal justice system.

Peer support has been defined as "offering help, based on the shared understanding, respect, and mutual empowerment between people in similar situations" (Mead, Hilton, & Curtis, 2001). The belief that recovery is possible for individuals with behavioral health challenges is fundamental to peer support, as is the concept of the development of a mutually beneficial relationship between individuals with similar life experiences. Individuals who have experienced mental illness, substance use disorders, and trauma have a unique capacity to support each other based on these shared experiences. Research shows the effectiveness of peer support on many levels, including increasing engagement in treatment and recovery, promoting a sense of hope and self-empowerment, improving social functioning and overall quality of life, and decreasing hospitalizations (Davidson, Bellamy, Guy, & Miller, 2012).

In order to serve in many of the peer support roles discussed during this webinar, individuals will typically be asked to self-identify as a person in recovery from mental illness, substance use disorders, or trauma. In some roles that involve mentoring veterans, military service is often considered the primary shared experience and may be all that is required for individuals providing support to fellow veterans. In other roles involving family support, the shared experience of having a family member in recovery may be all that is required for individuals providing support to other family members. In addition to these experiences, individuals providing peer support in criminal justice settings should also have the shared experience of having been involved in the criminal justice system. The experience with the criminal justice system impacts an individual's life in many ways and it is best understood by individuals who have experienced it.

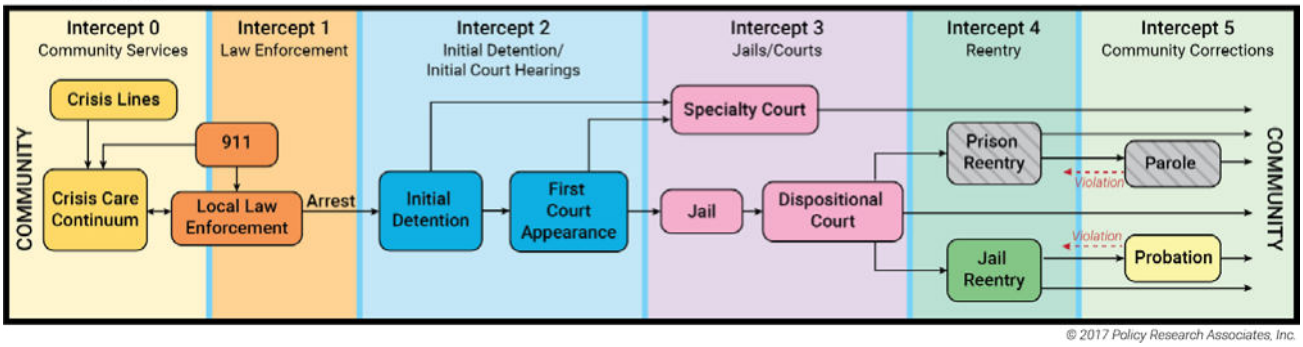
Peer support, by its nature, involves engaging and supporting individuals at various stages on their paths to recovery. Peer support services provided in the community to deter criminal justice involvement or to ease reentry after incarceration differ significantly from peer support services provided in incarcerated settings. Understanding the many different peer support roles in criminal justice settings and the similarities and differences between all of these roles can be challenging.

Federal and state behavioral health and criminal justice agencies, policymakers, community-based organizations, insurance providers, and peer organizations have sought guidance on the topic.

In May 2017, SAMHSA convened a group of national experts to discuss the current status of peer support in criminal justice settings. A natural product of this meeting was the development of a glossary of peer support roles for people with behavioral health challenges involved in the justice system. The chart below lists some common titles for peer supports delivered in the justice system and describes the roles, responsibilities, and key characteristics associated with each.

Title	Roles and Responsibilities	Key Characteristics
Peer Specialists and Peer Support Specialists	• Provide 1-on-1 peer support, facilitate support groups, share experiences, linkage to services and resources, advocacy, training and supervision. • Perform a wide range of tasks to support individuals in living their own lives and directing their own treatment and recovery process.	• Recovery from diagnosis of mental illness is the primary shared experience • Provides peer support services in wide variety of public and private settings including justice settings • Typically paid but may be volunteer positions • Training and certification is available and may be required • Many of the services are reimbursable from third party sources
Peer Recovery Coaches	• Provide 1-on-1 peer support, facilitate support groups, guide and mentor individuals seeking to achieve and sustain long-term recovery from substance use disorder, and enhance their quality of life. • Perform a wide range of tasks to support individuals in identifying and developing their own recovery goals, recovery pathways, and recovery plans.	• Recovery from substance use disorder is the primary shared experience • Provides peer support services in wide variety of public and private settings including justice settings • Typically paid but may be volunteer positions • Training and certification is available and may be required • Some services may be reimbursable from third party sources
Peer Mentors	• Build 1-on-1 relationships, providing encouragement, motivation, and support to individuals seeking to establish or strengthen their recovery.	• Recovery from diagnosis of mental illness and/or substance use disorder is shared experience • Provides peer support services in wide variety of public and private settings including justice settings • Typically volunteer positions but they may be paid • Training is available and is recommended but often not required
Veteran Mentors	• Mentor fellow veterans by offering support with accessing treatment, securing housing, obtaining employment, furthering education, accessing transportation, applying for benefits, contesting discharge status, and connecting with other services and resources.	• Military service is the primary shared experience • Typically volunteer positions but they may be paid • Training available (e.g. NADCP's Justice for Vets Mentor Corps Boot Camp) • Provides mentoring in Veteran Treatment Courts and other veteran services organizations • Services provided are not reimbursable from third party sources
Peer Navigators and Bridgers	• Help individuals understand system processes and how to effectively navigate systems to obtain services needed and access helpful resources.	• Recovery from diagnosis of mental illness is the primary shared experience • May be either paid or volunteer positions • Available in various settings, including justice settings • Frequently work with individuals during transition periods • Services may be reimbursable from third party sources
Family Support Specialist	• Provide support and information to family members of individuals with behavioral health conditions, and facilitate support groups.	• Having family member with behavioral health challenges (mental, substance use, or co-occurring disorders) is primary shared experience • May be either paid or volunteer positions • Training encouraged but may not be required • Provides support to families including those with loved ones who are justice-involved
Forensic Peer Specialist	• A term often used to describe the work of providing peer support services to justice-involved individuals. Forensic Peer Specialists have significant knowledge of both behavioral health and the justice system.	• Peer support services delivered exclusively to individuals involved in the criminal justice system • Lived experience with the justice system is highly preferred and training is encouraged • Typically paid but may be volunteer positions • Services may be reimbursable from third party sources

Using the Sequential Intercept Model to Explore Peer Support Roles in Criminal Justice Settings



The Sequential Intercept Model helps communities develop a comprehensive picture of how people with behavioral health disorders flow through the criminal justice system along six distinct intercept points: (0) Community Services, (1) Law Enforcement, (2) Initial Detention and Initial Court Hearings, (3) Jails and Courts, (4) Reentry, and (5) Community Corrections. It is often used by communities as a strategic planning tool to assess available resources, determine gaps in services, and plan for community change. Below is an overview of some of the peer support roles that exist at each of the six intercepts.

Intercept 0: Community Services

Prior to becoming involved in the criminal justice system individuals with untreated mental or substance use disorders may be engaged in the treatment and recovery process. Peer support activities at this intercept include general and targeted public outreach and engagement efforts, operating warm lines and crisis lines, serving on mobile crisis outreach teams, working in crisis stabilization units and respites or as a navigator or bridger in hospital emergency departments, serving on Assertive Community Treatment (ACT) teams, facilitating support groups, and providing a variety of peer support services in the community.

Intercept 1: Law Enforcement

Individuals in distress or crisis as a result of mental or substance use disorders who are encountered by law enforcement can be assisted into treatment and engaged in recovery through peer support services. Peer support activities at this intercept include involvement in Crisis Intervention Teams (CIT) and related training, co-responding with law enforcement and emergency services, and coordinating outreach and engagement efforts to follow up with individuals identified as being at risk for involuntary hospitalization and/or further involvement in the criminal justice system.

Intercept 2: Initial Detention/Initial Court Hearings

In situations where decisions are made to arrest individuals with mental or substance use disorders and charge them with specific crimes, peer support can help individuals process what has happened and prepare for what is coming next. Peer support activities at this intercept include explaining the arrest, detention, and arraignment processes; helping to ensure that the individual feels safe and respected; and giving the individual hope that they can recover from mental and substance use disorders and cope with criminal justice system involvement.

Intercept 3: Jails/Courts

After arrest, charges, and arraignment, additional opportunities exist to divert individuals with mental and substance use disorders from the criminal justice system. Many mental health, drug/recovery, and other

problem-solving courts use peer support services. Peer support activities at this intercept include providing forensic peer support services on treatment court teams or Forensic Assertive Community Treatment (FACT) teams. In jails and prisons, peer support, particularly mentoring and facilitating support groups, is increasingly being made available to support individuals with mental and substance use disorders.

Intercept 4: Reentry

Individuals completing their sentences and transitioning from incarceration to the community are often facing significant challenges. Peer support is an important component of reducing relapse and recidivism. During reentry, peer support provides assistance with treatment planning and system navigation (accessing housing, employment, benefits, etc.). When begun prior to release, peer support activities include preparing individuals in jails and prisons to develop plans and identify resources to ensure uninterrupted treatment and connection with a recovery community.

Intercept 5: Community Corrections

Individuals who are placed on probation or parole benefit from peer support to assist them with understanding and adhering to the provisions and conditions of their probation or parole and to balance such responsibilities with sustaining treatment and recovery. Peer support providers work with both the individual as well as community corrections officers to access resources and services including housing, employment, and benefits.

Best Practices for Recruiting, Hiring, and Retaining Peer Support Staff in Criminal Justice Settings

1. Build relationships with local peer-run organizations and recovery community organizations to learn about the availability of existing peer support services and how to access them. To find out more about these organizations, contact the GAINS Center (gains@prainc.com).

2. Begin by establishing a leadership or supervisory-type position within your agency or organization and filling that position first.

3. Explore existing practice standards, core competencies, training programs, certification opportunities and requirements, and job descriptions to inform the hiring process.

4. Avoid charging fees to peers for applications, training, and background checks.

5. Prioritize experience with the criminal justice system. Hire more than one peer staff member whenever possible.

6. Set clear and realistic expectations related to job duties and performance, and review those expectations with peer staff prior to hiring.

7. Encourage and support self-care.

8. Engage peer staff in comprehensive training and encourage peer staff to pursue opportunities for continuing education, skill building, and growth with the agency or organization.

9. Ensure that compensation for peer staff is adequate and reflects the value and effectiveness of the work.

10. Explain the value and effectiveness of peer support services and obtain buy-in from non-peer staff to create a welcoming and supportive environment.

11. Work with your criminal justice system partners to ensure their clear understanding of the purpose and role of peers.

12. Develop mechanisms to evaluate the effectiveness of the peer support services being provided.

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Disclaimer

Detailed Text of image on page 3
Community
Crisis Lines go to Crisis Care Continuum. 911 moves to Crisis Care Continuum or Local Law Enforcement. Local Law Enforcement can go to Crisis Care Continuum or Arrest which leads toInitial Detention.From Initial Detention you can go to Specialty Court or first court appearance. From First court appearance you may move to a Specialty Court or to jail. From the Specialty Court you may be moved to the Community. Form jail you may be nmoevd to Dispositional Court. From Dispositional Court you may be moved to the Community, Jail Reentry, or Jail Reentry. From Prison Renentry you can move to the Community or Parole. If you violate your parole you go back to Prison. From Jail Reentry you go either to the Community or Probation. If you violate your Probation you can go back to Jail.

Peer Recovery Support Services in Correctional Settings

Bureau of Justice Assistance
U.S. Department of Justice

May 2022

BJA's
Comprehensive
Opioid, Stimulant,
and Substance Abuse
Program

Peer Recovery Support Services in Correctional Settings

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Introduction

Incarcerated populations are both more likely to suffer from and be more vulnerable to mental health (MH) and substance use disorders (SUDs) and from violent and self-harm behaviors than the general population (American Academy of Family Physicians, n.d.). Eighty-five percent of incarcerated individuals were either struggling with active SUDs themselves or were under the influence of alcohol and/or drugs at the time of their crime (National Center on Addiction and Substance Abuse, 2010). Despite 1.5 million inmates meeting clinical criteria for SUD, only 168,000 received treatment (National Institute on Drug Abuse [NIDA)], 2020). Between 2004 and 2006, one-third of the 2.3 million persons incarcerated in the United States had a diagnosis of a mental illness, with roughly 25 percent experiencing a co-occurring SUD (NIDA, 2020).

During periods of transition, such as community reentry after incarceration, individuals with SUDs are vulnerable. Upon reentry, many individuals face barriers to reestablishing a healthy life outside of jail or prison, including inadequate access to health insurance, MH or SUD treatment, medical care, employment, and housing. Many individuals with SUDs return to their community and start using drugs again, not realizing they do not have the same tolerance they had before incarceration, which in turn can lead to an increased risk of overdose and death (Hanna et al., 2020) and a relapse-driven return to incarceration (NIDA, 2020). The risk of opioid overdose in the first 2 weeks following an individual's release from prison is 40 times higher than for the general population (Hanna et al., 2020).

Individuals who are incarcerated and living with SUDs face challenges both behind the walls and after release, particularly in transitioning back to the community. Separately, neither the correctional system nor the community behavioral health system can adequately meet their needs. Prison behavioral health staff members often lack the resources needed to address the emotional regulation, stress management, relapse, and overdose prevention needs of incarcerated persons or adequately prepare individuals for reentry into the diverse communities to which they return. Overburdened and under-resourced, community behavioral health systems, in turn, often lack the expertise and resources to address the unique needs of returning individuals confronting both SUD and readjustment to the community.

Peer support is a proven resource to address these demands in correctional and community settings to support recovery from SUD and MH conditions, prepare for release, and facilitate reentry. Peer support has proven to be effective for a range of emotional, informational, and instrumental supports; improved sense of wellbeing; and linkage to services for individuals in or seeking recovery from SUD and/or MH conditions (Bellamy, Schmutte, & Davidson, 2017; Bassuk et al., 2016; Reif et al., 2014). Peer support can be delivered while an individual is incarcerated and can follow the individual through release planning, reentry, and community supervision. Adding peer recovery specialists to existing multidisciplinary teams of correctional officers and staff, court staff, behavioral health clinicians, and social workers can reap both operational and fiscal benefits. Those benefits include successful community integration, connection to services, increased prosocial connections, and decreased recidivism (Bagnall et al., 2015; Taylor & Becker, 2015; Rowe et al., 2007).

In theory, adding peer support in correctional settings is as simple as hiring a peer specialist. In practice, it is more complex. There is an inherent tension between peer practice approaches and traditional correctional approaches. Peer support focuses on healing practices that are strengths-based, holistic, trauma-informed, and person-centered. It can be challenging to foster these peer program attributes in a corrections environment, which is punitive by design, relies on control, and can induce or trigger trauma. While peer support can augment behavioral health services, it can easily be undermined and thwarted by the overarching correctional culture, policies, and procedures. Successful integration of peer recovery support services (PRSS) requires a thoughtful, deliberate approach. The purpose of this technical assistance (TA) package is to assist organizations in that approach. This document will:

1. Define peer support in correctional settings.

2. Describe the core competencies for peer support in correctional settings.

3. Highlight the use of peer support in short-term, medium-term, long-term, and community corrections settings to improve recovery and reentry outcomes.

4. Identify emerging and best practices for integrating peer support into correctional settings.

5. Provide recommendations for program design and implementation.

The document contains implementation tools, including a start-up checklist and sample job descriptions.

Defining Recovery

It is important to define the term recovery to understand the role PRSS can play in jails and prisons. The Substance Abuse and Mental Health Services Administration (SAMHSA) (2020b) defines recovery as "a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential." SAMHSA also notes four major dimensions that support recovery: health, home, purpose, and community. These dimensions are relevant, even in correctional settings.

- **Health** relates to overall health and well-being. Individuals in recovery actively engage in improving their own physical and mental health. For incarcerated individuals, their health can be negatively impacted by reduced access to health care and social services, the controlled environments that limit the type and frequency of physical activity, and the nutritional profile of the foods provided. Conversely, incarceration can facilitate healthy choices, such as abstaining from substance use and adhering to recommended medications.

- **Home** is defined as a safe and secure place to live. Jails and prisons provide relatively stable housing wherein a person has a roof over their head, access to food and water, and

personal hygiene facilities, but incarcerated individuals lack control over where they are housed. Some correctional facilities struggle with issues of violence and overcrowding, which impact the overall safety of the space. Housing instability and insecurity increase upon reentry due to the stigma of a criminal record, limited employment opportunities, and structural obstacles to obtaining housing (Herbert, Morenoff, & Harding, 2015).

- **Purpose** is a connection to the activities of daily living in a meaningful way and having autonomy and responsibility. In secure settings, individuals have limited opportunities to practice independence, make critical decisions, or engage with the larger society outside the jail/prison. While many people hold jobs inside the facility, like laundry or kitchen positions, compensation is low, and there are seldom enough openings for every job seeker. Although limited, some jails and prisons provide individuals opportunities to pursue and learn new skills, take educational classes (GED/college), and engage in SUD and MH treatment. However, especially in jail, the average length of stay often is too short to afford meaningful participation in constructive activities.

- **Community** means establishing positive relationships, social networks, and personal support systems. In jails and prisons, opportunities to engage with others are limited, usually controlled, and confined. Individuals may be allowed time to participate in a limited range of activities, such as educational classes/workshops, library visits, recreational time, family visits, and SUD and MH treatment groups (Alcoholics Anonymous, Narcotics Anonymous, cognitive behavioral therapy, dialectical behavioral therapy). Each of these can serve as an opportunity for a positive, prosocial connection. However, demand for involvement in positive programming often outweighs supply, leaving many individuals without avenues to build a healthy recovery network. Additionally, housing and safety policies limit options about where people are housed, who is in their unit, and with whom they are allowed to engage.

As these dimensions suggest, the risk of reoffending can be reduced by helping individuals build richer and more fulfilling lives, and correctional settings have important roles to play.

Recovery-Oriented Corrections: Balancing Risk, Safety, and Recovery in Secure Settings

As the practices related to recovery from SUD and co-occurring MH conditions have evolved, the concept of recovery-oriented systems of care (ROSC) has emerged. A ROSC is a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resilience of individuals, families, and communities to improve health, wellness, and the quality of life for individuals experiencing or at risk of SUDs. In a ROSC, existing community resources are brought together to engage all stakeholders, enhance infrastructure to support individuals in recovery, and promote continuity of services and care. Peer support is a core element of a ROSC.

Correctional institutions can also be recovery-oriented systems, but the approaches must be interpreted and translated for correctional settings, and the value of such approaches must be understood.

Historically, managing risk has been a greater focus than promoting recovery. Risk assessment and management are deeply embedded in the culture, environment, and everyday practice of secure settings. Boundaries are necessarily and rightly established and maintained for the safety and security of staff members and others. In integrating recovery principles into what they call "secure settings," Drennan and Alred (2012) named their adaptation "secure recovery." They write:

"Secure recovery acknowledges the challenges of recovery from mental illness and emotional difficulties that can lead to offending behavior. It recognizes that the careful management of risk is a necessary part of recovery . . . but this can happen alongside working towards the restoration of a meaningful, safe, and satisfying life."

They note that instead of risk being understood as something separate from, or more important than, an individual's recovery, risk can be viewed and treated as one aspect of the recovery process. Programs can help individuals to shift from negative to positive risk-taking, that is, engaging in behaviors in which they take on new challenges leading to personal growth and development. Supporting positive risk-taking is not about lax security; rather, it is an approach to risk that is informed by the primary goal of supporting an individual's recovery—within the confines and limitations imposed by the setting. There will always be restrictions on how much autonomy, choice, and opportunities for positive risk-taking can be given to individuals who are incarcerated. The key in recovery-oriented settings is how the environment can be shaped to give people as much control as possible over their lives as they progress in their recovery journey.

Shifting Focus: Individual Recovery and Desistance Requires Community Involvement—Just as recovery from SUDs or MH diagnoses involves the process of behavioral change, so too does *desistance.* This concept is important in recovery-oriented correctional settings.

The National Institute of Justice (n.d.) defines recidivism as "a person's relapse into criminal behavior," and desistance as "the process by which a person arrives at a permanent state of non-offending." In this sense, desistance involves a shift not only in actions but in a person's individual and social identity and how they see themselves fitting into a community.

Recovery and desistance both highlight the importance of process and place the individual within a larger social context. While this does not remove the responsibility of persons to make changes in their own life, it acknowledges the impact that social support, services, and identity have on the process (Best, Irving, & Alberson, 2017). Maruna and Farrall (2004) describe *primary desistance* as times of non-offending and *secondary desistance* as measured changes in one's identity as a non-offender. McNeill (2014) describes *tertiary desistance* as changes to one's social identity and sense of belonging to a community.

Both hope and despair can be contagious. Recovery and desistance require the creation of a new social environment built on hope, support, learning, and positive connections to peers and the larger community (Best, 2019; Best, Musgrove, & Hall, 2018). Recovery-oriented correctional systems create hope and in the process also increase the safety and security of their facilities. Examples of different programs using peer supports to achieve both goals are provided throughout this document.

Defining Peerness, Peer Practice, and Peer Support

We begin our discussion of peer support by defining the distinct position of a *peer*. A peer supporter is defined by SAMHSA (2015) as "a person who uses his or her lived experience of recovery from mental illness and/or addiction, plus skills learned in formal training, to deliver services in behavioral health settings to promote mind-body recovery and resilience." In correctional settings, peer supporters are persons with lived experience of recovery from SUDs and/or co-occurring MH conditions and criminal justice involvement. They may be currently or formerly incarcerated individuals who have received specialized training (and often certification) to deliver peer education or peer support in a voluntary or paid capacity in the prison and can also provide support to others within the community. This duality of lived experience is required for individuals serving in a peer role to fully understand the traumas that may have occurred before, during, and after incarceration. This distinct experience helps others navigate criminal justice and health care systems simultaneously, providing stronger and more relevant support for individuals (Rowe et al., 2007).

Peer practice is an approach to working with others grounded in a set of principles that have emerged from people's experiences in long-term recovery. The primary principle is keeping recovery first for both the peer supporter and the individual seeking support. A second core principle is meeting individuals "where they are." In practice, this means being supportive rather than directive and focusing on strengths and resiliencies. Other foundational principles relate to the authority and expertise of lived experience, mutuality and reciprocity, relationships built on respect and trust, and self-efficacy and empowerment (White, 2009a; Reif et al., 2014; Hoffman et al., 2019).

***Peer suppor*t** is an evidence-based model of care that consists of a qualified peer support practitioner who assists individuals with their recovery from substance use and MH conditions. Peer-delivered services are supportive rather than directive; reciprocity and empathic human relationships are central components (Miyamoto & Sono, 2012). Peer support's core principles and values are being voluntary, non-judgmental, empathic, and respectful and requiring honest and direct communication, mutual responsibility, power-sharing, and reciprocity (Blanche, Filson, & Penny, 2012).

PRSS refers to the wide array of non-clinical supports peer recovery specialists provide. Five core values underlie PRSS programs and the work of peer supporters (SAMHSA, 2015):

1. Recovery-oriented: Peer specialists hold out hope to those they serve, partnering with them to envision and achieve a meaningful and purposeful life. Peer supporters help those they serve identify and build on strengths and empower them to make choices for themselves, recognizing that there are multiple pathways to recovery.

2. Person-centered: PRSS are always directed by the person participating in the program. Peer support is personalized to align with the specific hopes, goals, and preferences of the individual served and to respond to the specific needs the individual has identified.

3. Voluntary: Peer specialists are partners or consultants to those they serve. They do not dictate the types of services provided or the elements of recovery plans that will guide their work with peers. Participation in PRSS is always contingent on peer choice.

4. Relationship-focused: The relationship between the peer worker and the peer is the foundation for peer support. The relationship between the peer worker and peer is respectful, trusting, empathetic, collaborative, and mutual.

5. Trauma-informed: Peer specialists use strengths-based approaches that emphasize physical, psychological, and emotional safety and create opportunities to rebuild a sense of control and empowerment.

To successfully implement a PRSS program, organizations need to understand these core values and use them to guide service planning and delivery.

Trauma-Informed Peer Support

Individual trauma results from an **event**, series of events, or set of circumstances that are **experienced** by an individual as physically/emotionally harmful or life threatening and that have lasting adverse **effects** on the individual's functioning and mental, physical, social, emotional, or spiritual well-being (SAMHSA, 2014).

- Trauma is pervasive. Its impact is broad, deep, and life-shaping, and it disproportionately affects the most vulnerable.
- Significant percentages of individuals who are incarcerated, and those with SUDs, have been impacted by trauma.
- Systems themselves have often been traumatizing or retraumatizing.

Treatment plus peer support can break the cycle of beliefs that reinforce traumatic stress (e.g., believing that one is permanently damaged, that nobody could understand, that no one should or could tolerate one's story).

Peer support is embedded in the core principles of a trauma-informed approach. PRSS provide resources to help individuals understand triggering signs resulting from trauma and how to address them in a healthy manner while promoting safety and resiliency. Trauma-informed peer support means that peer recovery specialists are trained in understanding the 3 Es (events, experience, and effects) of trauma, how to address them in peer work, and when to encourage individuals to seek clinical support.

Understanding key elements of a trauma-informed approach in justice settings is essential to effectively provide peer support. It is equally important to understand that the peers providing services may have also experienced trauma. Integrating a trauma-informed approach should include steps to prevent retraumatization, recognize secondary/vicarious trauma, and build upon the resiliency of peer specialists. A trauma-informed approach should include support for the peer staff members by others who understand the impact of trauma and how to support peers in recognizing the need for self-care.

EVIDENCE FOR PRSS BEHIND THE WALLS

PRSS programs inside jails and prisons offer an evidence-based and innovative approach to supporting recovery from SUD and MH conditions. Not only are PRSS successful at reducing risky

behaviors for incarcerated participants, but they also help improve emotional well-being (Bagnall et al., 2015). Additionally, studies show that PRSS effectively reduce rates of recidivism by providing resources and support to persons with SUD and/or MH needs (Bellamy et al., 2019). PRSS also have the potential to address the unique needs of incarcerated individuals (Chapman, Blash, Mayer, & Spetz, 2018). Research also suggests PRSS can be implemented effectively within correctional settings in partnership with health and prison services (South et al., 2016).

Research has found that MH providers who integrate peer support into treatment are more successful at promoting hope and belief in the possibility of recovery, empowering clients, and increasing their self-esteem, self-efficacy, and self-management of difficulties (Repper & Carter, 2011). They also promote social inclusion, engagement, and expanded social networks better than professional staff working on their own (Repper & Carter, 2011). Research also indicates that being in a supportive role helps currently and formerly incarcerated peers to develop meaning and purpose, regain a sense of control over their issues, and increase their well-being (Barrenger, Maurer, Moore, & Hong; 2020; Addiction Policy Forum, 2019; Ashcraft & Anthony, 2011).

Among prison programs that engage incarcerated persons in delivering peer support, studies show that PRSS have been shown to fill gaps in service provision, with the result that peer support decreases demand for services offered by staff and thereby increases staff availability for other duties (South et al., 2016). Research also indicates that peer workers benefit from more fulfilling work opportunities within the prison setting, offering them the chance to gain skills and qualifications (Ross, 2011; Boyce, Hunter, & Hough, 2009; Brooker & Sirdifield, 2007). As research has documented, “the wounded healer or ‘professional ex’ role is related to desistance and can transform formerly incarcerated persons from being part of ‘the problem’ into being part of ‘the solution’ to reduce crime and recidivism” (Lebel, Richie, & Maruna, 2015).

Lastly, other research points to the positive impact on prison culture, ranging from peer workers being able to diffuse volatile situations to better relationships between staff members and prisoners to a more caring and humane atmosphere (Brookes, 2012). Peers can act as a bridge between correctional officers and individuals who are incarcerated, challenging a correctional culture where neither feels comfortable communicating with the other. Both inmates and officers will see peers communicating freely with both; thus, peer workers may add further social value to the correctional environment.

Identifying Program-Specific Peer Specialist Competencies, Roles, and Tasks

Peer recovery specialist is an overarching term that refers to persons with lived experience supporting others along their path of recovery—either before, during, after, or instead of treatment. This section describes peer recovery specialists' core competencies and expectations specific to working in correctional settings.

CORE VALUES AND COMPETENCIES

SAMSHA and peer-focused organizations such as the National Association of Peer Supporters have identified the core competencies needed to be effective in a peer-support role. **Peer recovery specialist core competencies bring core recovery values to life**. The competencies further define and extend the core values by specifying peer specialists' knowledge and skills and their tasks to put the values into practice. This makes the core competencies a useful program planning tool in that they also describe key elements of effective one-on-one support. Table 1 summarizes the competency categories.

Table 1. SAMSHA Core Competencies for Peer Workers

Category	Competencies
Engage Peers in Collaborative and Caring Relationships	Initiate contact, listen to peers with careful attention to the content and emotion being communicated, reach out to and engage peers across the whole continuum of the recovery process, demonstrate genuine acceptance and respect, and demonstrate understanding of peers' experiences and feelings.
Provide Support	Validate peers' experiences and feelings, encourage the exploration and pursuit of community roles, convey hope to peers about their recovery, celebrate peers' efforts and accomplishments, and provide concrete assistance to help peers accomplish tasks and goals.
Share Lived Experiences of Recovery	Relate personal recovery stories and, with permission, the recovery stories of others to inspire hope, discuss ongoing personal efforts to enhance health, wellness, and recovery, recognize when to share experiences and when to listen, describe personal recovery practices, and help peers discover recovery practices that work for them.
Personalize Peer Support	Understand personal values and cultures and how these may contribute to biases, judgments, and beliefs, appreciate and respect the cultural and spiritual beliefs and practices of peers and their families, recognize and respond to the complexities and uniqueness of each peers' process of recovery, and tailor services and support to meet the preferences and unique needs of peers and their families.
Support Recovery Planning	Assist and support peers to set goals and dream about future possibilities, propose strategies to help peers accomplish tasks or goals, support peers to use decision-making strategies when choosing services and support, help peers to function as a member of their treatment and recovery support team, and research and identify credible information and options from various resources.
Link to Resources, Services, and Supports	Develop and maintain up-to-date information about community resources and services, assist peers in investigating, selecting, and using needed and desired resources and services, help peers to find and use health services and supports, accompany peers to community activities and appointments when requested, and participate in community activities with peers when requested.

Category	Competencies
Provide Information About Skills Related to Health, Wellness, and Recovery	Educate peers about health, wellness, and recovery supports, participate with peers in discovery or co-learning opportunities to enhance recovery experiences, coach peers about how to access treatment and services and navigate systems of care, coach peers in desired skills and strategies, educate family members and other supportive individuals about recovery and recovery supports, and use approaches that match the preferences and needs of peers.
Help Peers to Manage Crises	Recognize signs of distress and threats to safety among peers and in their environments, provide reassurance to peers in distress, strive to create safe spaces when meeting with peers, take action to address distress or a crisis by using knowledge of local resources, treatment, services, and support preferences of peers, and assist peers in developing advance directives and other crisis prevention tools.
Value Communication	Use respectful, person-centered, recovery-oriented language in written and verbal interactions with peers, family members, community members, and others, use active listening skills, clarify their understanding of information when in doubt of its meaning, convey their point of view when working with colleagues, document information as required by program policies and procedures, follow laws and rules concerning confidentiality, and respects others' right to privacy.
Support Collaboration and Teamwork	Work together with other colleagues to enhance the provision of services and support, assertively engage providers from MH services, addiction services, and physical medicine to meet the needs of peers, coordinate efforts with health care providers to enhance the health and wellness of peers, coordinate efforts with peers' family members and other natural supports, partner with community members and organizations to strengthen opportunities for peers, and strive to resolve relationship conflicts with peers and others in their support network.
Promote Leadership and Advocacy	Use knowledge of relevant rights and laws (Americans with Disabilities Act, Health Insurance Portability and Accountability Act [HIPPA], Olmstead Act, etc.) to ensure that peers' rights are respected, advocate for the needs and desires of peers in treatment team meetings, community services, living situations, and with family, use knowledge of legal resources and advocacy organization to build an advocacy plan, participate in efforts to eliminate prejudice and discrimination of people who have behavioral health conditions and their families, educate colleagues about the process of recovery and the use of recovery support services, actively participate in efforts to improve the organization, and maintain a positive reputation in peer/professional communities.
Promote Growth and Development	Recognize the limits of peers' knowledge and seek assistance from others when needed, use supervision (mentoring, reflection) effectively by monitoring self and relationships, prepare for meetings and engage in problem-solving strategies with the supervisor (mentor, peer), reflect and examine own personal motivations, judgments, and feelings that the peer work may activate, recognize signs of distress and know when to seek support. Seek opportunities to increase knowledge and skills of peer support.

ROLES AND TASKS

Peer specialists may have many different titles or roles. While the competencies for peer specialists are somewhat universal—especially the sharing of lived experiences of recovery and inspiring hope and change—each role emphasizes different competencies, as the examples in table 2 show.

Table 2. Important Peer Specialist Competencies by Role—Examples Across the Sequential Intercepts

Core Responsibilities	Key Competencies
Recovery Interventionist/Crisis Interventionist	
Provide support and guidance to a person at a critical intercept point along the recovery support continuum, linking a person to treatment or other recovery support services requested by the person being supported.	• Supports personalized recovery planning that helps participants to manage crises and take steps toward more healthful behavior • Links to resources, services, and supports • Develops tools for effective outreach and continued support • Addresses stigma • Supports collaboration and teamwork
Recovery Coach	

Serve as a guide and mentor for a person seeking or already in recovery. Help identify and remove obstacles and barriers, support connections to the larger recovery community and other resources useful for building recovery capital, and respect the path to recovery chosen by the person seeking support.	• Engages peers in collaborative and caring relationships
	• Provides personalized support:
	  ○ Practices a strengths-based approach to recovery/wellness
	  ○ Tailors services and supports to meet preferences and unique needs
	  ○ Provides concrete assistance to help accomplish goals and tasks
	  ○ Assists individuals in identifying support systems
	  ○ Applies principles of individual choice and self-determination
	  ○ Assists individuals to identify and build on their strengths and resiliencies
	• Supports holistic, ongoing recovery planning
	• Provides information about skills related to health, wellness, and recovery
	• Promotes leadership, advocacy, growth, and development

Peer Specialist–Treatment and Recovery Courts	

Support people involved with the criminal justice system as a mentor, guide, and/or resource connector while they are engaged with the court and beyond.	• Supports personalized recovery planning and positive engagement in the criminal justice system
	  ○ Assists and supports participants in setting goals related to adherence to court requirements
	  ○ Proposes strategies to help participants accomplish tasks or goals
	• Links to resources, services, and supports
	  ○ Addresses barriers to housing and employment
	  ○ Assists to identify, select, and use resources and services
	• Provides information about skills related to health, wellness, and recovery
	• Advocates for individuals while supporting compliance

Core Responsibilities	Key Competencies
	• Supports collaboration and teamwork
Peer Advocate–Reentry	

Provide assertive advocacy on recovery-related issues that transcend personal, professional, and institutional interests. Reduce/eliminate service disparities, reduce/eliminate stigma/discrimination, and make addiction treatment more responsive, effective, and efficient.	• Supports personalized recovery planning focused on positive engagement in the criminal justice system
	• Advocates for individuals while supporting compliance
	  ○ Addresses the relationship between incarceration and trauma
	  ○ Addresses stigma, discrimination, and exploitation that individuals face within society as a result of their criminal justice involvement
	• Links to resources, services, and supports
	  ○ Addresses barriers to housing and employment
	  ○ Assists to identify, select, and use resources and services
	• Helps participants to manage crises
	• Supports collaboration and teamwork

As indicated above, different roles emphasize different aspects of the recovery process. For coaches, recovery planning and recovery check-ins across time are the cornerstones. For recovery interventionists, it is recovery planning within the context of a crisis (crisis management), and for corrections-based peer recovery specialists, recovery planning likely means aligning court or community supervision requirements with the goals and desires of the individual. The one-on-one support that peer specialists offer—recovery planning—is the same, but how it is undertaken may vary widely.

The competencies describe the specific tasks that peer recovery specialists do. Your program can use the defined competencies to fine-tune the specific job descriptions for your program, set learning objectives for on-the-job and advanced training, define specific services and supports to be offered, or identify needed partnerships to complement the PRSS that are directly offered.

Training Corrections Staff Members Regarding Peer Support and Peer Roles/Tasks

In addition to training for the peer recovery specialist (noted above), other prison staff members, regardless of their roles and functions, should receive education on SUD, recovery, and the services available at the prison; the collection and use of data to support and inform their work; and measurements that are recovery- and recovery capital-oriented rather than solely focused on abstinence or recidivism, including peer support services. This education will help reduce peer stigma among prison staff members and improve the integration of peer support workers in jail, prison, and reentry services.

Integrating Peers and Offering PRSS in Correctional Settings

Peers are increasingly recognized as beneficial to programs throughout justice settings, from the point of entry to community reintegration. Correctional facilities across the country are embedding peer support into all areas of services, programming, and daily life. Behind the walls, PRSS are complex programs taking place within a setting that has been described as a "total institution"—a site where every aspect of an individual's life is prescribed and controlled. The correctional setting requires a peer support program that is customized for jail/prison environments. It can be helpful to have an overarching framework for conceptualizing, planning, and evaluating how services fit into such a setting. Figure 1 summarizes dimensions related to the integration of PRSS into jail and prison settings (Burden & Etwaroo, 2020).

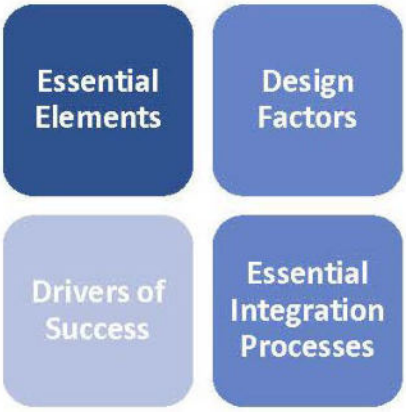

Figure 1. Conceptual Framework for PRSS Delivery in Jails and Prisons

CORE COMPONENTS OF A COMPREHENSIVE PRSS PROGRAM

There are five essential elements of a comprehensive PRSS program in correctional settings, listed in figure 2.

Figure 2. Core Components (Essential Elements)

Trained peers. The first core component is trained peers. Training, whether it leads to formal certification or not, standardizes the core body of knowledge and competencies for entry-level peer work. Prospective peer workers demonstrate their proficiency in meeting the requirements through an examination and/or other competency assessment.

Certification is not a requirement for program success, but adequate preparatory and on-the-job training and development *are* requirements. This means ensuring that new peer specialists have a thorough understanding of the stages of the change model (Prochaska, Redding, & Evers, 2008), the process of change, and the stages of recovery. However, having certified peer workers can lead to sustainable funding options if services are covered by private insurance or are eligible for Medicaid.

Choice and access. Choice, self-direction, and empowerment are foundational values of PRSS, even within correctional environments. For a program to align with peer recovery values, it must offer choice. This is possible within a jail or prison, although choice in this context looks different than for PRSS delivered in the community. Individuals' decisions to participate in services are conditional on housing status, classification, behavior, sentence, security permissions, and additional factors.

Programs can put choice into practice in several ways, such as supporting many pathways to recovery, assuming that the person seeking recovery is fully capable of making informed choices, and respecting an individual's goals, objectives, and preferences. As in wider society, where everyone has the choice of whether to conform to social norms, incarcerated individuals can decide at what level they are prepared to conform to the prison regime (whether or not to go to the yard to exercise, go to church services, attend educational sessions, or to actively take part in their reentry-planning process). These opportunities to exercise choice and control are even greater within prison-based therapeutic communities to which individuals must apply (Drennan, 2013).

There are several programmatic strategies for facilitating access, such as having peer specialists designated to specific housing units, holding hours for participant drop-ins, establishing reentry planning workshops/groups, offering technology-assisted (JPay, phone, text, web-based) peer supports, and providing access to peers in community-based settings upon reentry. Policies and procedures can be developed to increase accessibility to peers and peer supports by addressing location(s), hours, and access when emergent needs arise. (*Sample policies are provided in tool 3)*.

Peer Support in Residential Substance Abuse Treatment Programs

Residential Substance Abuse Treatment (RSAT) for State Prisoners programs promote the development and implementation of substance abuse treatment programs in state, local, and tribal jails and prisons and residential aftercare facilities. Programs provide residential substance abuse treatment for incarcerated persons, prepare them for their reintegration into a community by incorporating reentry planning activities into treatment programs, and assist released individuals by providing residential treatment in the community.

RSAT funding provides treatment and aftercare services, including case management and a full continuum of support services. State aftercare services involve the coordination of the correctional facility-treatment program with other human service and rehabilitation programs, such as educational and job training programs, parole supervision programs, halfway house programs, and self-help and peer group programs that may aid in an individual's rehabilitation.

Many RSAT programs use modified therapeutic communities (TCs) to treat inmates. However, since RSAT participants are separated from the general population, all RSAT programs provide aspects of TCs, which have been identified as a highly effective evidence-based treatment model for incarcerated individuals with SUD (Pearson & Lipton, 1999; Welsh, 2007). RSAT TCs provide a minimum of 90 days of highly structured, behavioral modification programs that foster increased levels of personal and social responsibilities, primarily through peer influence. The TC model uses a variety of group processes to help individuals learn and practice prosocial norms, values, skills, and behaviors. The core principle of "community as the agent of change" drives the TC model (Cook, McClure, Koutsenok, & Lord, 2008). RSAT TC programs differ, but all include individual and group counseling sessions, self-help groups, and other programming that provide opportunities for individual and group interaction.

West Tennessee State Penitentiary Peer Programming

Increasingly, TCs are including formal PRSS as a part of their programming. Of these, the West Tennessee State Penitentiary TC programs stand out. Both their men's and women's prison programs are 9 to 12 months long with three phases lasting 3 to 4 months each. The variability in timeframe depends on an individual's progress in meeting the milestones required to progress to the next phase, as well as their individual goals and objectives. TC residents have a variety of resources available to support their recovery. For example, tutors and mentors are available to assist with reading and writing. Residents are eligible for graduation when they complete all three phases, finish required pre- and post-tests and written work, meet their individualized treatment plan goals, and all TC staff members agree they are ready to move on.

Participants are paired with a peer supporter (another TC resident who has been trained to provide assistance and motivation). This support goes beyond the mutual aid that is common in therapeutic communities. Peer supporters model the value of every individual's recovery experience, teach effective coping techniques and self-help strategies, and encourage others to develop healthy independence.

The women's peer program operates both within the TC and as a resource for the entire women's complex. Within the TC, peer recovery specialists often co-lead community meetings and sessions with the clinical staff members. Peer recovery specialists also lead educational and peer support groups and can provide one-on-one support within the TC and for inmates in other pods.

Recovery capital building. Recovery is a journey that involves the growth of recovery capital, which is the sum of the strengths and supports—both internal and external—that are available to help someone initiate and sustain long-term recovery from addiction (Granfield & Cloud, 2004; White, 2008). A *recovery capital assessment* measures participants' strengths, resources, motivation, and aspirations to support their recovery journey (Groshkova, Best, & White, 2013).

Recovery planning assists individuals in (a) articulating and visualizing the kind of life they would like to have in recovery, (b) outlining their personal recovery goals, and (c) developing action steps to achieve their recovery goals upon reentry that include a safe and affordable place to live; steady employment and job readiness; education and vocational skills; life and recovery skills; health and wellness; sense of belonging and purpose; community and civic engagement; and recovery support networks.

Recovery check-ins improve the likelihood of sustained sobriety and engagement in a recovery program (Scott & Dennis, 2003). They provide opportunities for participants to reflect on progress toward the goals they set in their recovery plan, talk about challenges and barriers, and identify resources (Braucht, n.d.).

Recovery peer support groups and activities. Beyond one-on-one recovery check-ins, comprehensive PRSS programs include peer support groups, health education, stress and emotional management, crisis prevention, and community-building activities. Groups can be structured or semi-structured, educational or for emotional support, or have mixed components. They can be formed around a shared identity, such as belonging to a common cultural group or gender, or shared experience related to building a life in recovery.

Reentry support and linkage to the recovery community. Ideally, peer support can link individuals to treatment and recovery supports that are available upon reentry. Connecting individuals to the recovery community outside the walls is an essential part of reentry planning for individuals who have established their recovery while incarcerated.

Linking participants to a broader recovery community assists them in building a life in and sustaining recovery for three key reasons: (1) it can offer a positive sense of identity, belonging, and purpose; (2) it builds pro-social, recovery-oriented networks; and (3) it increases opportunities to access the community recovery capital (White, 2009b; Best et al., 2012; Kelley et al., 2017; Best, Musgrove, & Hall, 2018).

DESIGN FACTORS THAT IMPACT SUCCESSFUL INTEGRATION

Seven key program design factors impact the integration of peer supports into correctional facilities, as listed in figure 3.

Figure 3. Design Factors

Type of correctional facility/setting. Whether it be a jail or state or federal prison, PRSS delivery must be adapted to the specific carceral environment. Factors such as individual sentence, stay-away orders, security classification, and clearance level can dictate where a person is housed and what services they have access to—and all these factors must be considered in the planning of PRSS programs behind the walls. The advent of COVID-19 added virtual peer support to the mix of services. They relate to comprehensiveness and duration of supports. Jail-based PRSS programs need to be shorter and more flexible/fluid than those in prisons. (*More information on comprehensiveness and duration is provided below.)*

Security/perceptions of risk. Recovery principles emphasize hope, strengths, choice, empowerment, well-being, and a positive sense of identity. Applying recovery principles to correctional settings requires creative adaptation to address concerns related to security and risk. In their adaptation, Drennan and Aldred (2013) coined the term "secure recovery," which (1) acknowledges the challenges of recovery from mental health and SUDs that can lead to offending behavior and (2) recognizes that in secure settings, the careful management of risk can happen alongside working toward the restoration of a meaningful, safe, and satisfying life for individuals. *See* Recovery-Oriented Corrections: Balancing Risk, Safety, and Recovery in Secure Settings *on page 4 for more about the secure recovery model.*

Institutional perspective on its role in recovery. Detention can be an opportunity for recovery. For such a life crisis to be an opportunity for positive change requires the person to be an active participant in their recovery. Personal recovery cannot progress until the individual regains active control over their treatment and, ultimately, their life. Correctional institutions that incorporate a recovery-oriented perspective focus on changing the environment, not just to improve security and safety but also to foster more humanistic treatment. They move away from using segregation

Peer Support in Jail-Based Medication Assisted Treatment Program

The **Albany County, New York, Sheriff's Office** oversees a variety of programming at the Albany County Corrections and Rehabilitative Services Center (ACCRSC), including the addiction services unit. ACCRSC is one of the largest county correctional facilities in New York State, with a 1,043-bed maximum capacity and average daily population of more than 800 inmates. Currently, there are two full-time staff members along with several contracted behavioral health practitioners.

A large percentage of the ACCRSC population struggles with SUD. Some inmates are looking to engage with traditional treatment and recovery services, while most are interested in a harm reduction approach. ACCRSC became one of the first facilities in New York state to provide all three of the medications for opioid use disorder. It averages 30 to 40 medication-assisted treatment (MAT) participants at any given time. Staff members focus their efforts on creating a safe space to openly talk about issues as they arise, having honest conversations about the why the underlying reason(s) for the behavior occur(s), and how to change it/them.

ACCRSC contracts with Catholic Charities' Project Safe Point to provide two certified recovery peer advocates (CRPAs) who provide approximately 20 hours of in-jail support weekly. For individuals not interested in treatment, the CRPAs focus their efforts on harm reduction, building relationships while individuals are incarcerated, and ensuring that individuals are connected to community supports. For individuals engaged in MAT, CRPAs work to bridge gaps that can occur upon return to the community, helping to ensure the continuity of treatment.

The CRPAs have had a positive impact, including improved inmate morale and reduced anxiety and fear. ACCRSC staff members stress the importance of building a team that genuinely believes in the philosophies of the work being conducted and has some experience working with the incarcerated population which can be challenging. They also note that it is imperative to collaborate across systems to maximize program efficacy.

and other old-school justice approaches as a means of control and incorporate tools and resources to give people opportunities for positive risk-taking. These efforts decrease recidivism, decrease cell extractions, decrease disciplinary time, and increase prosocial behavior (Drennan & Aldred, 2013).

The institutional perspective on recovery directly relates to the role of peer workers, whom they serve, and for what purpose. Peer workers can be viewed as adjuncts (junior case managers/discharge planners) who are hired to support and reduce the work of other staff members, entry-level supplements to the behavioral health workforce whose job it is to complete routine tasks, or as fulfilling an autonomous new role focused on participant engagement and progress.

Internal or external peer staff members. Another key program design consideration is the employment status of the peer specialists. Within prison settings, peer supporters can be:

1. *Employees (or volunteers) of an external partner, such as a recovery community organization or behavioral health provider.* The benefits of this approach include ready-made expertise in providing peer support (which could lessen start-up time), building

relationships with/in the community, accessing resources that can assist individuals upon reentry, and gaining different perspectives on recovery and what supports individuals' recovery outside of the correctional environment. Challenges include finding appropriate partners and building trust, ensuring that your partner's vision for the program aligns with yours, clearly defining processes and protocols, obtaining clearances for partner staff members, sharing information, and addressing conflicts that may arise over program administration.

2. *Employees of the facility from the community*. The benefits of having peer specialists on the correctional facility staff include having direct supervision of the program, decreasing the program cost, resolving issues in a timely manner, enhancing opportunities for career advancement, and collaborating with other internal staff members. Challenges include consistently funding the staff, finding the right staff members, and addressing role and boundary conflicts.

3. *Currently incarcerated persons hired from within the facility*. In some ways, this is the truest approach, in that peer specialists who are incarcerated have the same current statuses and experiences as others in the setting. This approach has unique benefits and challenges. *See* Employing Peers Who Are Incarcerated *(below) for more information and example programs.*

Employing Peers Who Are Incarcerated

Peer work is not only an important service but also a vocational opportunity for individuals who will return to the community after their sentence. Offering peer work as a behind-the-walls employment opportunity is recognized as a best practice. It represents a win-win for the jail or prison. These programs show success for those trained as peer workers, individuals served, and for the correctional climate as a whole (Perrin & Blagden, 2016; Perrin, 2014).

However, programs that use peer workers who are currently incarcerated face unique challenges in implementing PRSS programs. Successful integration of programs employing incarcerated peers is dependent upon (1) effective recruitment, selection, and retention of inmates; (2) adequate training to prepare them for their role; (3) appropriate ongoing supervision; and perhaps most importantly, (4) buy-in of managers and support staff members at all levels (South et al., 2016), given that staff resistance is often a significant barrier. Prison staff members often raise concerns that security can be compromised by giving peers who are inmates increased access to restricted areas and freedom in their new role. These concerns can be overcome through staff education, by defining clear roles and responsibilities, and by devising strategies from the outset to alleviate security concerns. Additionally, PRSS programs can reach out to individuals who are already active leaders inside the facility not only as potential peer candidates but also to identify others who might be interested and have the skills and dedication to do the work.

Western Tennessee State Penitentiary uses inmates who are certified peer recovery specialists (CPRSs) as an essential component of SUD and MH treatment inside the facility. A successful candidate must meet the following criteria: (1) holds a high school diploma/GED; (2) has been in recovery for 24 months and has limited to no disciplinary actions; and (3) has the support of correctional officers and behavioral health staff members. After selection, individuals receive training and complete a minimum of 75 hours of supervised PRSS work. Training covers problem-solving and conflict resolution skills, ethics and boundaries, documentation, and self-care. To help maintain the scope of work, CPRSs do not receive any clinical skills training. In this model, CPRSs use their unique personal experiences to help inform peer-to-peer engagement and goals, stay abreast of current and changing understandings/treatments of SUD and MH disorders, and function as recovery leaders. Some unique challenges CPRSs face include pressure to affirm and promote prison norms and potential interference or manipulation by others.

The **Vermont Department of Corrections** implemented the Open Ears Program, which employs forensic peer recovery coaches (FPRCs) inside correctional facilities to help facilitate group reentry services and one-on-one mentoring sessions with incarcerated participants. Corrections staff members identify inmates who could be successful and effective coaches; if interested, they begin a week-long training process, using both external and internal training vendors. Once trained, the FPRCs earn seven dollars a day, which is the most any carceral position in the state pays. Coaching sessions are held in safe, confidential spaces. Depending on the facility, sometimes this is the space traditionally used for lawyer visits. The session is allowed to occur with no correctional officers within earshot and no recording devices present, with a clear expectation that coaches will not be used as informants for security staff members. FPRCs will only break confidentiality if the individual reports they have a plan to kill themselves or someone else, escape from custody, kill a victim upon release, or possess or have a plan to introduce a weapon. FPRCs also encourage soon-to-be-released individuals to connect with community resources and community-based peer support services.

Comprehensiveness and duration. Three interrelated factors determine the appropriate comprehensiveness and duration of a program (and the appropriate roles and tasks for the peer specialists):

1. **Anticipated number of peer specialists.** In project management, the "iron triangle" concept has three constraints: time, scope, and cost. It is generally held that you can have two of the three but not all: either you get something quickly and of quality (costly), or quickly and cheaply (low quality), or high quality and low cost (takes a long time). There is a similar maxim for peer supports, for which the three constraints are the *number* of individuals one peer specialist can serve, the *duration* of supports, and the *intensity, frequency, and range* of supports. The number of peer specialists you anticipate having on staff—as either employees, volunteers, or both—will impact the duration, intensity/frequency, and number of supports. Fewer peer specialists mean they can either work with:

    - Fewer individuals, intensively, for a long duration.
    - More individuals, intensively, for a short period of time.
    - More individuals, less intensively, for a longer period of time.

3. **Anticipated duration needed for effective peer specialist engagement with participants**. In criminal justice settings, the duration is often a function of the Sequential Intercept Model (SIM), in which the PRSS program focuses on the needs of the population being served. For example, the relationship that jail-based peer specialists have with individuals is often short-term and intensive. In contrast, prison-based peer specialists interact over a longer period during which the intensity of support may change—from intake to release.

4. **Location where supports will be offered**. The type of one-on-one support offered in a TC may be different from the groups offered in other units. The peer support's nature, tone, and approach need to match the setting, space, and tools.

Setting matters, followed by the length of stays. Programs in jails may need to consider how to increase the frequency of peer supports, both one-on-one and group, given the shorter (and sometimes unpredictable) length of stay for an individual, while programs in prisons may be able to plan for continuity of peer support across a year or more.

Community Partnerships Increase the Effectiveness of Peer Support

The Multnomah County, Oregon, Sheriff's Office partners with the Mental Health and Addiction Association of Oregon (MHAAO) to provide peer specialists in county jails and for reentry. The program also maintains close relationships with several recovery community organizations, such as the 4th Dimension Recovery Center and Central City Concern, which allows the program to connect individuals more easily with supports that build recovery capital.

The peer program is guided by the principle that recovery is driven by each individual's unique needs in a self-determined program of recovery. Participation is voluntary. Jail staff members identify individuals who may have an SUD and who may need connections to community resources upon their release. If the individuals are interested and agree, their information is passed to a peer specialist for initial connection while incarcerated or immediately upon release. The peer specialists focus on informal education and support, discussing recovery goals, and connecting individuals with recovery supports, housing supports, and other basic needs.

The program avoids duplication of services by specifically focusing on individuals who do not have other supports and who are not involved in specialty courts. No formal classes, support groups, or educational sessions are offered to incarcerated individuals. Instead, jail staff members inform them about supports and services that may be available.

To follow up on participants, the program maintains a database of all contacts who are connected to services. Peer specialists provide updates for documentation. A core practice of the program is a biweekly meeting among peer specialists, supervisors, and program directors to talk about processes, updates, challenges, and successes.

The COVID-19 pandemic presented the program with some challenges. It has not been able to hire additional peers, and volunteer groups that would have allowed for different types of contact have been suspended. There have also been logistical challenges, such as peer specialists being unable to make in-person contact with individuals prior to release. Still, the program has done its best to connect with individuals in other ways, including calling and visiting in no-contact rooms, meeting individuals "at the door," and ensuring individuals have the information they need to contact them upon release.

The program staff members identified several key lessons learned:

- Frequent and regular communication among peers, peer supervisors, and peer program directors is key. Biweekly meetings help to create a regular space to update documentation, garner feedback, address challenges, and gather success stories.
- Partnerships with the larger recovery community are essential. They ensure peers can quickly connect individuals with the supports they need upon release.
- Program success relies on buy-in from critical champions. For Multnomah County, it was important to have buy-in from the sheriff and a command staff member.
- Programs must think carefully about clearance and clearance challenges. Challenges can arise, for example, when a peer specialist works in a facility where they personally know individuals who are incarcerated there.
- Consider the desired experience and requirements of peers before recruiting. For Multnomah County, newer peers with less experience offering peer support struggled. They found it critical to have peers who had lived experience with the criminal justice system, not just with substance use. These and other requirements should be transparently communicated during all stages of the hiring process.

Engaged stakeholders and community partners. Successful PRSS programs in correctional settings actively engage the many people who have a stake in its design and implementation, including Department of Corrections (DOC) administrators and facility leadership (e.g., warden, superintendent, special sheriff); security personnel (officers, deputies); counselors, clinicians, and psychiatric services; incarcerated peers and participants; and discharge and reentry planners.

Successful programs also engage community partners, including SUD treatment programs (especially those that provide access to medications for treatment), community-based medical and MH providers, recovery community organizations, social service agencies, and other community-based organizations.

For these partnerships, like any other, to be effective, it is important to (1) clarify the "why" behind the partnership, (2) cultivate equal commitment and ownership, (3) build trust, and (4) establish clearly defined processes, including for communication and for resolving conflict.

DRIVERS OF SUCCESS

Seven key drivers of program success, shown in figure 4, advance effective integration of peer supports.

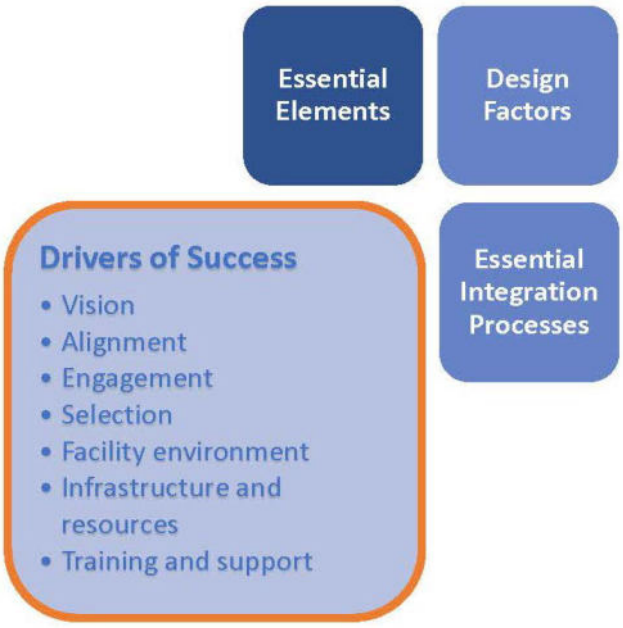

Figure 4. Drivers of Success

Vision. Although the value of PRSS is well-documented, each institution must define for itself how peer supports will benefit the incarcerated individuals in their custody and the facility as a whole. Each must also have a solid vision of the role of peer specialists and the role they will play within the facility. Each must also have dedicated resources that foster peer principles, foster support for the peers, and promote recovery capital.

Alignment. To effectively integrate PRSS into a jail or prison, the core philosophies of jail administration, SUD treatment provision, and peer practice need to be compatible. Corrections philosophy and practice, rules and regulations, physical setup, and staff members' roles associated with correctional facilities can undermine PRSS program goals. As much as possible, these need to be rethought and reframed to be more conducive to recovery.

Milwaukee County Behavioral Health Division Champions Peer Support Across Continuum of Care

The Milwaukee County, Wisconsin, Behavioral Health Division (BHD) partners with the Milwaukee County Jail and the Milwaukee County House of Corrections to provide a full spectrum of resources for individuals with SUDs, specifically opioid use disorders, while incarcerated and after release.

There is a strong continuum of care that begins with a comprehensive assessment that then connects participants to a whole system of care, including counseling and medical services, MAT, bridge housing (sober housing), and peer support.

A multidisciplinary team approach is essential and open communication is key. All staff members—(medical staff members, peer specialists, clinicians, staff members from community-based Access Point, and correctional officers—are connected and engaged in dialogue about the participant. Treatment team meetings also engage a family member or other loved one to enhance support. Due to the COVID-19 pandemic, both clinical services and peer support are being conducted virtually. This allows incarcerated participants to begin building a network of support that they can use post release. There has already been an increase in follow-through with aftercare appointments and in adherence to medication for opioid use disorder after release.

There is also a strong focus on training for correctional staff members around peer support and the strength, experience, and expertise a peer specialist contributes, as well as MAT, naloxone administration, and, most recently, cultural competency. These help to reduce the stigma associated with substance use and increase the efficacy of interventions.

One key lesson BHD staff members have learned is always to bring peers to the table when developing programming. The team notes that it would be a huge disadvantage not to include a diverse group of people and providers to help shape and promote a strong continuity of care. Be open and teachable; everyone brings experience and expertise to the table. Every life is worth saving, and that is the foundation of the project.

Engagement. The most effective PRSS programs are planned and refined with the deep participation of persons with lived experience of incarceration and recovery. Their meaningful input generates recommendations, strategies, solutions, and tailored approaches, leading to improved recovery support. For example, one prison in Pennsylvania created a peer leadership team that worked with staff members to address how to foster a model program and promote ownership of the program and the facility's needs.

Selection. Finding and hiring the right people for peer-specialist positions is key. The wrong person in the role can do more harm than good. Effective recruitment, hiring, and onboarding are essential to create a good fit between a new employee and the organization, increase job satisfaction, reduce staff turnover, and increase program performance.

Facility Environment/Climate. Organizational context, setting, and culture can profoundly affect the nature and quality of peer support. The movement toward a person-centered, recovery-oriented approach may require a climate shift within agencies and organizations that have historically implemented punitive measures to change behavior. For programs to be successful, it is important to create a safe environment in which positive, trusting, peer-to-peer relationships can thrive. To do so, programs should assess the readiness of facilities and the system to become recovery-oriented and develop and implement policies that are (1) mindful of fairness, dignity, respect, (2) safeguard individual welfare, and (3) protect from physical and psychological injury.

It is also important to create a climate in which all program staff members are supported in being effective in their program role, engaged in learning, and continuously improving based on best practices and the use of data.

Infrastructure and Resources. Perhaps it goes without saying that programs cannot be successful if they do not have the necessary infrastructure and resources. The infrastructure (the systems, processes, and policies that guide program staff members) has to facilitate and enable behaviors that support effective work performance. Key systems and processes include safety and security; data collection, analysis, reporting; scheduling and daily workflow; and supervision.

Additionally, the resource allocation has to be sufficient for the level of operations and the impact you want the PRSS program to have. This can be challenging in chronically under-resourced settings.

Training and Ongoing Support. While certified peer recovery specialists complete standard training and certification where available, it is important to remember that this training is basic. As for any other profession, additional on-the-job and continuing education will be needed for peer specialists to fulfill their specific roles and tasks within a particular correctional setting.

Peer specialists that come into the correctional setting from outside the walls will need additional training addressing issues in the criminal justice system, including the SIM, policies and protocols for the specific setting in which they will work, and, if specialists are formerly justice-involved, how to address issues that arise in adjusting to their "new identity" in this setting. Training on trauma-informed peer support is also essential. Additional topics to consider for supplementary training include (1) co-occurring disorders, (2) suicide prevention, (3) understanding reentry system navigation and supporting peers through reentry, (4) cultural competency, including in working with LGBTQIA populations, and (5) specific evidence-based practices such as motivational interviewing (adapted for the peer context) or evidence-based self-help programs such as Wellness Recovery Action Plan or Whole Health Action Management.

Supervision of peer practice is essential. It is a key means to provide ongoing support for peer specialists***.*** Supervision is a strengths-based process in which there is mutual accountability between the supervisor and supervisee. The supervision of peer recovery specialists enhances and develops the unique knowledge and skills necessary for effective peer practice and provides a safe space to address ethical dilemmas and boundary issues.

Supervision also helps peer specialists be consistent in setting and keeping boundaries and practicing self-care. Regular supervision provides opportunities to check in on roles, tasks, and boundary issues that arise (e.g., one-on-one problem-solving during supervision, group problem-solving with other peers) and to provide guidance on addressing boundary issues in peer-to-peer, peer-to-participant, and peer-to-corrections staff relationships.

Supervisors need an understanding of the impact of trauma, recognition of the effects of individual trauma and secondary traumatization, and how peers can provide safe, transparent support. Supervision reinforces how peer specialists can support their peers in minimizing risk factors, recognizing resiliency, and using positive coping mechanisms.

Supervision is for the *program*, not just for individual peer specialists. Therefore, in supervision, peer specialists are engaged in strengthening the program and fostering an organizational culture conducive to recovery. Supervisors must be champions for recovery, working with administrators to ensure that the program is structured appropriately and supported adequately to thrive within the facility's structure, consistent with its policies and practices.

Pennsylvania Department of Corrections Embraces System-Wide Peer Support

In 2012, the Pennsylvania Department of Corrections (PADOC) pilot tested a certified peer specialist (CPS) program at 6 of its 25 state correctional institutions (SCIs). The evaluation identified numerous benefits of the pilot program, including reduced institutional rule infractions, reduced need for and use of restrictive housing, and improved staff and peer communication and professional relationships. Since that time, CPSs have become an important ancillary component to PADOC's delivery of substance use and MH care services for individuals that are incarcerated at all SCIs. PADOC has continued to train new CPSs and continues to advocate for CPS services for individuals upon reentry.

CPSs within PADOC are individuals that are currently incarcerated who are trained and certified to offer one-on-one and group peer support services that are designed to promote individual empowerment, personal responsibility, self-determination, coping skills, and resiliency. CPS services also aim to provide support to individuals in recognizing triggers and difficult or adverse behaviors that may lead to restrictive interventions within a correctional setting. Of particular importance is the unique benefit CPSs provide to incarcerated individuals experiencing an MH crisis. CPSs are trained to use a person-centered and strengths-based approach to interacting with a person in crisis. Incorporating specific peer-led de-escalation efforts, when appropriate, greatly enhances PADOC's efforts to reduce the use of force and the risk of violence within the system. Consequently, a spillover benefit of incorporating peer support services into PADOC has been the reduced use of restrictive housing as well as increasing opportunities for incarcerated individuals to learn prosocial responses and other coping techniques to manage difficult emotions, which may inevitably help individuals with chronic mental illnesses achieve enhanced stability and well-being while avoiding correctional disciplinary sanctions.

CPS candidates within PADOC either volunteer or are identified by DOC staff members from within each SCI. Identified candidates are trained using the same curriculum as individuals seeking to become a CPS within the community. However, within PADOC, CPSs receive additional training in a variety of evidence-based practices including trauma-informed approaches, Mental Health First Aid, suicide prevention practices within a correctional setting, and Wellness Recovery Action Plans. CPSs in PADOC also receive training in other critical topics that support enhanced peer services and complement clinical services delivered by professional PADOC staff members. A small percentage of the CPS candidates that meet eligibility requirements are selected from the DOC's population of individuals that have been sentenced to life in prison. A common statement heard from this group is that becoming a CPS has given their own lives purpose. They, and others with shorter sentences, experience life-changing benefits by becoming a CPS and use this opportunity to promote mental wellness and recovery within the prison setting.

Pennsylvania Department of Corrections Embraces System-Wide Peer Support (continued)

Opportunity for Workforce Development

At the core of the CPS program is a workforce development opportunity for Pennsylvanians who are incarcerated in Pennsylvania state prison. CPSs trained within PADOC seek certification through the Pennsylvania Certification Board, not only to augment employment prospects and opportunities upon reentry to the community but also to ensure that the CPS' knowledge, skills, and abilities align with professional and community standards for CPSs. Consistent with PADOC's mission, the bedrock of the CPS program is to ensure that Pennsylvanians returning to the community are better equipped with educational and professional skill sets than when they arrived.

Challenges to Integration

Although there were many initial *cultural* challenges with implementing an initiative of this scale and scope within a correctional setting, over time, CPSs within PADOC have become a valuable complement to existing clinical services. For many years now, CPS services have been offered to individuals housed in all PADOC settings on all 3 work shifts (i.e., 24 hours per day) and within high-security areas, such as restrictive housing, diversionary treatment units, and psychiatric observation cells. However, prior to implementing the program, PADOC needed to ensure that the safety of all persons inside the facilities would not be inadvertently jeopardized. To accomplish this utmost responsibility, PADOC policies, procedures, and the operational needs of individual facilities and the systems were reviewed, contemplated, and updated.

Over the past decade, as the CPS program progressed from conceptualization to implementation to evaluation, input from all levels and disciplines of DOC staff members was critical and continues to be fundamental to the future growth and progress of the program. PADOC's ground-up approach provided ongoing opportunities for input by DOC staff members and incarcerated persons along the way. For example, initial planning for CPS services delivered within a restrictive housing unit required security personnel to provide input into the many operational and procedural enhancements that were needed. A similar challenge was to determine how to safely allow for CPS service delivery within a secure setting like an SCI in general. In the community, CPS principles support choice, self-advocacy, and self-empowerment. However, in a correctional system, these principles can create conflict with efforts to ensure the safety and well-being of everyone, including DOC staff members and other incarcerated people. It was imperative for PADOC to adapt recovery principles diligently and safely for the unique correctional setting.

Pennsylvania Department of Corrections Embraces System-Wide Peer Support (continued)

Lessons Learned

With its successful ongoing integration of CPSs, PADOC realized many lessons learned. A few of these lessons are summarized below:

1. There is likely not a one-size-fits-all approach when implementing a PRSS program. Whether considering a peer-based program in one facility or several facilities, it is critical to determine the specific need(s) that PRSS can address within the entire system as well as in individual facilities. Facilities should develop program goals based on identified individual and operational needs, while recognizing the unique structure and culture of the facility and industry.
2. One of the most prevalent challenges may likely be in aligning security operations with direct peer service delivery. Considerable attention should be paid to explicit details in this area and will greatly increase the chances of leading a successful program. It is imperative that frontline correctional staff members, including correctional officers and security staff members, have opportunities to contribute to the development of the program.
3. It is critical to identify administrative staff members who will lead and support the program. Across PADOC, administrators recognized the need to provide multiple avenues for supporting individuals living with substance use and co-occurring MH challenges and to enrich and diversify the multidisciplinary treatment process for vulnerable populations. They also recognized that CPSs promoted a cultural shift that improved the prison environment and encouraged other prison services to become more recovery oriented.
4. Creating a policy that delineates the "dos and don'ts" for the program through a multidisciplinary approach will increase the likelihood of success for the program. Through an annual review of policy—with multidisciplinary staff members and administrators—challenges, concerns, barriers, and successes are addressed, and subsequent changes are implemented.
5. Staff members that are dedicated to supervising the program daily are key to its success. CPS supervisory staff members should have direct access to prison leadership staff members (e.g., superintendents, deputy superintendents, and central office TA). These individuals should also have input into the development of policies and procedures and program adaptations and refinements.
6. Collaboration with a peer certification training vendor should be a priority. This may include cooperative work on adapting trainings and implementing training-of-trainers to maximize resources. This collaboration must include security personnel and treatment staff members to anticipate and address potential barriers to offering training behind the walls.
7. It is critically important to ensure that the boundaries of clinical MH and clinical psychological services delivered by qualified MH professionals are clearly delineated and differentiated from those services delivered by peers. Identifying and enforcing these boundaries will empower both groups of professionals and avoid any unintentional marginalization of either group.

Recently, PADOC's Psychology Office assumed oversight of the CPS program and has implemented several new enhancements to the program including: a biannual institution-by-institution CPS staffing analysis (i.e., similar to staffing analyses completed for professional DOC clinical staffing needs) for the purpose of identifying CPS service needs; ongoing development of a centralized, electronic community engagement unit (CEU) training library available to all SCIs; centralized and historical tracking of CPS credentialing within PADOC (so that staff members know who is a CPS, where they are currently located within the system, and the status of their certification); and the development and implementation of an *annual* centralized auditing process of CPS service delivery at all 24 SCIs.

Ensuring self-care is also an essential element of ongoing support. Being a peer specialist in secure settings can be stressful and challenging. This means providing resources for self-care. An effective peer program should include policies, practices, and procedures designed to acknowledge and recognize the importance of a self-care component for peers. Peers should be supervised by a trained peer supervisor who has received training in peer support, trauma-informed care, and the importance of wellness. Maintaining recovery is important in any type of peer engagement and even more so in a jail or prison environment. The availability of a wellness program through training, support options, and supervisory opportunities enriches the service's success and promotes a culture of wellness throughout the environment.

Additionally, peers should have an opportunity to participate in one-on-one supervisory sessions, peer group sessions, wellness training, and peer-led wellness groups and activities. An effective and comprehensive self-care strategy should include activities that promote physical, psychological, emotional, and spiritual aspects of one's life.

While working in a peer role during incarceration can improve personal behavioral health and emotional outcomes, taking on the burdens of others in a traumatic environment can take its toll over time. Whether the peer support worker is currently or formerly incarcerated, additional support is necessary to prevent retraumatization, vicarious trauma, and burnout.

ESSENTIAL PROCESSES

We have covered the core components, design factors, and drivers of success for the effective integration of PRSS in correctional settings. The final parts of the framework are the essential processes, shown in figure 5. These steps are like those for planning and launching any program; here, we examine the peculiarities of new PRSS.

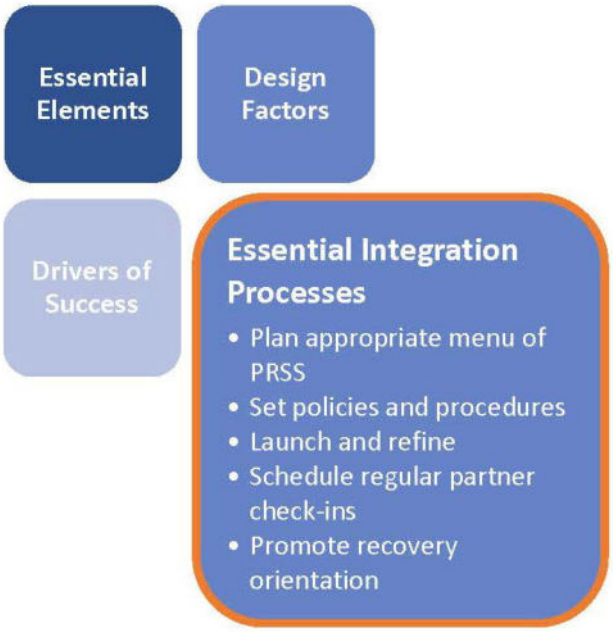

Figure 5. Essential Integration Processes

***Prepare to integrate*.** This process provides a foundation for exploring staffing, workflow, decision-making, communications, and other practices and building a commitment to making the changes necessary for peer work to be effective. Key preparation tasks include conducting an organizational self-assessment, identifying the specific roles and expectations that the program has for peer staff members, clarifying where and how peer specialists will be integrated into the jail/prison staff structure (including medical and MH services), and negotiating roles and expectations of partners.

Select the initial site/group to be served. Define the scope of the program (start small). Set clear program goals and objectives to identify the criteria for measuring program success. Outline key activities. Decide on a length of time to try out the program, allowing sufficient time to observe both process and outcomes. Plan to collect and use data to support and inform program development and refinement. Use measurement tools that are recovery- and recovery capital-oriented rather than solely focused on abstinence or recidivism.

***Plan an appropriate menu of PRSS*.** The overarching purpose of peer support is to help individuals build and sustain a life in recovery. The menu should include one-on-one supports (e.g., recovery capital assessment, recovery planning, recovery coaching), group supports (e.g., classes that all participants can benefit from, groups that further the recovery process), and connection to community-based recovery services and supports.

Set policies and procedures. Multiple organizations and systems working together to implement PRSS in jails and prisons require developing policies and procedures for all involved partners. Policies should reflect the organizational culture, which shapes the structure and functioning of a peer support program. While peer support approaches need to be tailored to the characteristics of a specific facility and its culture, it is also necessary to create new policies and procedures—and review and adapt existing ones—to guide the work of all staff.

Facilities should insert PRSS policies into existing jail and prison policies, evaluate current structure and workflows for alignment opportunities, and develop/adjust policies to reflect this partnered approach.

Launch and refine the program. Of course, the previous processes laid the groundwork for offering PRSS and beginning to collect data to assess the effectiveness of your processes and the outcomes of your PRSS program as designed.

Even with the best planning, you will need to refine your PRSS program to address unanticipated challenges, emerging needs, and lessons learned. Using a proactive process of thoughtful and deliberate adaptation to improve program fit or effectiveness involves careful consideration of what is to be modified, at what level, and at what scale, given the initial evaluation.

Schedule regular partner check-ins. It is important to build a process for partners and stakeholders to meet and review how things are going. This may need to be more frequent at the beginning of a new PRSS program but should continue throughout its life, as changes and adaptations often need to be made due to changing community and facility conditions. Include

both informal and formal partner check-ins, which help to (a) inform appropriate resource allocation, (b) identify potential problems and prevent them from escalating, and, as necessary, (c) make moderate adjustments or adaptations to workflows and roles of peers. It is an ongoing process of change and adaptation. Schedule frequent and structured forums for cross-system communication to address challenges through the collaborative development and continuous review of policies and procedures.

***Promote recovery orientation*.** Recovery is not only an individual, personal transformation process; it happens within systems of care that are recovery-oriented and communities that are rich in recovery. Programs must identify community resources where participants may receive the support and services they require to sustain recovery. It is important to prepare community and corrections partners and stakeholders to do the institution- and community-focused work that will lay a pathway toward personal recovery. The better the understanding of recovery—and the role that PRSS can play in that process—the better the chances are for the successful launch and continuation of PRSS in jails and prisons. Existing programs that have peers embedded create a recovery culture. Some examples that programs use to promote a recovery environment include emphasizing recovery language through painted murals and quotes on walls, facilitating wellness classes, and training staff members in PRSS supervision, trauma, and self-care.

Conclusion

Incarcerated populations are both more likely to suffer from and be more vulnerable to MH and SUDs and violent and self-harm behaviors than the general population. Individuals who are incarcerated and living with SUDs face challenges both behind the walls and after release, particularly in making the transition back to the community. Peer support is a proven resource to address these challenges in both correctional and community settings to support recovery from SUD and MH conditions, prepare for release, and facilitate reentry.

The term PRSS refers to the wide array of non-clinical supports provided by peer recovery specialists. Five core values underlie PRSS programs: (1) recovery-oriented, (2) person-centered, (3) voluntary, (4) relationship-focused, and (5) trauma-informed. Peer recovery specialist is an overarching term that refers to persons with lived experience trained to support others along their path of recovery. The core competencies that peer specialists have bring core recovery values to life.

Successful integration of PRSS requires a thoughtful, deliberate approach to address the inherent tension between peer practice and conventional correctional approaches. Organizations need to understand the PRSS core values and use them to guide service planning and delivery. They may also need to realign correctional culture, policies, and procedures to create environments in which positive peer-to-peer interactions can occur. At the outset of a program, engaging multidisciplinary staff members in all facets of planning, implementation, and ongoing peer program progression can help mitigate challenges.

PRSS can be implemented effectively within correctional settings in partnership with health and prison services or in partnership with community-based agencies. Programs that give attention

to the four dimensions of the integration of PRSS—core components, design factors, drivers of success, and process steps—can speed the development of a quality, effective PRSS.

Recovery-oriented practices and approaches within correctional settings emerge over time. It is an evolving process of uncovering, articulating, and addressing the complex, multifaceted nature of integrating recovery principles into practice in secure settings. Through clear and consistent policies and practices, peer support can be a resource that promotes recovery among incarcerated individuals with SUDs, enhances the correctional environment, and provides a bridge for successful community reintegration.

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Tools and Resources

Tools

1. Peer Recovery Support Services Integration Checklists
2. Sample Policies and Procedures
3. Developing Your Job Description
4. Sample Job Descriptions
5. Sample Peer Working Agreement

Resources

1. Acronyms List
2. Addiction Peer Recovery Support Services State Medicaid Coverage and Certification Requirements
3. Additional Resources

TOOL 1. PEER RECOVERY SUPPORT SERVICES INTEGRATION WORKSHEET

The framework for integration of peer recovery support services (PRSS) has four elements: (1) core components of programs, (2) drivers of success, (3) design factors, and (4) essential processes. This worksheet focuses on the last three parts of the framework and their underlying components.

For each section, use the suggested guidance and questions below to help frame your thoughts about what is needed for the effective integration of peer support.

Section 1: Drivers of Success

Setting Vision

- Identify the purpose and goals of the peer program.
    - What is the overall purpose of your program?

_____

_____

_____

    - Why are you interested in adding PRSS to your mix of services?

_____

_____

_____

> ***Example:***
>
> The Pennsylvania Department of Corrections program was designed to complement existing peer support services offered in the community and mirror the training, certification, supervision, and ethics of community-based programs while preparing incarcerated individuals for community integration and workforce development.
>
> Its aims were to supplement, increase, and enhance existing behavioral health services for incarcerated persons and to foster workforce development.

Cultivating Champions

- Identify the leaders and administrators whose buy-in is crucial for program success.
    - How do the goals for the peer program help to further the goals of organizational leadership?

      _____

      _____

      _____

    - What value will the peer program add to the organization?

      _____

      _____

      _____

- Develop a core team that will work collaboratively on peer integration.
  The core implementation team will be champions of the program's vision, and its members will plan and coordinate all aspects of the program, including a mix of services, eligibility criteria, candidate selection, scheduling, ongoing training and support, supervisory coordination, and supervisory training requirements.

Use the following table to brainstorm the identification of potential core team members. When possible, include people with lived experience of recovery and community partners.

Category	Name	Unit/Affiliation	Contact Information
Corrections Leadership			
Frontline Security Staff			
Behavioral Health Staff			
Other			

Aligning Policy and Workflow with Peer Practice

The core philosophies of jail administration, substance use disorder (SUD) treatment provision, and peer practice need to be aligned. Use the table below to consider how well key policies, procedures, and workflows in your program support effective peer practice.

	Policy/Workflow	Supportive of Peer Practice?
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

Using the list in the previous table, identify the three items that are most crucial to review and revise. Use the space below to describe each in depth. Consider: What needs to change to make it more supportive of peer practice? Who needs to be involved in creating that change?

Priority policy/workflow #1

Priority policy/workflow #2

Priority policy/workflow #3

Engaging Others

It is important to engage community stakeholders, partners, and persons with lived experiences of incarceration, addiction, and recovery in the planning and implementation process in order to develop effective strategies and approaches tailored to your setting.

- Identify your key external stakeholders.

Type of Stakeholder	Already Involved	Not Yet Involved/ Need to Be Engaged	Contact
Funders and/or Grantors			
State Behavioral Health Agency			
Corrections Officials, Commissions on Crime/Delinquency			
Others			

Using the list in the above table, identify the three stakeholders that are not yet involved and that are most crucial to engage now.

- Identify important community partners.

Community Partner	Already Involved	Not Yet Involved/ Need to Be Engaged	Contact
Substance Use Disorder Treatment Providers			
Recovery Community Organizations			
Social Service Providers			
Justice Community Peers			
Others			

Using the list in the above table, identify the three partners that are not yet involved that are most crucial to engage now.

- Identify the correctional facility/facilities where the program will be piloted/demonstrated, or which facility will be the first start-up site(s). List them in the table below and answer the questions for each.

Site	Why This Site	Proposed Launch Date	Key Tasks to Prepare the Site for Project

For each site:

- Determine whether to use internal peers, external peers, or a mix.
- Identify how many peer specialists each facility needs.

  Recommend 15 to 20 peers for every 1,500 incarcerated persons. If your facility has a mental health disorder or co-occurring disorders program, a minimum of 20 peer specialists is recommended.
- Determine where peers will provide services in each facility.
- Identify funding source(s)/funding mechanisms (e.g., grants, state/county funding).

Balancing Security/Perception of Risk and Recovery Perspective

Reflect on the Guiding Principles of Recovery, how they align with current facility practice, and how they will be incorporated into your program. Include the chain of command structure in discussions on program alignment. Use the worksheet below to consider how your program will reflect the principles.

Recovery Principle	How Program Will Adapt and Incorporate Principle
Recovery emerges from hope. The belief that recovery is real provides the essential and motivating message of a better future—that people can and do overcome the internal and external challenges, barriers, and obstacles that confront them. Hope is the catalyst of the recovery process.	
Recovery is person-driven. Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s) toward those goals. Individuals optimize their autonomy and independence to the greatest extent possible by leading, controlling, and exercising choice over the services and supports that assist their recovery and resilience.	
Recovery is holistic. Recovery encompasses an individual's whole life, including mind, body, spirit, and community. The array of services and supports available should be integrated and coordinated.	

Recovery Principle	How Program Will Adapt and Incorporate Principle
Recovery is supported through relationships and social networks. An important factor in the recovery process is the involvement of people who believe in the person's ability to recover; offer hope, support, and encouragement; and suggest strategies and resources for change. Through these relationships, people leave unhealthy and/or unfulfilling life roles behind and engage in new roles that lead to a greater sense of belonging, personhood, empowerment, autonomy, social inclusion, and community participation.	
Recovery is supported by addressing trauma. Services and supports should be trauma-informed to foster safety (physical and emotional) and trust and promote choice, empowerment, and collaboration.	
Recovery involves strengths and responsibility. Individuals have strengths and resources to serve as foundations for their recovery; they also have a personal responsibility to self-care and work toward recovery. Individuals, families, and communities have responsibilities to provide opportunities and resources to foster social inclusion and recovery.	
Recovery is based on respect. Community, systems, and societal acceptance and appreciation for people affected by mental health and substance use problems—including protecting their rights and eliminating discrimination—are crucial in achieving recovery. There is a need to acknowledge that taking steps toward recovery may require great courage. Self-acceptance, developing a positive and meaningful sense of identity, and regaining belief in oneself are particularly important.	

Section 3: Processes

Setting Policies and Procedures

Internal Peers Who Are Incarcerated

Use the checklist below to walk through the policies and procedures that need to be addressed before using incarcerated peers.

- Determine certified peer specialist (CPS) wage, hours of weekly work, and other aspects of employment.

_____

_____

_____

- Identify eligibility criteria for peer candidates.

_____

_____

_____

- Develop a peer candidate selection process.

_____

_____

_____

- Determine training needs and certification needs.
  If your program includes a workforce development plan, it is important to evaluate if the state requires formal certification of peers. If so, the credentialing process and fees must be considered in the planning process.

Identify an internal structure to oversee the program and describe it in detail.

Determine the frequency of supervision.

Identify project coordinator/supervisor.

- Develop policies and protocols, including expectations for staff members and inmates.
    1. Identify how long CPSs may spend on a particular unit or program.
    2. Determine disciplinary actions and procedures for levels of infractions. Sanctions may include a leave of absence, a suspension, misconduct(s), or termination.
    3. Determine respite options for peer supporters who experience stressors due to their work or when they experience interpersonal concerns that limit their ability to provide peer support effectively.
    4. Determine which staff disciplines can utilize peer support in programming and/or other services such as peer support in personal care or hospice units.
    5. Differentiate the roles and scope of peer support and treatment staff members.
    6. Determine peer support identification, such as name badges, colored t-shirts, etc.
    7. Develop a plan to inform incarcerated persons about the peer support program. This may be through inmate channels, announcements, posters, handouts, and other marketing materials.

8. Determine how staff, especially security staff members, will identify peer specialists. An example may be posting pictures of the peer supporters in the officer security areas.

Training Peers

Regardless of whether your peer specialists are internal or external, they will need to be trained to fulfill their role in your facility.

Options for training:

(1) Select an external training vendor who directly trains your peer specialists at regular intervals.

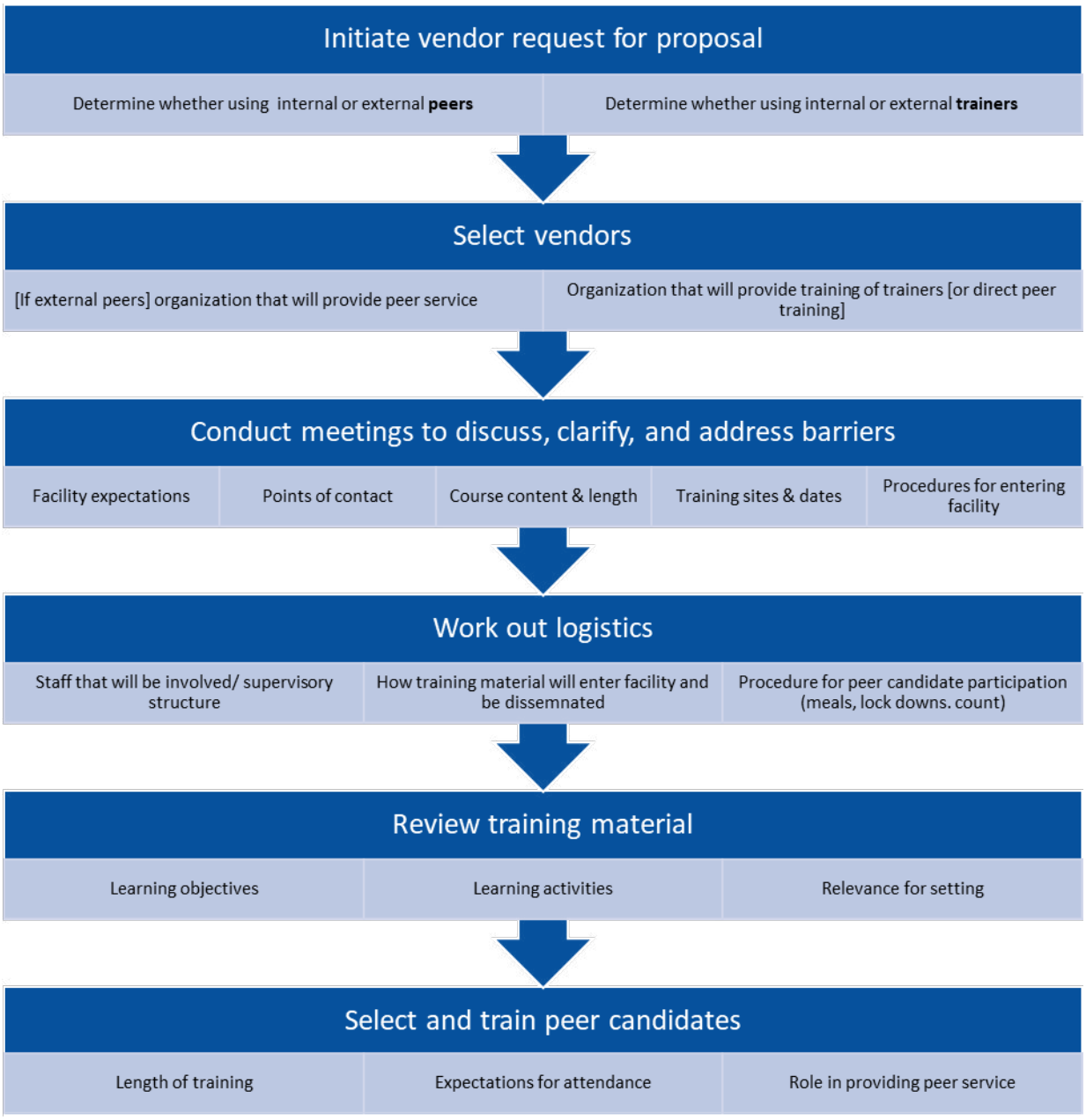
(2) Use internal instructors who go through a training-of-trainers program provided by an external vendor wherein the internal instructors then train the peer specialists using a standard curriculum provided by the external vendor.

(3) Develop an internal peer support curriculum. If your facility chooses this approach, be aware that the credentialing will likely not transfer to the community and thus will not allow for workforce development opportunities.

Example:

The Pennsylvania Department of Corrections partnered with a vendor to develop a cadre of in-house trainers, use the vendor's curriculum, and receive ongoing technical support through a user agreement contract.

Use the flow chart below to identify tasks for selecting a training vendor.



TOOL 2. SAMPLE POLICY—PENNSYLVANIA DEPARTMENT OF CORRECTIONS

Section 15 – Certified Peer Specialist (CPS) Initiative

Section 15 – Certified Peer Specialist (CPS) Initiative

A. General Considerations

1. The purpose of the Certified Peer Specialist (CPS) initiative is to train select individuals from the ***inmate*** population to serve as CPSs.

2. The certification process will afford all successful participants the opportunity to become a recognized CPS by the Pennsylvania Department of Human Services (DHS) and the Pennsylvania State Civil Service Commission (SCSC). Certification will provide the potential for employment in a peer support setting after release from a state correctional facility.

3. The CPS employment wage is .51 cents per hour. The work day can be between six to eight hours, dependent upon the needs of the facility. A CPS can be employed full or part time and does not have to give up his/her existing employment to work as a CPS. However, he/she must provide CPS services a minimum of 10-15 hours per week in order to maintain his/her CPS position.

4. CPS training will provide selected ***candidates*** with the skills required to act as mentors/role models for other ***inmates*** in specialized units and other places within a state correctional facility, such as:

    a. visiting rooms;

    b. Residential Treatment Units (RTUs);

    c. Special Needs Units (SNUs);

    d. Secure Residential Treatment Units (SRTUs);

    e. Therapeutic Communities (Alcohol and Other Drug [AOD] TC);

    f. Restricted Housing Units (RHUs);

    g. ***Diversionary Treatment Units (DTUs)***;

    h. ***Behavior Management Unit (BMU)***;

    i. Psychiatric Observation Cells (POCs);

    j. General Population housing units;

    k. ***Diagnostic and Classification***;

    l. library;

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m. Transitional Housing Units/Reentry Service Offices (THUs/RSOs);

n. infirmary (to include the oncology and hospice wards);

o. chapel;

p. med lines;

q. education center;

r. commissary;

s. dietary section;

t. Veteran Service Units (VSUs);

u. recovery units;

v. Mental Health Units (MHUs);

w. Capital Case Unit; and

x. Forensic Treatment Center (FTC).

5. A CPS can be utilized to augment staff's efforts to effectively support ***inmates with mental health or emotional concerns*** thus enhancing their own recovery and wellness. In addition to ***promoting recovery*** skills, such as ***personal wellness and positive coping skills***, a CPS can:

   a. utilize his or her first-hand knowledge about mental health recovery to help his/her peers ***in their recovery***;

   b. demonstrate recovery in a way that inspires his/her peers and helps them to see their own potential for recovery;

   c. assist his/her peers with the identification of their ***short and*** long-term goals and to subdivide those goals into manageable steps;

   d. provide his/her peers with an opportunity to evaluate the choices and decisions that they make/have made;

   e. demonstrate the value of self-determination and personal responsibility;

   f. assist in establishing/maintaining a recovery environment within the facility setting that empowers others to succeed in accomplishing goals, reconnecting to themselves, reconnecting with others, and having purpose in life;

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g. demonstrate the power of resilience;

h. assist assigned ***inmates*** in understanding the grievance process; and

i. assist his/her peers with shifting their focus from symptom management to recognizing and developing their wellness, their accomplishments, and their abilities.

6. ***CPSs are trained in the Copeland Center's Wellness Recovery Action Plan (WRAP©) Seminar I and should introduce WRAP© to those they support as a CPS. WRAP© is an evidenced based wellness practice to assist a person in his/her daily wellness and to prevent a crisis. When assisting an individual who chooses to develop a WRAP©, notebook paper, outlining the sections of a WRAP© may be used.***

7. In addition to providing individual services, a CPS may also facilitate workshops and didactic groups. The workshops provided by a CPS shall be periodically monitored by a member of the Unit Management Team and/or the Psychology Department.

8. ***CPSs selected by the CPS Committee may act as mentors to newly certified CPSs, CPSs who are on suspension or probationary status, and CPSs who are experiencing difficulty in their CPS capacity. Identification of mentors/mentees should be coordinated by a CPS Committee designee. CPSs serving as mentors must limit this role to CPS-related activity.***

9. The Unit Manager will post a notice of CPS facilitated workshop/group schedules on the bulletin board in his/her housing unit. An ***inmate*** interested in attending these sessions will submit a **DC-135A, Inmate's Request to Staff Member** in order to be scheduled for attendance.

10. ***In addition to providing peer support, a CPS may be asked to address specific concerns assigned by his/her supervisor(s).*** The Licensed Psychology Manager (LPM), ***CPS Supervisor(s)***, or Unit Manager will be available to the CPS for consultation and assistance as needed.

11. Each facility shall develop an identification (ID) badge that acknowledges the ***inmate*** is a CPS. This ID badge shall be worn/carried along with the inmate ID at all times while performing CPS services. ***The recommended badge is the cell door card and will state that the inmate is a CPS, work assignments, and will be signed by the Deputy Superintendent for Centralized Services (DSCS)/designee.***

12. ***Photos of CPSs shall be placed in the control center on the housing unit so staff are aware of which CPSs are assigned to a particular unit.***

13. ***Photos of CPSs shall be placed on the unit so that residents of the unit are aware of who the CPS is for that particular unit.***

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B. *Certified Peer Specialist (CPS) Candidate* Selection

1. ***A candidate*** shall be selected via a **DC-46, Vote Sheet** process. To be considered for selection as a CPS candidate, ***he/she*** must meet specific criteria:

   a. must be a custody level two or three;

   b. must be misconduct free for a minimum of one year ***(misconducts will be reviewed by the CPS Committee)***;

   c. have no misconducts for assaultive behavior in the last two years;

   d. ***have no history of substantiated allegations of institutional sexual abuse or sexual harassment; and not found to be at high-risk of being sexually abusive via the Department's risk screening pursuant to Prison Rape Elimination Act (PREA) standard §115.41. PREA standard §115.42 requires that information from the risk screening process inform housing, bed, work, education, and programming assignments with the goal of keeping separate inmates at high risk of being sexually victimized from those at high risk of being sexually abusive. Any individual identified at high risk of being sexually abusive through the most recent risk screening score shall disqualify an individual from serving as a CPS***;

   e. a history of mental health treatment/services while incarcerated and/or in the community. ***B Roster candidates may be considered only if a mental health diagnosis during incarceration or while in the community has been validated. Steps to obtain community information is required prior to selecting a candidate identified as B Roster stability; it is the inmate's responsibility to obtain this information and present it to the CPS Supervisor***;

   f. program compliancy. ***If a candidate has refused to participate in programming, he/she is ineligible***;

   g. recommended by the LPM and/or Psychiatric Review Team (PRT);

   h. if the ***candidate*** is on the AOD TC waiting list, his/her potential start date for AOD TC may not begin before the conclusion of his/her CPS training and he/she must be permitted to provide CPS services while in the TC;

   i. have more than ***three*** years remaining on his/her ***minimum release date***, unless he/she qualifies under the Long-Term Offender (LTO)/lifer criteria listed below;

   j. have a high school diploma or General Education Diploma (GED);

   k. if the ***candidate*** is a LTO/lifer with positive adjustment records, he/she may be given consideration and the requirement for high school diploma/GED may be waived; and

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l. ***each State Correctional Institutions (SCI) shall determine the number of LTOs, but should not have a majority of LTOs as CPSs.***

2. The Facility Manager/designee shall designate the maximum number of LTO/lifers on the CPS Roster at his/her facility. D Roster facilities should have a minimum of ***30*** CPSs. Non-D Roster facilities should have a minimum of ***20*** CPSs.

3. ***The CPS complement shall be supervised by staff that are designated by the Facility Manager/designee. If a facility determines there is an increased need for additional CPSs, a request shall be made to Office of Mental Health Advocate (OMHA)/ designee.***

4. Staff designated by the Facility Manager/designee will review ***inmate*** records to identify potential participants in the program.

5. ***When a CPS worker is transferred to another SCI, the sending SCI CPS supervisory staff should inform the CPS supervisory staff at the receiving SCI of any information pertaining to his/her status as a CPS and any other important information, including security concerns.***

6. ***Parole Violators (PVs) returning to an SCI who have a valid CPS certification may request employment. The CPS Supervisor(s)/designee shall verify certification of the certification and continuing education requirements prior to approving CPS employment status. CPS employment for PVs is determined on a case-by-case basis; employment as a CPS will not begin until 60 days after a return to an SCI and approval from the CPS Committee.***

C. Certified Peer Specialist (CPS) Training *Program*

1. The CPS Training Program is designed to provide selected ***inmates*** with basic educational training on the following topics:

   a. ***mental health*** recovery;

   b. the philosophy and practice of the power of peer support;

   c. the development of self-esteem and managing self-talk;

   d. community, culture, and environment;

   e. emotional intelligence;

   f. employment as a path to recovery;

   g. substance ***misuse***;

   h. conflict resolution;

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i. ***suicide prevention;***

j. working with other professionals; and

k. ***trauma informed approach to peer support.***

2. ***Select*** Department staff ***who are certified by an approved vendor through the DHS Office of Mental Health and Substance Abuse Services*** will deliver the CPS ***core certification*** training. All requests for training shall be routed through OMHA/***designee*** at Central Office.

3. ***A selected candidate*** may not miss more than six hours ***of the CPS certification*** training and ***may only miss six hours if approved by the instructor and/or CPS Supervisor(s) prior to the date of the anticipated absence. The CPS candidate*** must make up any missed work under the direction of the CPS training facilitator(s). All selected ***candidates*** must also participate in classroom activities and must successfully complete the mid-term and final exam.

4. The CPS training instructor has the discretion to ***disqualify*** a CPS student if there are indications that the student is unable to fulfill the requirements of the course, such as classroom exercises, homework assignments, and fidelity to the CPS model.

5. Any student observed cheating on the exam will be ***disqualified*** from the class and unable to continue. ***He/she*** may apply to be a CPS candidate at a later date, ***but not less than one year of removal from the original class.*** Approval ***to be considered for future CPS certification training*** will be determined by designated facility staff.

6. ***A candidate*** who receives the certification and signs the **CPS Confidentiality Acknowledgement Form (Attachment 15-A)** may be utilized as a CPS at an assigned facility.

7. ***Once certification is completed, all CPSs will sign the CPS Orientation Checklist (Attachment 15-B) which will be maintained by the CPS Supervisors.***

8. ***All CPSs must earn at least 18 continuing education hours per year to maintain his/her state certification. Training topics must primarily focus on wellness, life skills, boundaries, and other related topics. Code of Ethics and PREA Level 2 Contractors/Volunteers training is mandatory for all CPSs. In accordance with Department policy DC-ADM 008, "PREA" the Contractors/Volunteers PREA Training (Attachment 2-G) shall be utilized for this training, which shall be documented under the "Other" group of the PREA Training and Understanding Verification Form (Attachment 2-F). Weekly or monthly meetings should not be counted as education hours.***

9. ***Continuing education will be facilitated by facility staff, CPSs, or volunteer facilitators as approved by the facility staff and will include:***

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a. ***review of modules from the original certification training annually; and***

b. ***wellness topics, life skills, and other recovery topics.***

10. ***CPS Supervisor(s)/designee should be present during continuing education workshops as often as possible.***

11. ***Training facilitated by external facilitators must be supervised at all times by facility staff.***

12. A CPS must report for the scheduled workshops/groups during the designated time.

13. ***All CPSs completing the annual education requirements will receive a CPS Continuing Education Certificate (Attachment 15-C) at the end of the calendar year verifying completion of the requirement.***

D. Supervisory Staff

1. ***All SCIs will convene a CPS Committee which will consist of, but is not limited to Unit Management, Psychology, Security, Deputy, Training Sergeant/Lieutenant, and Counselor.***

2. ***All SCIs will have a minimum of two certified CPS Supervisors. CPS Supervisors shall:***

   a. ***provide guidance, support, and supervision of CPS workers;***

   b. ***oversee daily operations of the CPS program; and***

   c. ***meet with the CPS Committee quarterly; minutes will be taken of each meeting and submitted to OMHA within two weeks of the meeting.***

3. ***Operation*** of the CPS program should be facilitated as a committee whose members, including treatment and security staff, are united and equal in their decision-making authority.

4. A designated ***committee*** member shall function as the primary CPS Coordinator who develops all CPS schedules and on call schedules/***needs, work assignments***, and coordinates CPS Committee meetings.

5. ***CPS Supervisor(s)/designee will track the 18 required continuing education hours on the CPS Training Tracking Form (Attachment 15-D)*** to include the ***CPSs*** name and number, his/her ***CPS*** state certification number which appears on his/her training certificate, the topic of the ***training***, how many hours the session spanned, and the date the session was facilitated. ***Continuing education hours*** correlate to the calendar year, January through December. ***The CPS Training Tracking Form*** shall be forwarded to OMHA at Central Office each year by December ***31***.

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6. ***The facility CPS Coordinator/designee will provide an informational overview of the CPS program, titled "CPS Defined Power Point" (Attachment 15-E) to all staff assigned to areas where CPSs are utilized. This overview will include familiarization with the roles, responsibilities, and expectations of a CPS to include specific training received by a CPS in suicide prevention. Other benefits of the program, such as providing support to inmates with mental illness and assistance in de-escalating situations, will be addressed during the overview as well as identifying the facility CPS Supervisor for staff to contact with any additional questions or concerns.***

E. General Conduct

1. When providing one-on-one peer support, a **Daily Contact Record *Book*** will be maintained by the CPS and will be turned into the CPS Supervisor(s) at the end of the ***week*** that the ***peer*** support takes place. ***The Daily Contact Record Book will be provided to all SCIs from OMHA***.

2. All information shared in peer sessions is to remain confidential except when threats of suicide or expressions of intent to harm others are verbalized ***and/or witnessed, when there is a threat to the security of the SCI, and disclosure and/or witnessing of sexual abuse or harassment***.

3. The CPS statewide certification includes CPSs as para-professionals ***who*** have a "duty to warn." In these ***circumstances***, the CPS shall report such threats and expressions to staff immediately. (The CPSs are informed of this duty during their training and confirm their agreement to do so by signing the **CPS Confidentiality Acknowledgement Form**.)

4. Abuse of ***position***/privileges by a CPS shall be reason for suspension/termination from the program.

5. A CPS may be terminated for a breach of confidentiality.

6. Every CPS is subject to random urinalysis testing, in accordance with Department policy **6.3.12, "Drug Interdiction."** ***If a CPS refuses to random urinalysis, he/she may be terminated from CPS employment.***

7. A CPS and the ***inmates*** attending such workshops/groups are subject to monitoring at any time by Department staff. Staff will provide intervention as needed.

8. A CPS may be ***suspended or placed on probationary status at the discretion of the CPS Committee or subject to termination*** if he/she receives any Class 1 misconduct (assault, fighting, sexual misconduct, possession of drugs) ***and/or is a threat to the security of the SCI***.

9. Termination of CPS employment will result in the ***inmate*** being rendered ineligible for rehire as a CPS and training opportunities related to maintaining CPS certification.

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10. A CPS may receive a **Letter of Recommendation (Attachment 15-*F*)** from the multi-disciplinary team and/or the immediate supervisor for use upon release for employment purposes.

F. ***CPS Guidelines for Level 5 Housing***

1. ***When assigning a CPS to the RHU, DTU, or SRTU, a CPS should be informed of the assignment and that he/she will be required to be strip searched upon entering the unit and at any time there is a security or safety concern. If a CPS refuses to follow this procedure, he/she is ineligible to work on these units and may be subject to CPS status review.***

2. ***CPSs who work on a level 5 housing unit should be rotated periodically. Rotation should be determined by the CPS Supervisor(s)/designee.***

3. ***CPSs shall provide services on the RHU/DTU during all three shifts daily and shall be informed of new receptions so they can conduct a check in with the new reception. It is a priority to have a CPS on second and third shifts.***

    a. ***A CPS shall provide services on the RHU/DTU throughout the 6:00 AM-2:00 PM shift.***

    b. ***A CPS shall make rounds during the 2:00 PM-10:00 PM and 10:00 PM-6:00 AM shift and visit each person who has arrived within the last seven days as soon as possible. The CPS should make contact with every individual regardless if there has been indication of suicidal ideation or not. It is not the expectation that a CPS be assigned for the duration of second and third shifts.***

4. ***CPSs shall be on call to provide services to inmates in a level 5 unit.***

5. ***CPSs will be visually supervised by level 5 staff at all times.***

6. ***CPSs will not give or receive any item to/from an inmate without staff permission.***

G. ***CPS Guidelines for Psychiatric Observation Cells (POCs)***

1. ***CPSs shall provide services in the POC area during all three shifts daily and shall be informed of new receptions so they can conduct a check in with the new reception. It is a priority to have a CPS on second and third shifts.***

2. ***A CPS shall provide services in the POC area throughout the 6:00 AM-2:00 PM shift.***

3. ***A CPS shall make rounds during the 2:00 PM-10:00 PM and 10:00 PM-6:00 AM shift and visit each person who has arrived as soon as possible. It is not the expectation that a CPS be assigned for the duration of shifts.***

4. ***CPSs shall be on call to provide services to inmates in a POC.***

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5. ***CPSs shall be visually supervised by staff at all times.***

6. ***CPSs shall not give or receive any item to/from an inmate.***

TOOL 3. DEVELOPING YOUR JOB DESCRIPTION

Peer recovery support services (PRSS) cover a wide range of potential programming and possible roles, tasks, and responsibilities for peer recovery support specialists. Although you need to develop a job description specific to your program, you do not have to start from scratch. Existing competency lists and job descriptions from other programs can be useful in crafting your unique description. The Substance Abuse and Mental Health Services Administration's (SAMHSA) Core Competencies for Peer Support Workers in Behavioral Health Services is a good place to start. Be specific when determining what your peer specialists can and cannot do.

Example from one prison program:

Peer Specialists:

- *Augment staff efforts to effectively support inmates with behavioral health or emotional concerns while enhancing their recovery and wellness.*
- *Promote recovery skills, such as personal wellness and positive coping skills, and assist in establishing/maintaining a recovery environment within the facility setting.*
- *Assist others by empowering others to succeed in developing and accomplishing goals, reconnecting to themselves, self-improvement, connecting/reconnecting with others, and finding meaning and purpose.*
- *Offer the ability to demonstrate employable skills transferable to community peer support programs.*
- *Facilitate workshops and didactic groups, which a staff member shall periodically monitor (determine which discipline).*

Act as mentors to newly certified peer specialists (CPSs), CPSs who are on suspension or probationary status, and CPSs who are experiencing difficulty in their CPS capacity. Any peer specialists identified as having mentoring skills should be informed that mentoring another peer specialist should be limited to this role.

Use the steps below to identify the job-specific requirements for your peer specialists.

- What are three words or phrases that you would use to describe the general role that you expect your peer support workers to play?

  1. _____

  2. _____

  3. _____

- Review the SAMHSA core competencies. Select two to four categories from the list that best fit or are most important for peer support workers' roles in your program.

  1. _____

  2. _____

  3. _____

  4. _____

- For each category selected, choose one to two underlying competencies that are priorities for your program.

  1. _____

  2. _____

  3. _____

  4. _____

- Under each category, consider if there are additional competencies or tasks specific to your program that are not on the list. If so, add these to your list.

  1. _____

  2. _____

  3. _____

  4. _____

TOOL 4. SAMPLE JOB DESCRIPTIONS

Certified Recovery Specialist

Qualifications

GED/high school diploma; three letters of recommendation; must have worked within the last 3 years with at least 12 months total of part- or full-time paid or voluntary work experience; and have acquired or met the qualifications for certification as a certified recovery specialist. Must understand and demonstrate respect for each individual's unique path to recovery. Must have a working knowledge of the substance use disorder treatment system and a demonstrated commitment to the recovery community.

The recovery specialist's role is to support others in recovery from a substance use disorder. The recovery specialist will serve as a role model, mentor, advocate, and motivator to recovering individuals to help prevent the return to substance use and to promote long-term recovery. The recovery specialist must demonstrate an ability to share personal recovery experiences and develop authentic peer-to-peer relationships.

Duties and Functions

1. Maintain project logs, reports, and records in appropriate files and database(s).

2. Provide recovery education to participants for every phase of the recovery journey, from pre-recovery engagement to recovery initiation, recovery stabilization, and sustained recovery maintenance.

3. Provide a model for both people in recovery and staff members by demonstrating that recovery is possible.

4. Assist recovering persons to identify their personal interests, goals, strengths, and weaknesses regarding recovery.

5. Assist/coach people in recovery to develop their plan for advancing their recovery.

6. Recovery planning: facilitate (via personal coaching) the transition from a professionally directed service plan to a self-directed recovery plan. The goal should be to transition from professionally assisted recovery initiation to personally directed, community-supported recovery maintenance.

7. Promote self-advocacy by assisting people in recovery in having their voices heard and their needs, goals, and objectives established as the focal point of rehabilitation and clinical services.

8. Actively identify and support linkages to community resources (communities of recovery, educational, vocational, social, cultural, spiritual resources, mutual self-help groups,

professional services, etc.) that support the recovering person's goals and interests. This will involve a collaborative effort including the recovering person, agency staff, and other relevant stakeholders.

9. Support connections to community-based, mutual self-help groups. Link individuals to appropriate professional resources when needed. Provide vision-driven hope and encouragement of opportunities at varying levels of involvement in community-based activities (e.g., work, school, personal relationships, physical activity, self-directed hobbies, etc.).

10. Develop relationships with community groups/agencies in partnership with others in the agency.

11. As the recovery specialist position evolves and knowledge increases, visit community resources with recovering persons to enable them to become familiar with potential opportunities.

12. Identify barriers (internal and external) to full participation in community resources and assist in developing strategies to overcome them.

13. Maintain contact by phone and/or e-mail with recovering persons after they leave the program to ensure their ongoing success and to provide re-engagement support in partnership with others in the agency if needed. Provide long-term engagement, support, and encouragement.

14. Perform other duties as directed by the executive director or management staff members.

15. Develop, implement, and promote ongoing community training opportunities.

16. Work with staff members and other community professionals to implement and promote recovery-oriented training programs and opportunities.

Certified Recovery Peer Advocate

Certified recovery peer advocates (CRPAs) assist individuals in recovery from addiction by setting and supporting the pursuit of their recovery goals, monitoring their progress, lending assistance with treatment, modeling effective coping techniques and self-help strategies, and supporting individuals in advocating for themselves to obtain effective services.

Education Requirements

Minimum high school diploma or equivalent. Must meet education and other baseline criteria for certification as a certified recovery peer advocate or provisional CRPA.

Experience Requirements

A certified recovery peer advocate, if in recovery, must be at least two years in recovery and highly motivated to help others. Must be able to work cooperatively as a member of a team of professionally trained clinicians and counselors. Must possess knowledge and experience in accessing local resources, such as housing, medical, and social services. Should have a working familiarity with 12-step programs and an understanding of wellness and recovery principles and behaviors. Candidates must have reliable access to transportation.

Principal Duties and Responsibilities

- Engages with individuals to offer living proof of the transformative power of recovery.
- Exhibits faith in clients' capacity for change and celebrates their recovery achievements.
- Encourages the client's self-advocacy and economic self-sufficiency.
- Genuinely cares and listens to the client and can be trusted with confidence.
- Facilitates the transition from a professionally directed treatment plan to a client-developed recovery plan and assists in structuring daily activities around this plan.
- Helps resolve personal and environmental obstacles to recovery.
- Assists with linking individuals with sources of sober housing, recovery-conducive employment, health and social services, and support groups (e.g., mutual support or 12-step).
- Serves as a sober companion accompanying individuals to appointments with legal, medical, and social service entities.
- Cultivates opportunities for people in recovery to participate in volunteer activities and performs other acts of service to the community.
- Facilitates agency-based peer support groups.

Other Responsibilities

Complies with agency policies and procedures. Attends trainings, seminars, etc., to increase skill level. Promotes the safety of all patients and staff. Contributes to the achievement of organizational goals. Participates as an active and supportive member of the treatment team.

Peer Support Specialist/Harm Reduction Outreach Worker

Program description

Provides direct services to people who use drugs (PWUD) and other marginalized groups at high risk for overdose, Hepatitis C, HIV, overdose, and other chronic health conditions. Prevents the spread of infectious disease and overdose fatalities by offering lifesaving supplies to directly-impacted people. Follows up with individuals who have experienced overdose for education, access to risk reduction services, and referrals to care as needed.

Provides services and support to individuals and friends/family/bystanders who experience and/or witness an opiate overdose. These services include harm reduction services, referral services, support services, and knowledge of payor sources and systems. Through these efforts, the peer support specialist will assist in placing individuals in recovery-oriented programs, including but not limited to syringe exchange programs, detox facilities, and inpatient and outpatient treatment facilities.

Description of duties

- Establish mobile service sites for syringe services programs.
- Coordinate mobile services for program participants.
- Do regular outreach to individuals and geographic areas within counties affected by drug use and/or sex work to connect them to the program.
- Respond to dispatched overdose calls in the county while on duty.
- Provide individualized harm reduction education to participants on overdose prevention, use of naloxone, Hepatitis C virus, sexually transmitted infections (STIs), HIV risk reduction, and safer drug use.
- Provide program members with community resources and help connect them to local services.
- Conduct follow-up visits to individuals who have experienced an overdose.
- Train community members on local overdose reversal protocol and offer harm reduction resources and care options.

- Distribute naloxone kits to populations in need.
- Follow up with individuals who experience an opiate overdose via phone call or in-person visit.
- Maintain up-to-date knowledge of local resources, including health care, treatment, and social services providers.
- Track data meticulously and report all program interactions to supervisors as well as naloxone distribution data, outreach interactions, and referrals to care.
- Participate in staff meetings and in-person training sessions on best practices in syringe service program operations and harm reduction.
- Collaborate with community-based organizations and county emergency medical services (EMS) to evaluate programs.

Requirements

- Applicants must have a valid driver's license, reliable transportation, and appropriate auto insurance for this position. Applicants must also have a smartphone with a data plan to receive active 911 notifications.
- Possesses the ability to work as a team member, accept constructive criticism, and provide input.
- Able to work effectively with all public service agencies, including EMS, fire, and law enforcement personnel.
- Willing to work with community agencies to link participants to wraparound services as needed.
- Must be able to attend CPR training and become CPR certified.

Knowledge and experience

Minimum of three years of experience as a certified peer support specialist with community outreach experience preferred.

Must have a working knowledge of:

- Harm reduction framework.
- Strategies and approaches for effective peer recovery support.
- Geographic area.

- Drug use, syringe service programs (SSPs), Hepatitis C, STIs, and HIV/AIDS services.
- Local treatment facilities, including those that provide medication-assisted treatment (MAT).

Must be able to:

- Establish and maintain ethical relationships with SSP participants.
- Appropriately discuss and share social, sexual, and other personal issues and experiences with individuals and groups.
- Demonstrate strong communication skills and self-direction.
- Maintain professionalism in the face of a medical emergency.
- Use appropriate and respectful approaches with people who use drugs, people who do sex work, people living with HIV or Hepatitis C, currently and formerly incarcerated people, the LGBTQIA community, and individuals from different racial and ethnic backgrounds.
- Maintain strict confidentiality and treat all participants non-judgmentally and with warmth and positive regard.
- Work flexible hours.
- Work autonomously.

Education/certifications required:

- High school diploma or GED.
- Peer support specialist certification.

TOOL 5. SAMPLE PEER WORKING AGREEMENT

Source: Adapted from Recovery Coach University

This sample agreement clarifies roles and expectations and is a collaborative agreement between the peer specialist and the individual served. It should be adapted as needed to fit the agency/peer role and should be approved by a supervisor/agency management before being used.

We agree to the best of our abilities to uphold these agreements and seek supervision/support when needed. We strive to enjoy an open, transparent, honest, empowering, strengths-based, and mutually satisfying peer-to-peer relationship that honors each person's autonomy of choice, recovery pathway, values, and strengths.

	Recovery Coach Preference	Peer Preference
Phone Number		
Meeting Location/Address		
Meeting Duration		
Number of Meetings Per Week/Month		
Calls/Week (Max)		
Length of Calls (Max)		
Beginning and End of Workday (and Availability)		
After-Hours Calling/Emergency Plan		
Social Media Policy		
Emergency Contact		
Other		
Other		

Additional needs/preferences for ensuring an effective, safe, and mutually respectful working relationship:

Together we agree to do our best to honor these working agreements.

Peer/Recovery Coach	Peer/Individual Served
Name:	**Name:**
Signature:	**Signature:**
Date:	**Date:**

RESOURCE 1. ABBREVIATIONS AND ACRONYMS LIST

AA	Alcoholics Anonymous
PRSS	peer recovery support services
RSAT	residential substance abuse treatment
SUD	substance use disorder
ACCRSC	Albany County Corrections and Rehabilitative Services Center
ACHR	Albuquerque Center for Hope & Recovery
ADA	Americans with Disabilities Act
BH	behavioral health
CBO	community-based organization
CBT	cognitive behavioral therapy
COD	co-occurring mental health and substance use disorder
CPRS	certified peer recovery specialist
CPS	certified peer specialist
CRPA	certified recovery peer advocate
DBHS	Department of Behavioral Health Services
DBT	dialectical behavior therapy
DEA	U.S. Drug Enforcement Administration
DOC	Department of Corrections
GED	General Educational Development
HARP	health action and recovery plans
HIPAA	Health Insurance Portability and Accountability Act
IC&RC	International Certification & Reciprocity Consortium
LGBTQIA	lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual

MAT	medication-assisted treatment/medications for addiction treatment
MH	mental health
MHA	Mental Health America
MH(D)	mental health (diagnosis)
NA	Narcotics Anonymous
NAADAC	Association of Addiction Professionals
NCPRSS	National Certified Peer Recovery Support Specialist (a credential offered by NAADAC)
PADOC	Pennsylvania Department of Corrections
PRSS	peer recovery support services
RCO	recovery community organization
RFP	request for proposals
ROSC	recovery-oriented system of care
SAMHSA	Substance Abuse and Mental Health Services Administration
SOR	State Opioid Response -
SUPPORT Act	Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment Act (for patients and communities)
TC	therapeutic community
WHAM	Whole Health Action Management
WRAP	Wellness Recovery Action Plan
WTSP	Western Tennessee State Penitentiary

RESOURCE 2. ADDICTION PEER RECOVERY SERVICES STATE MEDICAID COVERAGE AND CERTIFICATION REQUIREMENTS

Distinctions: Peer and Recovery Community Support

For at least 75 years, people in recovery from alcohol and other drug addiction have relied on connections with others in recovery for support to achieve their mutual recovery goals. Involvement in and expansion of these informal support networks are critical components of recovery success.

All 12-step fellowships and many other recovery community groups are influenced by the 12 Traditions of Alcoholics Anonymous (AA), founded in 1935. One of the strongest traditions is voluntary service to others seeking recovery. People in long-term recovery function without authority or the expectation of remuneration. Upon request, they may offer suggestions based on their own experiences or function as a sponsor. Ironically, the word peer and its connotations are seldom used in recovery circles.

Many religious congregations also offer faith-based recovery support and groups. Recovery community centers offer fellowship, meetings, and other activities in some areas. SMART Recovery, Women for Sobriety, AA, NA (Narcotics Anonymous), and other peer recovery support are available online free of charge.

These activities do not constitute treatment any more than support groups for people with diabetes constitute interventions to regulate insulin. However, attending treatment along with AA or NA meetings has been shown to be more effective than treatment alone (Sheedy and Whitter, 2009). The foundational principles that guide these fellowships also distinguish them from the emerging field of professional peer recovery support services (PRSS).

Recovery Support Services

Individuals with lived recovery experience may also decide to pursue training and/or certification to qualify them for paid positions as recovery support specialists. They may function as mentors, recovery coaches, health educators, or navigators. Such individuals generally do best when they have boundaries in place to distinguish what they do to manage their own recovery from their professional roles.

Peer recovery specialists can provide invaluable support to individuals in custody settings. They can also offer post-release support when these individuals re-enter the community. It is crucial to have appropriate policies in place for success in criminal justice settings. For example, it is important to clarify the limits of confidentiality and ensure peer specialists effectively communicate those limits. It is usually counter-productive to place excessive monitoring or reporting demands on peer support specialists, which can compromise their effectiveness by diminishing their status as “peers.”

Recovery Capital

Recovery capital refers to the totality of beneficial resources available to an individual that can work toward recovery objectives. Some people can count on the support of an intimate partner, family, employer, or friend who has encouraged attempts to stop using, while others either cannot look to or do not have any of those sources of support. In such cases, increasing recovery capital is essential.

Supportive Services

In addition to personal relationships and informal networks of support, social determinants also impact recovery. Many community-based agencies offer these essential, non-clinical supportive services. Access to safe and drug-free housing, education, gainful employment, and health care is essential to recovery, as is the pursuit of drug-free interests and leisure activities.

Medicaid Coverage of Peer Support Service

The Center for Medicare & Medicaid Services (CMS) has recognized the role of peer support services in comprehensive behavioral health care and has a long history of reimbursement for peer mental health services. However, the value of peer addiction recovery support services has become more widely recognized, especially as communities impacted by the drug overdose crisis strive to increase access to care. CMS allows states many options for authorizing reimbursement of PRSS through state Medicaid plans or different types of CMS-approved waiver programs.

Section 1905 (a) (13) Authority—This part of the Social Security law allows approved state Medicaid plans a rehabilitative services option for reimbursement of certain non-clinical supportive services for beneficiaries with SUD. Examples include peer recovery support, supported employment or skills training, recovery housing, or transportation.

Section 2703 of the ACA—The Affordable Care Act (ACA) allows state Medicaid plans to include a Health Home option to coordinate primary, acute, and behavioral health care for people with multiple chronic conditions. Health Homes may offer recovery support as a part of covered bundled services for beneficiaries with SUD. More than half of the 22 states using the Health Home option target SUD.

Section 1915(b) or (c) Waiver Authority—These can waive freedom-of-choice requirements and allow states to mandate enrollment in Medicaid-managed care or primary care case management (PCCM) if they demonstrate managed care is cost-effective, efficient, and consistent with Medicaid principles. Any cost savings are to be used to expand services.

Section 1115 Waiver Authority—Section 1115 waivers allow states the flexibility to demonstrate innovations that can waive certain Medicaid rules. CMS has approved or is considering 1115 waivers to transform behavioral health and addiction treatment services for 24 states; nearly all include reimbursement for PRSS.

Other mechanisms—Options for authorizing reimbursement for peer recovery services are expanding. In 2010, Section 1915(i) of the Social Security Act was amended to include home and community-based rehabilitative services (HCBS) for people with disabilities, mental illnesses, or SUDs who might otherwise require institutional care.

More recently, the American Rescue Plan Act of 2021 incentivized rehabilitative HCBS and encouraged the adoption of mobile community-based crisis services for beneficiaries with mental health disorders or SUDs by increasing the federal contribution to costs. Mobile crisis services may deliver interventions to help people avoid hospitalization and incarceration. PRSS are specified as a reimbursable element of mobile crisis services.

Requirements for Coverage of Peer Support Services

In 2007, CMS released a letter to state Medicaid directors with guidance for authorizing reimbursement for PRSS. States have the flexibility to choose the authority by which they cover and reimburse for services as long as they identify it and describe the services, the providers, and their qualifications. The following are the minimum federal requirements for supervision, care coordination, training, and certification:

Supervision: A competent mental health professional (as defined by the state) must provide supervision that complies with State Practice Acts in amount, duration, and scope appropriate to the level of competency, experience, and the service mix.

Training and Certification: Peer support providers must complete training and certification as defined by the state to equip them with the basic competencies necessary to perform their functions. Like other provider types, ongoing and continuing education requirements must be in place.

Care Coordination: Services must be coordinated within the context of a comprehensive, individualized plan of care that includes specific individualized goals that have measurable results.

The SUPPORT Act of 2018 required the U.S. Government Accountability Office (GAO) to complete a report on peer support services under Medicaid that recently became available. The GAO report found that 37 state Medicaid programs covered PRSS for adults with SUDs as a stand-alone service for beneficiaries. At least three additional states covered PRSS with limitations—as part of a treatment or treatment team. Medicaid covers peer recovery services in both expansion and non-expansion states.

Mental health peer services have a longer history with Medicaid and are more likely to be covered. In some cases, reimbursement for mental health peer support services has been tied to psychiatric hospitals or community mental health centers; in other cases, addiction peer support services have only been covered for individuals with co-occurring mental health disorders and SUDs. Recently, several states have increased training and continuing education requirements for certification as a PRSS and are offering advanced or specialized credentials.

The information below is currently based on the 2020 GAO report and other publications that reviewed state Medicaid programs between 2018 and 2020 but may omit very recent developments. It is best to consult individual state Medicaid websites for the most up-to-date information on coverage of PRSS. States listed below may also fund PRSS with state revenues, Federal Access to Recovery funds, or other sources instead of or in addition to Medicaid.

State	Title	Certification	Time in Recovery?	Medicaid Authority
Alabama	Recovery Support Specialist	Alabama Dept of MH 40-hr. training + passing test score (70%)	2 yrs.	Covered in-state plan under rehabilitative services
Alaska	Peer Support Specialist (plus sub-specialties)	Alaska Commission for BH Certification 80 hrs. training, 1000 hrs. experience + 25 hrs. supervision.	1 yr.	Covered in-state plan under rehabilitative services
Arkansas	Peer Recovery Specialist	Arkansas works with NAADCA to certify; 46 hrs. approved training, 500 hrs. experience = 25 hrs. supervision	2 yrs.	Covered in-state plan under rehabilitative services
Arizona	Peer and Recovery Support Specialist	Arizona Health Care offers core, advance, and supervisor certification: 40 hrs. approved training + 80% on exam.	Lived experience requirement	Covered in-state plan under rehabilitative services
California	Peer Support Specialist	Counties certify according to state training standards by Sept 2021. 80 hrs. training + exam	Lived experience requirement	Covered under 1115 waiver program
Colorado	Peer and Family Specialist	Certification from providers' association + IC&RC, 60 hrs. training, 500 hrs. experience + 25 hrs. supervision	Lived experience requirement	1915(b)(3) waiver included in bundled services
Connecticut	Peer Recovery Support Specialist	80 hrs. of approved training, 500 hrs. + 25 hrs. supervision, certification by an RCO in the state	Lived experience requirement	Covered under 1115 waiver program
Delaware	Peer Recovery Specialist	Delaware Certification Board + IC&RC, 1000 hrs. + 25 hrs. supervision	Lived experience requirement	Covered under 1115 waiver program
District of Columbia	Peer Specialist	Certification: DC Dept of BH Health - IC&RC exam; 6-week course plus 80-hr. supervised practicum	Lived experience requirement	No
Florida	Peer Recovery Specialist	40 hrs. training by Florida Certification Board; 500 hrs. experience + 16 hrs. supervision	2 yrs.	Covered in-state plan under rehabilitative services
Georgia	Addiction Recovery Empowerment Specialist	40 hrs. training w/exam from Georgia Council on Substance Abuse	2 yrs.	Covered in-state plan under rehabilitative services
Hawaii	Hawaii Certified Peer Specialist	Hawaii Adult Mental Health Division with approved training	1 yr.	COD only under state plan rehabilitative services

State	Title	Certification	Time in Recovery?	Medicaid Authority
Idaho	Peer Recovery Coach	46 hrs. from Idaho Certification Board, IC&RC exam, 500 hrs. experience + 25 hrs. supervision	1 yr.	No
Illinois	Certified Peer Recovery Specialist	100 hrs. training from Illinois Certification Board + IC&RC exam, 2,000 hrs. experience + 100 supervision	2 yrs.	Covered under 1115 waiver program
Indiana	Certified Peer Addiction Recovery Coach I and II	Level I = 30 hrs. from MHA of NE Indiana + IC&RC exam, 500 hrs. + 25 supervision; Level II = 46 hrs. training	1 yr. for level II	Covered under 1115 waiver program
Iowa	Certified Peer Recovery Support Specialist	46 hrs. from ID Certification Board + IC&RC exam, 500 hrs. experience + 25 hrs. supervision	Lived experience requirement	1915(b)(3) waiver covered for expansion population
Kansas	Peer Mentor in Training Certified Peer Mentor	6 hrs. training; 15 hrs. for certification from Kansas Dept for Aging & Disability Services	1 yr.	Covered in-state plan under rehabilitative services
Kentucky	Adult Peer Support Specialist	60 hrs., training approved by Dept of Behavioral Health, IC&RC exam, 500 hrs. experience + 25 hrs. supervision.	2 yrs.	Covered in-state plan under rehabilitative services
Louisiana	Peer Support Specialist	76 hrs. training from Louisiana Dept. of Health, Office of BH + 80% on exam	1 yr.	No
Maine	Peer Recovery Coach	Maine Certification Board: 50-hr. CCAR recovery coach training + 500 hrs. experience, 25 hrs. supervised	Lived experience requirement	Covered in-state health homes plan
Maryland	Peer Recovery Specialist	46 hrs. from Maryland Certification Board, IC&RC exam, 500 hrs. experience + 25 hrs. supervision	2 yrs.	No
Massachusetts	Recovery Coach Recovery Support Navigator	Massachusetts Certification Board: 60-hr. CCAR recovery coach training + 500 hrs. experience, 25 hrs. supervised	Lived experience requirement	Covered under 1115 waiver program
Michigan	Peer Recovery Coach	Michigan Dept of Health & Human Services training w/exam, 10 hrs. a week providing recovery support services	2 yrs.	Covered in-state plan under rehabilitative services
Minnesota	Peer Recovery Specialist, Certified Peer Recovery Specialist Reciprocal	CPRS: 46 hrs. of training from Minnesota Cert. Board + C&RC exam CPRSR: 500 hrs. of work experience + 46 hrs. of training from Minnesota Cert. Board + 25 hrs. of supervision + IC&RC exam	No	Covered in-state plan under rehabilitative services

State	Title	Certification	Time in Recovery?	Medicaid Authority
Mississippi	Certified Peer Support Specialist	34 hr. training w/exam from Mississippi Dept of MH, 250 hrs. experience in the state MH system	6 mons.	Covered in-state plan under rehabilitative services
Missouri	Peer Specialist (2 higher levels)	Approved 5-day training w/exam from MO Cert. Board for level 1.	Lived experience requirement	1115 waiver and covered for Certified Community BH Clinics
Montana	Behavioral Health Peer Support Specialist	40 hrs. training from Montana Board of Behavioral Health w/exam.	2 yrs.	No
Nebraska	Peer Support Specialist	40 hrs. from Dept of Health & Human Services w/exam.	1 yr.	Covered in-state plan under rehabilitative services
Nevada	Peer and Recovery Support Specialist	46 hrs. from Nevada Certification Board + IC&RC exam, 500 hrs. experience + 25 hrs. supervision	Lived experience requirement	Covered in-state plan under rehabilitative services
New Hampshire	Recovery Support Worker	46 hrs. approved training from New Hampshire Licensing Board + IC&RC exam, 500 hrs. experience + 25 hrs. supervision	Lived experience requirement	Covered in-state plan under rehabilitative services
New Jersey	Peer Recovery Specialist	46 hrs. from New Jersey Certification Board + IC&RC, 500 hrs. + 25 hrs. supervision	Lived experience requirement	Covered for Certified Community BH Clinics
New Mexico	Peer Support Worker	40 hrs. from New Mexico Credentialing Board w/exam plus 40 hrs. 'pre-exposure' at approved agency.	2 yrs.	Covered under 1115 waiver program in managed care plans.
New York	Addiction Recovery Coach Recovery Advocate	Coach: 60 hrs. training approved by New York Certification Board; Advocate: 46 hrs. + IC&RC exam, 500 hrs. + 25 hrs. supervision	No	Covered under 1115 waiver program as part of HARP
North Carolina	Peer Support Specialist	60 hrs. approved by Div. of MH, Developmental Disabilities & Substance Abuse Services	1 yr.	1915(b)(3) waiver bundled service in managed care plans
North Dakota	Peer Support Specialist	North Dakota Division of MH & Substance Abuse training w/exams.	Lived experience requirement	No
Ohio	Peer Recovery Supporter	40 hrs. training or 3 yrs. experience + 16 hrs. online courses w/exam from Ohio MH & Addiction Services	Lived experience requirement	Covered in-state plan under rehabilitative services.
Oklahoma	Certified Peer Recovery Support Specialist	40 hrs. from Dept of MH & Substance Abuse Services w/exam	Lived experience requirement	Covered in-state plan under rehabilitative services

State	Title	Certification	Time in Recovery?	Medicaid Authority
Oregon	Addictions Recovery Mentor (2 other certifications)	40 hrs. training approved by Oregon Certification Board; Advanced-80 hrs. + 500 hrs.+ 25 supervision hrs. & exam	2 yrs. suggested	As bundled service in-state plan rehabilitative services
Pennsylvania	Recovery Specialist Family Recovery Specialist	54 hrs. + exam from Pennsylvania Certification Board; Family Recovery Specialist, 60 hrs. + exam	18 mons. suggested	Covered for Certified Community BH Clinics
Rhode Island	Peer Recovery Specialist	46 hrs. training approved by Rhode Island Certification Board + IC&RC exam, 500 hrs. experience + 25 hrs. supervision.	2 yrs.	Covered under 1115 waiver program
South Carolina	Peer Support Specialist	40 hrs. training approved by South Carolina Peer Support Specialist Certification Board + IC&RC exam + 100 hrs. experience	1 yr.	Covered in-state plan under rehabilitative services
South Dakota	Peer Specialist Services	South Dakota is in the process of developing a credential. Two SOR-funded programs offer peer services and training	N/A	No
Tennessee	Peer Recovery Specialist	40 hrs. training approved by Department of MH & Substance Abuse + IC&RC exam + 75 hrs. supervised experience	2 yrs.	Covered in-state plan under rehabilitative services
Texas	Recovery Support Peer Specialist	8 hrs. core training + 46 hrs. w/exam approved by Texas Health & Human Service Commission	1 yr.	State plan only as a bundled service
Utah	Peer Support Specialist	40 hrs. approved training w/ exam by Division of Substance Abuse & Mental Health	1 yr.	Covered in-state plan under rehabilitative services
Vermont	Recovery Coach	46 hrs. recovery coach training from Vermont Certification Board + IC&RC exam	1 yr.	Covered under 1115 waiver program
Virginia	Peer Recovery Specialist	72 hrs. of Virginia Department of BH Training IC&RC exam + 500 hrs. experience; 25 hrs. supervision	1 yr.	Covered in-state plan under rehabilitative services
Washington	Peer Counselor	40 hrs. training w/exam approved by the Division of BH & Recovery	1 yr.	Covered in-state plan under rehabilitative services
West Virginia	Peer Recovery Support Specialist	46 hrs. training approved by West Virginia Certification Board + IC&RC exam 500 hrs. + 25 hrs. supervision	2 yrs.	Covered under 1115 waiver program
Wisconsin	Peer Specialist	Training w/exam approved by Wisconsin Peer Specialist Employment Initiative	1 yr.	Covered in-state plan under rehabilitative services

State	Title	Certification	Time in Recovery?	Medicaid Authority
Wyoming	Peer Specialist	36 hrs. peer specialist training from Wyoming Dept of Health	1 yr.	Covered in-state plan under rehabilitative services

RESOURCE 3. ADDITIONAL RESOURCES

Best Practices for Successful Reentry for People Who Have Opioid Addictions
https://csgjusticecenter.org/wp-content/uploads/2020/01/Best-Practices-Successful-Reentry-Opioid-Addictions.pdf

Collaboration and Partnership in the Community: Advancing the Michigan Prisoner ReEntry Initiative
https://nicic.gov/sites/default/files/022780.pdf

"How Peer Specialists Can Support Harm Reduction"
https://www.mhanational.org/sites/default/files/HarmReductionSlides.pdf

Peer Specialists State Comparison Tool
https://copelandcenter.com/peer-specialists

Recovery Capital Assessment Plan and Scale (ReCAPS)
http://www.brauchtworks.com/yahoo_site_admin/assets/docs/Recovery_Capital_Assessment_Plan_and_Scale_-_ReCAPS_160717.3200420.pdf

REC-CAP Assessment & Recovery Planning Tool
http://www.recoveryoutcomes.com/rec-cap/

Reducing Homelessness for People with Behavioral Health Needs Leaving Prisons and Jails: Recommendations to California's Council on Criminal Justice and Behavioral Health
https://csgjusticecenter.org/wp-content/uploads/2021/02/Reducing-Homelessness-CA_Final.pdf

The Role of Housing Supports in Reentry
https://www.youtube.com/watch?v=RU0yDLxdMAE

State Directory of Peer Specialist and Recovery Specialist Credentialing
https://c4innovates.com/brsstacs/BRSS-TACS_State-by-State-Directory-of-Peer-Recovery-Coaching-Training-and-Certification-Programs_8_26_2020.pdf

Wellness Recovery Action Plan
https://mentalhealthrecovery.com

Whole Health Action Management
https://www.thenationalcouncil.org/wp-content/uploads/2022/02/WHAM-One-Pager_new.pdf

Medication-Assisted Treatment for Opioid Use Disorder in Jails and Prisons: A Planning & Implementation Toolkit
https://www.thenationalcouncil.org/resources/medication-assisted-treatment-mat-for-opioid-use-disorder-in-jails-and-prisons-a-planning-and-implementation-toolkit/