Strengthening Recovery Through Social Support: The Impact of Peer Recovery Services

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Editor's note: *Dr. Peter Treitler is an assistant professor at the Boston University School of Social Work. Dr. Treitler's work aims to improve the wellbeing of people with substance use disorders and inform more effective solutions to the nation's critical substance use challenges. His research has been featured in JAMA Health Forum, Journal of General Internal Medicine, and Journal of Substance Use and Addiction Treatment. This op-ed is part of our Special Series on Addiction and Social Support.*

As a person in long-term recovery, I know firsthand that social support is essential for achieving and sustaining recovery. Yet, many people early in recovery find themselves disconnected from the very institutions that typically provide support – family and friends, workplaces, religious communities, and recreational activities. When I was in the depths of active addiction, I had lost the trust of my loved ones, my job, and the hobbies that once brought me joy and connection. Isolated and experiencing relentless cravings fueled by my dependence on substances, recovery felt nearly impossible. For me and many others, rebuilding these social connections was not just a part of recovery – it was the foundation that made it possible. While evidence-based treatment, including medications for opioid or alcohol use disorder, is critical, lasting recovery and a high quality of life ultimately depend on meaningful social support that fosters connection and belonging.

More than a decade into recovery, as an addiction researcher, I found myself studying these very issues – particularly the role that peer recovery support

specialists (PRSS) play in providing social support and treatment linkages for individuals with substance use disorder. PRSS, also known as recovery coaches, peer mentors, or by other names, can be invaluable in helping people rebuild social connections and access the resources they need. My research has examined the impact of PRSS in non-traditional settings, such as hospitals and correctional facilities, where they work with patients at particularly vulnerable moments in their recovery.

One study I conducted focused on the effectiveness of the Opioid Overdose Recovery Program, a PRSS program in emergency departments across New Jersey. We compared treatment participation and repeat overdose rates among patients treated for opioid overdose at hospitals with and without the PRSS program. The findings were promising: patients who enrolled in the program were more likely to receive medications for opioid use disorder (the most effective treatment available) and had a lower risk of repeat overdose in the months after discharge. While our study did not identify the exact mechanisms driving these improvements, a growing body of research suggests that PRSS programs may work by fostering trust through shared lived experiences, providing deep knowledge of treatment and recovery resources, and offering mentorship and emotional support similar to what people find in 12-step programs like AA and NA.

Another PRSS program I have studied, New Jersey's Intensive Recovery Treatment Support (IRTS) program, provides wraparound recovery support to individuals with substance use disorder as they transition from incarceration back into the community. PRSS serve as the primary contacts for clients, helping them navigate reentry by providing social support, care coordination, transportation, and reentry planning. IRTS is based on the Critical Time Intervention (CTI) model, which helps individuals establish strong connections to long-term, community-based support systems during major life transitions. The post-release component of IRTS is delivered in three structured phases: 1) Transition, where PRSS provide intensive support and begin linking individuals to community resources; 2) Try-Out, where PRSS gradually step back as individuals take on more responsibility in managing their recovery; and 3) Transfer of Care, where PRSS provide minimal direct support as clients fully integrate into their long-term support networks. In this model, PRSS play a crucial role in providing immediate social support post-release while also helping individuals cultivate sustainable, long-term social connections.

Interviews with 39 participants in the IRTS program highlighted just how impactful these relationships can be. Participants described a range of support they received from PRSS, including help with goal setting, encouragement, feedback for self-monitoring, and emotional support – especially during moments of vulnerability and risk for relapse. They also noted the tangible resources PRSS connected them to, such as treatment services, recovery programs, housing support, and even material needs like clothing and cell phones. Many participants viewed the support from PRSS, both emotional and practical, as instrumental to their recovery.

Preliminary findings from our research on the IRTS program suggest that it significantly improves post-release outcomes. Individuals with opioid use disorder who participated in the program were much more likely to engage in treatment within six months of release compared to those who did not. They were also more likely to be enrolled in Medicaid, a key benefit that improves access to essential healthcare and recovery services.

While these and other studies highlight the promise of PRSS programs in providing social support, they also expose gaps that require further research. PRSS models vary widely across programs, and we still do not fully understand which program features lead to the best outcomes. Additionally, most studies have focused on short-term outcomes that are easier to measure, like treatment engagement, rather than the complex, long-term effects that PRSS programs aim to address, such as recovery capital, the strength of social support networks, and overall quality of life. More research is needed to optimize PRSS models and better understand their long-term impact on a broad array of outcomes.

An additional challenge is the sustainable funding of peer services, which has largely relied on time-limited federal, state, and local grants. Much of this funding was introduced in response to the opioid crisis and is at risk of expiring in the coming years. Some states have attempted to address this by establishing Medicaid benefits for PRSS services, but reimbursement rates are often too low to support long-term viability, or billing is restricted to specific settings, such as licensed specialty addiction treatment facilities. To ensure sustainability, states and other entities could consider increasing Medicaid reimbursement rates, expanding the range of eligible billing settings, or integrating PRSS into bundled payment models that incentivize comprehensive, recovery-oriented care.

Despite these uncertainties, one thing is clear: PRSS programs offer a vital source of social support for people in early recovery, particularly those who lack strong support systems. By fostering trust, bridging people to treatment, and helping individuals rebuild relationships and community connections, PRSS programs fill an important gap in addiction care. Expanding these programs and strengthening the research base to guide their implementation can help ensure that more people have access to the support they need, not just to survive, but to thrive in recovery.

— Peter Treitler, PhD

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