This draft document is intended as a reference document within Foundry and YWHO to support service development and delivery. It is neither appropriate to or intended for publication.

Peer support for young people and substance use

Rapid Evidence Review | 2021

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Qualifier for Rapid Evidence Reviews

This report is a rapid evidence review, i.e., an examination of empirical evidence that has a shortened time frame and a specified scope. The goal of such a review is to provide robust, accessible evidence in a timely and practical manner for busy decision makers. Rapid evidence reviews contain elements of comprehensive ("systematic") evidence reviews with modifications to processes such as timeline, literature searching, appraising and reporting.

In a rapid evidence review, the following modifications are typically made:

- The project timeline is short;
- One reviewer conducts the literature appraisal, rather than two or more reviewers;
- The reviewer queries one database (MEDLINE/PubMed), limited to English language articles only, with a search focused on recent publications; and
- The reviewer does not conduct a formal quality assessment of included materials.

Note that rapid reviews aim to accurately report what appears in the literature in an unbiased way. To this end, the information is uncensored and, to as great an extent possible, does not reflect interpretations flowing from author's or reviewers' opinions.

Foundry and Youth Wellness Hubs Ontario would like to acknowledge, with much gratitude, that our work takes place on the traditional and unceded territories of many First Nations and Métis peoples across the two provinces in which our initiatives operate, Ontario and British Columbia.

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Executive Summary

Background

Peer support is provided by peer workers who have lived experience and experiential knowledge. Through nonprofessional, nonclinical assistance, its aims for the person receiving care are recovery, empowerment and hope via development of the skills people need to take charge of their lives. Although peer support is primarily used in the area of mental health, it is also being used for people with substance use issues.

Young people are at risk for the development of substance use disorders and this can lead to poor school performance, injury (or death) and habits continuing into adulthood. Only 10% of adolescents who need treatment for a substance use disorder actually get it; even then, relapse rates at a year can be 80%.

Depending on a youth's needs, peer support workers can mentor, coach and make connections to necessary resources. They may also facilitate community-building activities, helping to build alternative social networks with substance-free social options.

Report objective

The report explores the use of one-on-one youth peer support for young people (ages 12–24) with substance use issues.

Methods

An experience medical information specialist conducted MEDLINE and grey literature searches in mid-February, 2020. One author reviewed and selected the relevant material and prepared the report.

Findings

There is not yet a body of published evidence reporting on youth peer support in substance use. To determine the overall effectiveness of peer support in substance use, four systematic reviews were reviewed that focused primarily on adults. Although some individual studies were supportive, consensus was that the available primary studies are of low quality and there is a need for further effectiveness research.

Specific to youth peer support for substance use, two narrative reviews and eight primary studies were identified. One review focused on prevention through use of formal sport programs and found benefits engaging young people and documenting lower intentions to use substances. The other described the Alternative Peer Group program in the USA that integrates recovering peers and prosocial activities into clinical practice, relying on positive social influence; however, no outcomes were reported.

Primary studies on youth peer support for substance use covered traditional cigarettes (n=2), vaping (n=1) and overall substance use (n=5). Not all included outcomes.

- With respect to smoking cessation, a Canadian study found that embedding smoking cessation information into social media was feasible and encouraged use of existing social networking platforms versus designing stand-alone resources, while an evaluation of 10 years of a Youth Quitline in Hong Kong reported successful six-month outcomes.
- For vaping, a study in France looked at informal peer support and found it be to associated with less vaping in those mentored.
- The five primary studies on substance abuse reported on four programs designed for young people in the USA. At least two used trained youth peers, and those that measured outcomes reported benefit.

There has been some work in British Columbia (BC) about the barriers and enablers to peer support for substance use (not specific to age) where focus groups around the province involved people who were using or had used illicit drugs. Barriers to peer engagement included individual, geographical, systemic and social factors, whereas engagement was facilitated by compensation, setting, consistency, use of the right people (peers) and use of peer networks.

Issues and challenges in providing peer support have also been described, such as role differences between friendship and a peer support relationship and dealing with issues around information and privacy. Systemic issues related to implementation of peer support were listed as lack of access and referral to peer support, inadequate planning and funding, poorly targeted accountabilities and lack of workforce development.

Beyond exploring the evidence for the impact of youth peer support in substance use, this report presented material about core competencies for peer support workers, including the foundational principles underlying the competencies. Training for peer support workers and accreditation and certification in Canada were also discussed.

Although there appears to be growing interest in the field, it appears to be “early days” for a fulsome evidence base for peer support in substance use, particularly in youth. However, there are a number of interesting programs and benefit has been shown. There are complex considerations related to barriers and enablers to peer support for substance use, as well as issues and challenges in the day-to-day provision of services.

Contents

1. Background

1.1. What is peer support?

Peer support, also known as "peer recovery support" and "peer-delivered recovery support," is a structured relationship where trained workers or volunteers who have gone through a process of recovery themselves assist other people who are their peers to identify and achieve life goals. Peer support is provided by people who are felt to have a broad range of firsthand knowledge and, as a result, credibility in the field, i.e., shared experiences and therefore common ground (Barton & Henderson 2016). Another description of peer support is the process of giving and receiving nonprofessional, nonclinical assistance to achieve long-term recovery, with the support provided by peers who have lived experience and experiential knowledge (Bassuk et al 2016).

The values and processes of peer support include recovery, empowerment and hope. This approach helps individuals develop the skills they need to take charge of their lives and helps them contribute to the recovery process (Cyr et al 2016). The relationship of the peer support provider to the peer receiving help is supportive rather than directive. The duration of the relationship between the two depends on a number of factors, such as how much recovery time the peer has, how much other support the peer is receiving or how quickly the peer's most pressing problems can be addressed (SAMHSA 2009).

Peer support can also benefit peer support workers themselves. O'Hagan (2011) listed the following benefits: (a) learning new skills, developing routines and increasing income; (b) restoring confidence and increasing self-awareness, fulfillment and friendships; and (c) assisting with recovery and staying well.

Peer support is distinct from the "mutual aid modalities" of peer support that are typically provided in the context of 12-step groups such as Alcoholics Anonymous. Such mutual aid is informal, does not require training and is rooted in bidirectional relationships of mutual support. Also, mutual aid typically presents a single pathway for recovery as defined by the mutual aid group model (Bassuk et al 2016).[1]

NOTE: The literature's emphasis is on peer support for people with mental health issues, but this report focusses on peer support for substance use issues.

1 One reference (SAMHSA 2009) distinguished the role of a peer mentor or coach from that of a 12-step sponsor in several ways, i.e., a 12-step sponsor helps a person in early recovery understand and follow the specific guidance of the 12-step program versus a peer support mentor who may help peers in early recovery to make choices about which particular recovery pathway(s) will work for them. Also, a peer mentor may devote more time connecting the person in early recovery to community resources versus a 12-step sponsor.

1.2. Rationale for peer support in substance use

Substance use has traditionally been treated through intense professional services during acute episodes. While this can be effective, relapse rates are generally high. Viewing substance use as a chronic condition has led to a shift in its treatment, from the prevalent acute care model to a longer-term continuum of care model like that used for other chronic conditions. Recovery-oriented approaches involve a multi-system, person-centred continuum of care where coordinated services and supports are tailored to individuals' recovery stage, needs and chosen recovery pathway to promote abstinence and a better quality of life (Bassuk et al 2016, Eddie et al 2019). Peer support is one tool in this care.

Peer support has grown from "patient navigator" models that have played important roles in the coordination of care for chronic medical conditions such as cancer, and they later included peers with lived experience to aid engagement. Navigator models were then developed for care of individuals with severe mental health conditions (Eddie et al 2019).

1.3. Functions of peer support in substance use

Peer support can help individuals navigate systems to build recovery capital, attain employment, attend mutual-help groups and address criminal justice issues. Common functions include facilitating and supporting engagement with substance use treatment and transitions between levels of care. In addition, peer support can connect people in need with community-based recovery support services and mutual-help organizations in ways not possible for conventional treatment providers who are bound by ethical considerations like not forming dual relationships with patients (Eddie et al 2019).

1.4. Youth and substance use

Youth are at risk for the development of substance use disorders. In adolescents in particular, although the brain systems governing emotion and reward-seeking have developed, the circuits governing judgement and self-inhibition are still maturing. Young people may therefore be easily swayed by their peers, act on impulse and seek new sensations. Because critical neural circuits are still actively forming, modification of the brain may occur, making the development of a substance use disorder more likely (NIDA 2014, Nash et al 2016).

About 80% of people with substance use disorders began before age 18, and additional impacts for youth include poor school performance, accidents and injury and death (Winn et al 2019). Problematic substance use in adolescence and emerging adulthood is a significant public health concern in this age group due to evidence of increased use, high recurrence rates and unmet treatment needs. Both improved service use and availability of recovery supports are required (Curtis et al 2019). Only 10% of adolescents who need treatment for a substance use disorder actually get it; most don't want or think they need help and parents may be blind to indications that their teenagers are using drugs, or they

may dismiss drug use as a part of growing up (NIDA 2014). Even for adolescents who do receive treatment, reports of first year relapse rates are 60–80%, suggesting that treatment gains quickly fade for many (Nash et al 2016). Young people who are affected by substance use disorder can be a particular challenge as they are more likely than their adult counterparts to be polysubstance abusers, to have comorbid mental health issues and to enter treatment with poor internal motivation for changing their behavior (Nash et al 2016).

Historically, the focus in youth has been on prevention—steering them clear of drugs before problems arise—but different interventions are needed along the substance use spectrum. Some youth require treatment, not just prevention. The efficacy of a number of treatment approaches has been explored to address substance use during the teen and young adult years, including peer support, although it is important to note that peer support is not a substitute for drug use treatment (NIDA 2014).

1.5. Peer support for youth and substance use

During adolescence, the protective effects of peer support seem to grow in importance as youth become less strongly influenced by their parents (Barton & Henderson 2016). Peer support services help individuals remain engaged in treatment and/or the recovery process by linking them together in relationships with peer leaders who have direct experience with addiction and recovery. Depending on the needs of a young person, peer workers may provide mentorship and coaching and help connect individuals to treatment or other resources. They may also facilitate or lead community-building activities, helping recovering youth build alternative social networks and have drug- and alcohol-free social options (NIDA 2014).

2. Objective of this Report

The objective of this report is to explore one-on-one peer support for youth in the area of substance use, i.e., not peer support groups or peer support for families. To guide the report, the population, interventions, comparators and outcomes (PICO) were defined in advance (Table 1).

Table 1: Project PICO (Population, Interventions, Comparators and Outcomes)

Population	Young people ages 12–24
Interventions	Peer support for individuals with substance use with a focus on comparator jurisdictions like the USA, UK, Australia and EU
Comparators	Against each other, placebo, usual care or no treatment
Outcomes	Any outcomes mentioned in the literature

3. Methods

An experienced health information specialist used the PICO to design MEDLINE literature searches that were run on February 19 and 20, 2020, including a separate search that was run to identify systematic reviews (SRs). The main search strategy (Appendix A) used the National Library of Medicine's MeSH (Medical Subject Headings) controlled vocabulary, limited to the English language and the past five years. A grey literature search sought additional relevant materials. One author assessed the identified material and prepared the report.

4. Results

Although a number of references were located that included some information of use, there is a shortage of directly relevant research on peer support for youth in the area of substance use. For example, a recent reference (Paquette et al 2019) noted, "*Peer support research is in its infancy, and especially scant specific to young adults in substance use disorder peer support roles…Peers in recovery—and especially young adult peers—are a valuable resource to expand prevention and early intervention capacity for young people. Because of their near-peer age and [with] training and experience in peer and recovery support practices, young peers are well suited to engage youth in discussion, intervention, and support specific to substance-use-related risks. Young peers also represent a willing, capable, and largely untouched segment of the workforce…With the current scale of substance use nationally, exploring how peers can support preventive efforts is essential. Further research is needed to explore roles for young peers in youth-serving settings, and to determine effectiveness.*"

4.1. Systematic reviews on peer support for substance use

The search for evidence started with SRs, considered by many to be the most rigorous form of evidence[2]. Four relevant SRs on peer support for substance use were located, although none focused specifically on youth (Table 2 on page 10).

2 Australian National Health and Medical Research Council (NHMRC). NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. 2009. Available at: mja.com.au/sites/default/files/NHMRC.levels.of.evidence.2008-09.pdf

Table 2: SRs on peer support for substance use (not specific to youth)

Author (year)	Search details # studies included	Findings	Notes
Rief (2014); USA	5 databases Search 2005–2012 11 publications (1998–2011) including 2 randomized controlled trials (RCTs)	The literature was limited and methodologically weak. Strong conclusions were not possible; however, peer support appeared to fill a gap in care and there was promising evidence of benefit.	Studies of adolescents were excluded (either peers of this age did not have personal experience or studies focused more on social support).
Bassuk (2016); USA	3 databases + grey literature Search 1998–2014 9 comparative publications (2005–2013) including 4 RCTs	Overall, the participation of peers in recovery support had a beneficial effect on participants and made a positive contribution to substance use outcomes; however, study quality was weak and the effectiveness of various approaches was not clear.	All studies focussed on adults (mean age ~40) with alcohol or drug use problems—there was no mention of youth.
Barker & Maguire (2017); UK	4 databases + grey literature + conference abstracts Search 1946–Feb 2015 11 publications of 10 studies	Peer support had significant impacts on quality of life, drug/alcohol use and social support. Shared experiences, role modelling and social support appeared to be vital aspects of peer support and led to moderate changes for clients; however, most studies were of low to moderate quality.	The focus was on people who were homeless including young adults (age 18+); 2 of 10 studies were exclusively in young adults and another had 17% under age 30.
Eddie (2019); USA	4 databases Search end date Oct 2018 24 publications including 7 RCTs	Peer support has potential across a number of substance use treatment settings; however, its effectiveness must still be established. Ethical and practical challenges to peer support include roles, work schedules, expectations, funding and fit with traditional 12-step services.	There were no age restrictions, but youth were not specifically mentioned and the mean age of study participants was not reported.

As Table 2 shows, there were four SRs relevant to peer support for substance use, although there was no specific focus on youth. Overall, the SRs suggested that research in this area shows promise but it appears to be "early days" with respect to evidence of benefit.

According to the authors of the most recent SR (Eddie et al 2019), while a number of individual studies have made a compelling case for peer support in substance use, research is limited. Eddie et al (2019) noted that earlier SRs published by Reif et al (2014) and Bassuk et al (2016) reported that peer support has been associated with benefits such as reduced substance use and relapse rates, as well as improved relationships with treatment providers and social supports. However, both reviews expressed concerns about primary study quality, including: (a) poor methodological rigour; (b) small sample sizes; (c) heterogeneous populations; (d) inconsistency in the definitions of peer workers; (e) lack of comparison groups; and (f) inconsistencies in the quantity of peer-provider supervision. All SR authors pointed out a need for further research to determine the effectiveness of peer support services in substance use.

4.2. Publications specific to youth peer support for substance use

Ten publications, including two narrative reviews[3] (Table 3) and eight primary studies (Table 4 on page 12), reviewed initiatives involving peer support provided by and for youth in substance use.

Table 3: Narrative reviews of initiatives of youth peer support in substance use

Lead author (year)	Topic	Findings
Canadian Centre on Substance Use & Addiction (CCSA) (2016); Canada	Youth peer-to-peer sports programs to address drug prevention in young athletes	Peer-to-peer sports programs (n=11) appeared to effectively engage participants and resulted in less intention to use substances and more inclination to adopt healthier habits. The authors highlighted the need to provide healthy alternatives in substance use prevention and pointed to the value of a sports team as an information source, instilling behaviour change throughout peers.
Nash et al (2016); USA	Description of the "Alternative Peer Group (APG)" model (Developed in the 1970s in Houston, Texas and still in use in a number of areas)	APG integrates recovering peers and prosocial activities into clinical practice. The APG model relies on the positive social influence of recovering peers and adults through regular fun, structured prosocial activities. APGs aim to build adolescents' "recovery capital" and help them establish pro-recovery social networks. Program alumni can become skilled peer role models for newly enrolled teens and families.

3 Unlike protocol-based SRs that are concerned with minimizing bias in evidence interpretation, narrative reviews are less structured and based more on authors' experience and intuition and this can introduce bias (Pae 2015).

Table 4: Primary studies of youth peer support in substance use initiatives

Lead author (year)	Intervention type study details	Findings
Cigarettes		
Haines-Saah (2015); Canada	**"Picture Me Smokefree"** n=60 youth (ages 19–24) who participated in a smoking cessation photo Facebook group over 12 weeks	The program model was feasible. The authors concluded that tobacco interventions for young people should be embedded within the existing social networking platforms they access most frequently, rather than designing a stand-alone online prevention or intervention resource.
Li (2017); Hong Kong, China	**Evaluation of a Youth Quitline Service** n=1,694 young smokers (mean age 18) who received counselling by phone from trained peers over 10 years	The Youth Quitline successfully increased youths' awareness of the risks of smoking and smoking cessation services and provided individualized smoking cessation counselling services to young smokers. At six-month follow-up, 24% had quit, 17% had cut down by >50% and 34% had tried quitting.
Vaping / E-cigarettes		
Gentina (2017); France	n=666 adolescents ages 14–17 surveyed at 3 schools	Positive (informal) peer support was associated with less vaping, whereas loneliness and susceptibility to peer influence were linked with vaping—in both cases, more so for girls than boys.
Substance use		
Mason (2015), Mason (2017); USA (2017 is specific to heavy cannabis use)	**Peer Network Counselling (PNC)** Using peers trained in motivational interviewing (single session). n=119 teens (mean age 16) who reported occasional or problem substance use, mainly alcohol and marijuana	Mason (2015): A significant intervention effect was found for boys re offers to use alcohol from friends, along with a significant effect on decreasing alcohol use. The intervention reduced marijuana use for youth who had positive and prosocial peer networks. Mason (2017): PNC increased the probability of abstinence and reduced heavy cannabis use.
Laudet (2016); USA	**College Recovery Programs (CRPs)** n=486 students (median age 23, range 17–58) from 29 CRPs surveyed in 2013 about their reasons for enrolling in a CRP	CRPs are campus-based (informal) peer support programs for students recovering from substance abuse, e.g., alcohol, stimulants, heroin. Survey results showed the top reasons for joining a CRP were the need for same age peer recovery support and wanting to "do college sober."
Nash (2019); USA	**Alternative Peer Group (APG)** n=12 teens ages 15–19 in the southern USA surveyed about APG recovery barriers and resources to promote recovery	Participation often generated a tightly knit group of pro-recovery peers. Involvement in APG social norms led to development of participant "recovery capital" with positive changes in attitudes and beliefs about substance use, behaviors and social identity.
Winn et al (2019); USA	**Project Amp** A 4-session 1:1 early intervention to enhance SBIRT (screening, brief intervention and referral to treatment) for teens Trained peer mentors in recovery ages 18–28 (n=30) worked with participants ages 13–17 (n=20)	Sessions focused on interests and goals, social supports and influences, wellness and community supports. Six-month outcomes showed positive movement on adolescent measures of substance use risk, well-being, self-efficacy, coping skills, resistance to peer influence, social support and attitudes and perceptions of substance use.

4.3. Core competencies for peer support workers

The USA Substance Abuse and Mental Health Services Administration (SAMHSA) identified the core competencies[4] needed by people who are providing peer support services to people with, or in recovery from, a mental health or substance use condition (SAMHSA 2015). The core competencies pertain to services delivered by or to adults, young adults, youth and family members and are based on foundational principles shown in Table 5. The principles were identified by the mental health consumer and substance use disorder recovery communities.

Table 5: Principles underlying core competencies for peer support workers (SAMHSA 2015)

Principle	Detail
Recovery-oriented	Peer workers hold out hope to those they serve, partnering with them to envision and achieve a meaningful and purposeful life. Peer workers help those they serve to identify and build on strengths and empower them to choose for themselves, recognizing that there are multiple pathways to recovery.
Person-centred	Peer support services are always directed by the person participating in services, are personalized to align with the hopes, goals and preferences of the individual served and respond to specific needs an individual has identified to a peer worker.
Voluntary	Peer workers are partners or consultants to those they serve. They do not dictate the types of services provided nor the elements of recovery plans that will guide their work with peers. Participation is always contingent on peer choice.
Relationship-focused	The relationship between a peer worker and a peer is the foundation on which peer recovery support services are provided. The relationship between a peer worker and a peer is respectful, trusting, empathetic, collaborative and mutual.
Trauma-informed	Peer support uses a strengths-based framework that emphasizes physical, psychological and emotional safety and creates opportunities for survivors to rebuild a sense of control and empowerment.

Based on the foundational principles above, SAMHSA developed core competencies. Peer support competencies were also developed by Peer Support Canada[5] (Table 6 on page 14). Earlier material from the Mental Health Commission of Canada is similar (Sunderland & Mishkin 2013).

4 Core competencies are defined as the knowledge, skills and attitudes a person needs to have in order to successfully perform a role or job—or as the ability to integrate the necessary knowledge, skills and attitudes. Training, mentoring and supervision can help people develop the competencies needed to perform a role or job (SAMHSA 2015).

5 Peer Support Canada was established in 2010 to promote the growth, recognition and accessibility of peer support. The organization provides certification of peer support workers. It has now merged with the Mental Health Commission of Canada (more at: peersupportcanada.ca).

Table 6: Core competencies for peer support (Peer Support Canada 2017)

Principle	Detail
Interpersonal relations	Interacts in a manner that honours the dignity of others and strives to build positive and respectful relationships. Strives to make others feel comfortable and conveys genuine interest in the peer. Even in a difficult or tense situation, strives to maintain a level of respect and consideration for the other.
Demeanor	Is sensitive to what another might be feeling, demonstrates a capacity for nonjudgmental empathy and responds from an equal, genuine and sharing point of view. Selectively self-discloses own experience in a manner that ensures the relationship remains peer-focused.
Communication	Listens with empathy and without judgement, holding peers in unconditional high regard. Uses communication styles and skills to improve understanding and adapts the style and tone of communication to suit the listener and the situation. Communicates using recovery language and emphasizes the strengths of the peers.
Critical thinking	Engages in active listening skills to better understand a situation and recognizes that there is more than one way to look at an issue. Considers the possible implications or outcomes of actions and will help peers to explore the outcome or possible consequences of various options, when asked. Demonstrates good judgement in respecting the limits and boundaries of the role.
Hope	Operates from a sense of hope, expressing confidence that others will be successful in their own personal journeys of recovery. Strives to model realistic optimism and a belief that, even in difficult situations, positive choices can be made.
Self-management & resiliency	Understands the importance of self-care and stress management and models the practices that work best for them to remain healthy while supporting others. Strives to maintain calm and diffuse stressful or challenging situations.
Flexibility & adaptability	Is open to new ideas, deals comfortably with ambiguity and adjusts plans or behaviour to better suit a given situation. Is willing to be open-minded and compromises when needed.
Self-awareness & confidence	Interacts in a manner that demonstrates a balance of self-confidence with openness to the thoughts and opinions of others. Self-reflects and understands that personal thoughts and attitudes can influence behaviour and actions.
Initiative & commitment	Is dependable and carries tasks through to completion. Demonstrates good judgement, knowing when insight or assistance should be requested from another and is trustworthy when working independently.
Teamwork	Shares knowledge, ideas and resources with team members in a cooperative and collaborative manner. Strives to fulfill the peer mentor role and responsibility within the team while respecting the roles and responsibilities of the other team members.
Continuous learning & development	Strives to approach life and work in a curious manner, identifies areas where personal growth may be helpful and takes advantage of opportunities to learn and develop. Recognizes the value of on-going personal growth and skill development and maintains a connection with a peer support community as a resource to stay “grounded” in the work of authentic peer support.

4.4. Peer support training

Providing an international perspective, O'Hagan (2011) from New Zealand (NZ) noted that, at the time of publication, peer support curricula and qualifications had been developed in England, NZ, the USA, Australia, Canada and Scotland, including national curricula in the latter three. The curricula emphasize lived experience and recovery as foundations for peer support, although to date the focus has been on mental health more than substance use. Overall, curricula have tended to concentrate on: (a) personal development (e.g., understanding one's own distress and recovery and personal skills, plus work-related personal development); (b) knowledge development (e.g., well-being, mental distress, addiction and recovery); and (c) skills development (e.g., process, one-to-one, group, workplace and community).

Not all peer support workers have received formal training. An online Ontario survey conducted in 2014[6] that focused on peer support for mental illness found the following responses for required training or certification among peer support workers (Table 7):

Table 7: Qualifications for Ontario peer support worker (OPDI 2014)

Type of qualification	Paid	Volunteer
Training and/or certification	50%	35%
Job-related experience	52%	19%
Lived experience with mental illness	84%	49%
Lived experience with the mental health system	60%	44%
Other	16%	23%

The requirement for training for peer support workers seems to be variable. A USA review of peer support in the emergency department (ED) that focused on aiding people who had survived opioid overdoses stated, "*Employment requirements and hiring processes for peer support workers differ greatly due factors such as state or county regulations, hospital rules and codes, and unique community factors. Regulations often dictate which trainings or certifications are required and many states have their own certification. Most trainings or certifications include topics such as peer ethics, the science of addiction, motivational interviewing, and multiple pathways to recovery. Organizations looking to employ peer support workers should ensure that they are abiding by any state or local requirements for employment, particularly if peer support services are reimbursable by specific payers.*" (NCHB 2019)

6 Although the exact number of peer support workers reached through the survey recruitment process was unknown, a total of 154 people responded to the survey from 50 cities and 85 organizations (111 were paid workers and 43 were volunteers) (OPDI 2014).

Length of time in recovery is another consideration when hiring. According to the USA ED review, a requirement for a minimum of two years is common, with a range from several months to four years. Besides recovery time requirements, other considerations are screening applicants to ensure "right fit" in the ED setting, having ED staff participate in the interview process and the use of shadowing/on-the-job training prior to official start date (NCBH 2019).

Peer support training in Canada has been developed by several bodies. For example, the Ontario Peer Development Initiative (OPDI) is an umbrella organization of mental health and peer support organizations across the province. Since about 1990, OPDI has played a role in providing support, coordination, research, training and advocacy for peer support and consumer-led initiatives across Ontario (OPDI 2016). The OPDI Peer Support Core Essentials™ program uses face-to-face and webinar-based training and builds capacity by ongoing education of its trainer community of practice (OPDI 2016).

Likewise, PeerNetBC offers services in capacity-development and training for peer support and peer-led groups, with an interest in the growth and sustainability of diverse peer support and peer-led groups. It is unclear whether peer support in substance use has received specific attention, although there is mention of involvement of youth in the activities (PeerNetBC 2020).

The Mental Health Commission of Canada (MHCC) has produced guidelines for peer support training, although they appear to be focussed on adults (Appendix B).

With respect to training of youth in peer support, scant information was found:

- **The Oregon Youth Empowerment Support (YES!) Program 2013:** In Portland, a locally-initiated program[7] implemented a peer support specialist role for youth and young adults ages 12–26.[8] The program hires youth ages 18+ with a strong work ethic; who are dependable, flexible and adaptable; who can work cooperatively and decisively with individuals and groups with different educational, economic, cultural and racial backgrounds; and who have the knowledge of and ability to learn positive youth development, strengths-based practice and cultural competence. Candidates must also pass a criminal background check and drug screening. Staff members are then trained in motivational interviewing, suicide prevention and cultural competency, and they receive training from California's Youth Development Institute. Other training is provided as needed, and county and community partners provide affordable training and online resources.

7 The project is funded by the USA National Institute on Disability and Rehabilitation Research, US Department of Education, and the Center for Mental Health Services Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services.

8 Although focussed on people with serious mental health conditions, the logistics of the program may provide useful information for a substance use program.

- **Pisani et al 2019:** A New York study briefly described training for a text message initiative focused on substance use prevention in which 8th grade students were trained to be peer leaders. All 8th grade students were asked via questionnaire to identify several students seen as leaders, and administrative staff added students to the list to increase diversity and expand into different social groups. Of the 58 students identified, 41 (71%) participated as peer leaders. In initial 3-hour training, peer leaders were coached to: (a) identify positive personal and relational resources that help them stay "true to themselves"; (b) identify negative social influences; (c) adopt personal resistance strategies; and (d) learn accurate information about peer drug and alcohol use. Trained adult mentors facilitated a number of half-hour meetings over three months to help the peer leaders plan and conduct the campaigns.

4.5. Peer support accreditation and certification in Canada

Peer Support Canada/Mental Health Commission of Canada has published guidance on peer support accreditation and certification (PSACC 2016). Details are provided in Appendix C.

4.6. Peer support barriers and enablers

A BC study (focused on adults ages 18+) assessed the barriers and enablers to peer support for substance use (Greer et al 2019). Thirteen focus groups around the province (all but one outside Vancouver) involved 83 people who were using or had used illicit drugs, excluding marijuana. Demographics were 43% female, mean age 44, 36% Indigenous and mean drug use 44 years. (Note that a number of the participants had only engaged in peer support once or twice or not at all.) The group facilitators were also people who had used drugs.

- Barriers to peer engagement included individual, geographical, systemic and social factors including issues related to stigma, confidentiality and mistrust. Being "outed" in one's community was a barrier to engagement, particularly in rural areas.

- Engagement was facilitated by compensation (this showed respect and value for time and knowledge); setting (convenient and confidential); consistency (promoted trust and capacity building); use of the right people (peers); and use of peer networks.

4.7. Concerns about unresolved issues and a downside to peer support

In a background paper on peer support in mental health and addictions, O'Hagan (2011) listed a number of unresolved issues and challenges in peer support (Table 8 and Table 9).

Table 8: Unresolved issues and challenges in peer support

The difference in role between friendship and the peer support relationship
The degree to which being a paid peer support worker compromises reciprocity
How peer supporters can keep permeable boundaries and avoid the burnout that can come from over-involvement
How peer support workers frame and deal with risk
How peer support workers deal with information and privacy issues
The risk that peer support qualifications will erode the "natural" peer support relationship and deny employment opportunities to some people who have not completed school qualifications
The need to build an evidence base using methodologies and outcome measures consistent with its values of empowerment, participation, recovery and hope
How to manage the tensions between peer support values and the values played out in the mental health system and stay true to peer support
How peer support workers should avoid slipping into old ways learned in the mental health system regarding thinking about and treating people

Table 9: Systemic challenges in peer support

Lack of access and referral to peer support
Inadequate planning and funding
Poorly targeted accountabilities
Lack of workforce development

Additional comments from researchers:

- **Potential confusion around the boundaries of friendship and a staff-client relationship (Barton & Henderson 2016):** By design, peer leaders disclose personal and intimate information about their experiences. Mentees may therefore desire or assume a level of friendship that is beyond the scope of the treatment setting, i.e., how can peer leaders succeed at being friendly with clients without actually becoming friends with them?

- **Support from peers in the absence of family support (Moore et al 2018):** A 2013 study in Wales tested the roles of family, peer and school relationships in predicting substance use, subjective well-being and mental health symptoms among about 9,000 11 to 16-year-olds. Results showed that relationships with family and school staff can protect young people against substance use and interventions focused on student-staff relationships may be important for young people with less family support. However, interventions based on (informal) peer support should be mindful of potential harmful effects for pupils with less support from family, i.e., where young people perceive limited closeness to family members, influence from peers may become greater than that of family members, and lower levels of family support may therefore exacerbate the more negative influences of adolescent social relationships on young people's health and well-being.

5. Summary

The report's objective was to explore the evidence relevant to the use of peer support for youth and substance use. Although this is an area that shows promise and there is a need for effective treatments, it is "early days" in terms of published evidence reporting on peer support in substance use (versus mental health), particularly for youth.

Specific peer support evidence for youth and substance use was sought, but the net had to be cast more widely due to the lack of directly relevant material.

- To determine the effectiveness of peer support in substance use overall, four SRs were identified. The SRs focused primarily on services by and for adults and reported that some individual studies were supportive. However, all SR authors commented on low study quality and the need for further effectiveness research to confirm benefit.

- With respect to youth peer support for substance use, two narrative reviews and eight primary studies were identified.
  - One review focused on prevention through use of sport programs and found benefits engaging young people and documenting lower intentions to use substances (CCSA 2016). The other described a program in the USA called the Alternative Peer Group (APG) that integrates recovering peers and prosocial activities into clinical practice, relying on positive social influence; however, no outcomes were reported (Nash et al 2016).
  - The eight primary studies covered traditional cigarettes (two), vaping (one) and overall substance use (five). Not all included outcomes. With respect to smoking cessation, a Canadian study found that embedding smoking cessation information into social media was feasible and encouraged use of existing social networking platforms versus designing stand-alone online resources (Haines-Saah et al 2015). The other evaluation of 10 years of a Youth Quitline in Hong Kong reported successful six-month outcomes (Li et al 2017). For vaping, a study in France looked at informal peer support and found this was associated with less vaping in those mentored, more so for girls (whereas loneliness and susceptibility to peer influence were linked with higher rates of vaping) (Gentina et al 2017). The five primary studies on substance abuse reported on four programs designed for young people in the USA: Peer Network Counselling, Alternative Peer Group, Project Amp and College Recovery Programs. At least two use trained youth peers and the first three programs (reported in four studies) listed reported benefits for peer support recipients (Mason et al 2015, Mason et al 2017, Nash et al 2019, Winn et al 2019). The reference on College Recovery Programs reported on a survey of recipients as to why they had participated (Laudet et al 2016).

There has been some work in BC about the barriers and enablers to peer support for substance use (not specific to age) where Greer et al (2019) led focus groups around the province involving people who were using or had used illicit drugs. Barriers to peer engagement included individual, geographical, systemic and social factors, whereas engagement was facilitated by compensation, setting, consistency, use of the right people (peers) and use of peer networks.

O'Hagan (2011) identified issues and challenges in providing peer support, e.g., role differences between friendship and a peer support relationship and dealing with issues around information and privacy. Systemic issues were listed as lack of access and referral to peer support, inadequate planning and funding, poorly targeted accountabilities and lack of workforce development.

Beyond exploring the evidence for the impact of youth peer support in substance use, this report presents efforts published in the areas of core competencies for peer support workers, including the foundational principles underlying these competencies. Training for peer support workers, as well as accreditation and certification in Canada, are also discussed. Growing interest in the field is reflected in work around foundations, training and ultimately certification to ensure that peer workers provide suitable high-quality services.

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Appendix A: MEDLINE Search Strategy

SEARCH: Database(s): Ovid MEDLINE(R) ALL 1946 to February 18, 2020

TERMS		# HITS
1	exp Peer Group/ and exp Social Support/	2758
2	exp *Self-Help Groups/	5685
3	((peer* adj3 (advis* or coach* or counsel* or engage* or support*)) or "peer-to-peer" or (recover* adj2 (enhanc* or promot* or support*))).tw,kf.	24973
4	((((lived or understanding) adj experience?) or recovery or (support* adj program*)).ti,kf.	83162
5	((selfhelp* or self-help*) adj5 group?).ti,kf.	641
6	or/1-5	107462
7	exp Substance-Related Disorders/	273490
8	exp *Amphetamine/	10747
9	exp *Methylphenidate/	5069
10	exp *Cocaine/	18114
11	*Ephedrine/	3017
12	exp *Phenylpropanolamine/	2019
13	exp *Smoking/	72980
14	exp *"Tobacco Use"/	2757
15	((amphetamine* or amfetamine* or centramina or desoxynorephedrin or levo-amphetamine? or lofetamine? or p-Hydroxyamphetamine? or dextroamphetamine? or molly or ecstasy or MDMA or ephedrine* or MDPV or mephedrone? or methamphetamine? or methylphenidate? or ritalin or cocaine* or phenylpropanolamine? or propylhexedrine? or pseudoephedrine? or pseudo-ephedrine? or dexedrine? or adderall or MDA or N-Methyl-3,4-methylenedioxyamphetamine? or speed or Methylphenidate) adj3 (abus* or addict* or dependen* or disorder? or misuse* or mis-use* or overdos* or over-dos* or smok* or use? or using)).ti,kf.	9308
16	((alcohol* or ecigaratte? or e-cigarette? or ecig? or e-cig? or cannabis* or cigarette? or crack or drug? or glue? or hash* or heroin or inhalant? or marijuana* or marihuana* or medication? or medicine? or morphine* or narcotic? or nicotine? or opiate* or opioid* or opium* or pharmaceutical* or phencyclidine? or prescription? or substance? or tobacco* or vape?) adj3 (abus* or addict* or dependen* or disorder? or misuse* or mis-use* or overdos* or over-dos* or smok* or use? or using)).ti,kf.	161041
17	(addiction* or (binge? adj drinking) or ((co-occur* or concurrent) adj disorder?) or (harm? adj reduc*) or ((mental* or psychiatr*) adj2 (disease* or disorder* or health* or ill*))).ti,kf.	134107
18	or/7-17	544959
19	6 and 18	6162
20	limit 19 to ("child (6 to 12 years)" or "adolescent (13 to 18 years)" or "young adult (19 to 24 years)")	1336
21	(adolescenc* or adolescent? or collegiate or college* or teen? or teenage* or teen-age* or youth? or (young* adj2 adult?) or university or universities).mp,kf.	2878454
22	(("12" or "13" or "14" or "15" or "16" or "17" or "18" or "19" or "20" or "21" or "22" or "23" or "24") adj3 year? adj old*).ti,ab,kf.	162987
23	or/21-22	2941608
24	19 and 23	1544
25	20 or 24	1603

TERMS		# HITS
26	exp animals/	22957443
27	exp animal experimentation/ or exp animal experiment/	9303
28	exp models animal/	556603
29	exp vertebrate/ or exp vertebrates/	22307309
30	or/26-29	22959379
31	exp humans/	18287908
32	exp human experimentation/	12411
33	or/31-32	18288562
34	30 not 33	4671441
35	25 not 34	1600
36	limit 35 to (english language and yr="2015 -Current")	756

Appendix B: Peer Support Worker Training

Guidelines for peer support training (no age specified) were issued by the Mental Health Commission of Canada in 2013, with a focus on peer support for mental health challenges (Sunderland & Mishkin 2013). At the outset, training is based on the following background considerations for each trainee:

- **Lived experience:** The recollection of, and insights gained from, each participant's personal experience and recovery path will enhance their understanding of concepts being presented. Participants will also learn from the insights shared by others.
- **Self-awareness:** Each participant enters training with a certain degree of awareness of their personal stressors, resilience strategies, areas of strength and areas still requiring attention, heightened due to their lived experience and recovery path.
- **Innate interpersonal communication skills:** Interacting with and supporting others is a normal social function. Participants will likely have already been in supportive relationships and have discovered an innate ability and a strong desire to help others. The goal in training is to further enhance each person's natural approach, making them aware of potential pitfalls and different strategies so they can build on their existing strengths.

Recommended training themes are shown in Table B1.

Table B1: Recommended training themes for peer support (Sunderland & Mishkin 2013)

Theme	Detail
Fundamental principles	Fundamental principles such as the gift of lived experience, the power of hope, the concept of recovery and the value of self-determination set the stage for the remainder of peer support topics. An understanding of peer support values and ethics and the range of settings in which peer support can take place also enhance a prospective peer support worker's understanding of their role.
Social and historical context	Peer support happens in the context of human relationships, where each person brings the impact of life experience that might include discrimination, stigma, social exclusion, poverty and trauma. A peer support worker who understands the broader social and historical context of these experiences and grasps their potential impact will be better prepared to support others.
Concepts and methods that promote peer-to-peer effectiveness	Peer support relies on interpersonal communication, building trust within relationships and supporting other people as they choose to take steps towards change and recovery. Peer support workers often have an innate ability to do this, but these skills can be enhanced through sharing knowledge and learning through experience. Other areas of importance include negotiating limits and boundaries within a peer relationship, collaborating with community resources and building resilience through self-care. Resilience and self-care are equally important for peer support workers to foster their own wellness.

The Mental Health Commission of Canada provided the following training guidance (oriented to adults) (Sunderland & Mishkin 2013):

- The participatory approach to training, in which learners are directly engaged in their own learning, is more empowering and has the best results, i.e., provide less in the way of lectures and more experiential activities such as interactive discussions, small group exercises, individual reflection and journaling, role playing and learning from demonstrations (recorded or live) of role-play scenarios.

- Prior to developing or delivering a training session, education theories and approaches should be researched to ensure an effective learning opportunity is provided.

- Continued development of skills occurs through practice in real-life situations. If the opportunity exists, a new peer support worker can benefit from observing and functioning in the role with guidance from an experienced worker.

- Progression can occur from role-playing, through shadowing, to practice opportunities with close supervision and support and finally to working on one's own.

- Practical considerations include:
  - **Scheduling:** Training may occur in the span of several days or be spread out across a period of time. This is dependent on the prefer¬ence of the training organization and the needs of the participants. Some prospective peer support workers may require flexibility in terms of in-class duration and/or pace or progression of training in order to fully comprehend and integrate the knowledge being offered. Peoples' ability to learn in a class¬room environment does not necessarily predict their success as empathetic and supportive peer workers.
  - **Accessibility:** Because prospective peer support workers come from a wide variety of situations, geographic regions, cultural norms and income groups, there may be challenges in arranging training.
  - **Diversity:** Facilitators and organizations must respect and learn from the insights that potential peer support workers bring, and they may need to innovate to meet the specific needs.

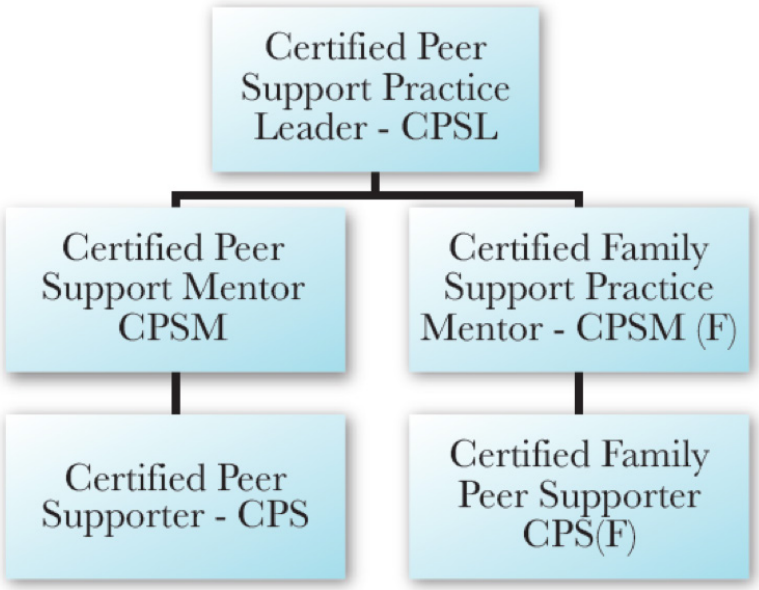
Appendix C: Accreditation and Certification

Peer Support Canada, with assistance from the Mental Health Commission of Canada, published a peer support National Certification Handbook in 2016 (Version 3). It includes Standards of Practice and the certification process for Certified Peer Supporters and Certified Peer Support Mentors. A key resource in the development process was the Peer Leaders Group, consisting of 13 people from all provinces and territories except Prince Edward Island and the Northwest Territories and other advisors recognized for peer support expertise (PSACC 2016).

Peer Support Accreditation and Certification Canada (PSACC) formalized national (voluntary) peer support certification to indicate that a peer support worker (or "peer supporter") has attained PSACC's national standards. The rationale is that certifying peer supporters recognizes the contribution of peer support in the mental health and addiction fields and endorses peer support work as a valid and respected career.

A number of different roles are certified (Figure 1).

Figure 1: Peer support roles certified by PSACC (PSACC 2016)

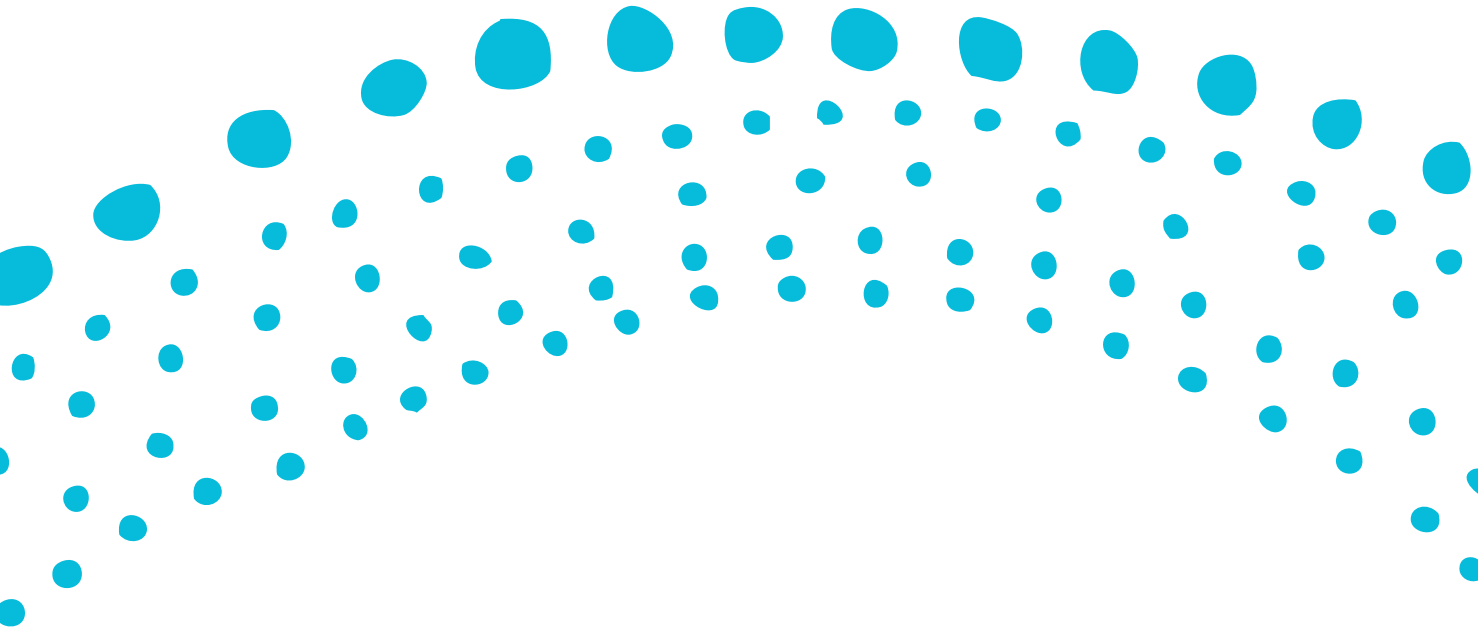


The requirements to achieve certification as a peer support worker ("peer supporter") are based on PSACC Standards of Practice. To become certified, a peer support worker must:

- Disclose lived experience through to a path of recovery (personally or as a family member);
- Successfully complete the PSACC assessment of knowledge standards;
- Sign the PSACC Code of Conduct;
- Demonstrate acquired experience by successfully completing a supervised practicum or by demonstrating previous experience providing one-on-one peer support with a credible and recognized provider of peer support services; and
- Meet PSACC's competency requirements.[9]

PSACC also offers certification for peer support mentors. Details are included in the PSACC (2016) document. Re-certification of the various roles/titles is also available.

9 A final competency assessment occurs following the acquired experience/practicum component. Mentors, supervisors and others are asked to complete a competency questionnaire, and the candidate also completes the same questionnaire. Feedback from peers who have received support from the candidate is sought. This results in a 360-degree assessment on a person's competencies.



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