# Peer Recovery Support Specialists in Adult Drug Treatment Courts: A National Survey

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**MUCH OF THE** success of treatment courts is attributed to the formal coordination of professionals from across systems and disciplines to address the needs of justice-involved individuals with substance use disorders. Treatment courts were purposefully designed to holistically address the multiple needs of participants in real time and to coordinate access to the fragmented systems of care necessary to improve justice and treatment outcomes (Lutze & van Wormer, 2014, 2007; National Association of Drug Court Professionals, 1997). Even with these coordinated efforts, it can be difficult for treatment court professionals to fully understand, from the participants' perspectives, what it is like dealing with the National Association of Drug Court Professionals (NADCP) emotional, psychological, and practical demands of participating in these programs.

In response, treatment courts have started to include peer support within the court and staffing processes. The peers have lived experience with treatment and recovery and may have been graduates of a treatment court program. Peer support services are intended to be oriented to recovery by supporting participants in achieving meaningful purpose, personalizing services within a voluntary relationship based on respect, trust, empathy, and collaboration steeped in trauma-informed care (see National Association of Peer Supporters, 2019; SAMHSA, 2020). Although peer support services appear to be aligned with much of the treatment court model, little is known about how peer support is being implemented by treatment courts across the United States.

The purpose of the current study is to (1) determine the extent to which peer support is being implemented in adult drug treatment courts (ADTC), (2) describe how peer support workers are being used by adult drug treatment courts, and (3) determine if there are common models of peer support emerging in adult drug treatment courts across the nation. We begin by defining peer support and how it may align with the treatment court model. Second, we review prior research on the implementation and effectiveness of peer support in general and in treatment courts specifically. Finally, we build upon existing research by presenting the results of a national survey of adult treatment courts and the use of peer recovery support specialists (PRSSs).

## Defining Peer Recovery Support Services

Peer support originated as a movement by those in recovery to resist the justice and mental health systems' narrow conceptualization of mental illness as a lifelong deficit of being a "mental patient" or an "addict" with perpetual illness and disability (Mead et al., 2001; Ostrow & Adams, 2012; White & Evans, 2013). Peers, formally and informally, were demonstrating that they can and do get well when allowed to inform the process about their care. The peer recovery movement initiated a shift from the inflexible and oppressive nature of a deficit-based philosophy in the justice and mental health systems to a strength-based approach in which clients are empowered to participate in decisions about their treatment and given hope about their future (du Plessis et al., 2020; Mead et al., 2001; White, 2007; White & Evans, 2013). Thus, the commonly used definition of peer support is built upon trusting relationships and mutual agreement in pursuing care. Thus, *peer support* is often defined as "a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful. … It is about understanding another's situation empathically through the shared experience of emotional and psychological pain" (Mead et al., 2001, p. 4; also see SAMHSA, 2015).

Peer-based support for individuals with substance use disorder (SUD) is often associated with self-help initiatives such as

Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and other types of recovery communities (such as therapeutic communities and Oxford Houses), where relationships are reciprocal in exchanging support and guiding each other through the process of recovery based on shared lived experiences (see Bassuk et al., 2016; Taylor, 2014; White & Evans, 2013).

Recognizing peer support as important to recovery was instrumental in the evolution and development of peer-based recovery services for those with SUD (White & Evans, 2013). Peer-based recovery support services[1] are defined as "the process of giving and receiving nonprofessional, nonclinical assistance to achieve long-term recovery from substance use disorder" (Bassuk et al., 2016, p. 1; also see White & Evans, 2013). Thus, peer support services remain true to the origins of the peer support movement by acknowledging a degree of separation and independence from formal systems of care, emphasizing "nonprofessional, nonclinical assistance" based on mutual benefit between those initiating and participating in recovery (White & Evans, 2013).

Yet, more recent conceptualizations of peer support have evolved into a hybrid of the informal and nonclinical and the formal professional specialization including through educating, training, and certifying people to become Peer Recovery Specialists (PRS) (SAMHSA, 2020). Thus, the relationship is no longer reciprocal in providing mutual aid, because the peer provider is not at the same skill level or degree of recovery to mutually benefit (Chinman et al., 2014, p. 3). *Peer recovery specialists* are defined as "…individuals trained to utilize their lived experience of recovery from mental health disorder or SUD to help others succeed in their recovery" (Belenko et al., 2021, p. 2).

White and Evans (2013, p. 4) suggest that peer recovery support services represent "a new category of specialized resources—not treatment and not purely mutual aid—that link and supplement traditional recovery mutual aid and addiction treatment" (also see Eddie et al., 2019, p. 2). The incorporation of peer recovery specialists into the recovery support model commonly mirrors implementation models of recovery support services (Chinman et al., 2014; White & Evans, 2013). For example, recovery support services are often delivered through a "sequential model" (professional care followed by recovery support services), "parallel models"(simultaneous delivery of professional and recovery support services), and "integrated models" (treatment services and recovery support services delivered by the same organization or highly coordinated multiagency teams) (White & Evans, 2013, p. 4).

Interestingly, it is unknown how treatment court professionals are envisioning or incorporating peer recovery support within the treatment court model. Given that treatment courts are informed by research and sustained through evidence-based practices, it is important to know whether peer support remains an informal practice of mutual aid informally exchanged between participants or whether it is formally constructed, clearly defined, and qualifies as a new category of promising or evidence-based practice.

## Peer Support and the Treatment Court Model

Treatment courts are uniquely positioned to elevate recovery by engaging participants in strength-based approaches that build supportive relationships, create opportunities for change, and promote the stability necessary to sustain recovery over time (Taylor, 2014; Zschau et al., 2016). The movement to integrate peer support into the treatment court model appears to be a natural evolution, as several of the key components and best practices guiding adult treatment courts encourage opportunities for participants to inform their care and for professionals to be flexible in their decision making (Lutze & van Wormer, 2014; National Association of Drug Court Professionals, 1997, 2018b, 2018a). For example, participants' ability to communicate directly with the case manager each week and with the judge during weekly court hearings allows participants to share responsibility for creating an individualized treatment plan while building mutual trust, respect, and understanding with the treatment court team (Key Component 7; see NADCP 1997, 2018a, 2018b). Relatedly, treatment court participants are required to regularly attend court hearings, especially during phases one and two, to witness and to share in the experience with others involved in the same process, and they are likely to have similar lived experiences.

In addition, interdisciplinary treatment court teams are purposefully designed to coordinate and streamline the process for participant engagement with the traditional justice system, the SUD/mental health treatment systems of care, as well as access to support services necessary to improve participants' quality of life and to build recovery capital (Key Components 1 and 4) (National Association of Drug Court Professionals, 1997; Taylor, 2014; Zschau et al., 2016). Similarly, the non-adversarial approach between defense and prosecution is made easier by the professional expertise and collaboration between team members (i.e., probation, police, treatment, case manager) in presenting the pros and cons about what evidence-based interventions are most likely to work in motivating or changing behaviors (Key Components 2, 6, & 9) (Lutze & van Wormer, 2014, 2007; Mei et al., 2019; National Association of Drug Court Professionals, 1997). Each of these elements of treatment courts provides an opportunity for staff and clients to engage in humanistic, informed contexts that are often missing from the traditional justice system.

Although treatment courts provide many opportunities for professionals to understand another's situation and to serve with empathy and compassion, the original design does not purposefully include those with lived experience who may fully understand "another's situation empathically through the shared experience of emotional and psychological pain" (Mead et al., 2001, p. 4). Process evaluations, however, suggest that treatment courts have attempted to create spaces for informal peer support to exist. It is common for treatment courts to encourage successful participants and graduates to remain involved by creating voluntary participant support groups, mentoring programs, and alumni groups to provide support for each other based on a foundation of shared lived experience (McLean, 2012; Taylor, 2014). Thus, the most recent trend in treatment courts to integrate peer recovery support specialists (PRSSs) into the model appears to be a natural progression building on existing practices.

Yet, there may also be challenges to incorporating peer support into the treatment court model. Peer support is grounded in

[1] Peer recovery support workers are often referred to by different titles depending on the discipline in which they serve. Titles often include peer mentor, certified peer specialist, peer recovery specialists, peer support specialists, and other similar variations of these. Certified and specialist generally refer to those with formal training. When reviewing the research, we use the term used by the study's authors reflecting those being studied. For consistency in the current study, we use "Peer Recovery Support Specialist" (PRSS) to capture adult drug treatment courts' focus on SUD "recovery" and "support specialist" to reflect the general structure of drug courts and the importance of formal training to an evidence-based service delivery model.

voluntary, mutual relationships based on trust and respect within the process of giving and receiving nonprofessional, nonclinical assistance (White & Evans, 2013). A key feature of treatment court is the leveraging of sanctions to motivate compliance with program rules, treatment attendance, and participation in prosocial behaviors such as work and education. Noncompliance can result in curfews, loss of privileges, extended time in the program, jail time, and ultimately a return to traditional systems for processing (such as criminal justice, child protective services, and mental health) (Lutze & van Wormer, 2014, 2007). A return to use may also result in treatment program changes, increased treatment intensity (i.e., intensive outpatient to residential), a return to earlier program phases, increased drug testing and surveillance, and in some courts, additional sanctions. The coercive leverage that treatment courts hold may cause tension between peer support as envisioned by the movement's reformers in opposition to institutional control over individuals' care and an all-encompassing surveillance by the criminal justice system within a therapeutic model managed by the drug court team (Hucklesby & Wincup, 2014; Lutze & van Wormer, 2007). This tension may be resolved, however, if peer support is defined and implemented as a new category of specialized services that is neither clinical or mutual aid and is responsive to participants' individual circumstances and needs.

## Peer Recovery Support Specialists and Program Outcomes

Most studies of peer support have been conducted in programs serving clients with SUD, serious mental illness, or co-occurring disorders. Few studies have assessed peer support within the treatment court context. Thus, a brief overview of the existing research on peer support in service to populations similar to treatment court participants is relevant to understanding existing variations in peer support implementation nationally. Reviews of PRSS tend to focus on the hiring criteria and education for PRSS, PRSS's experiences working with the agency and with clients, the client's perspectives in relationship to PRSS services, and evaluations of client's engagement in the process, programs, and future outcomes.

### *Peer Support in Mental Health and Substance Use Disorder Settings*

**Hiring criteria and education.** As peer support has become formally recognized as a meaningful service to support justice and treatment-involved individuals, hiring criteria, education, and certifications have developed to guide the field and create a baseline for understanding the role of peer support workers (Foglesong, Knowles, et al., 2022; National Association of Peer Supporters, 2019). Nationally, there is variation across states in the requirements to serve as a peer support advocate, mentor, or specialist (SAMHSA, 2020). In general, the minimum requirements are to be at least 18 years old, possess a high school diploma or GED, have recovery experience,[2] and be a resident of the state where the program is located (SAMHSA, 2020). Advanced requirements include state or national certification, which often includes an average of 58 hours of training, annual requirements for continuing education, and an average of 500 hours of work experience and/or service related to recovery (SAMHSA, 2020). PRSSs may also serve as volunteers or be paid employees with wages ranging from $8.00 to 30.00 per hour (mean = $13.75 per hour).

To become certified, peer recovery support specialists are trained to understand the role of peer support in recovery, the dimensions of recovery, how to build relationships and develop communication skills, how to set boundaries and deal with ethical issues, how to connect peers to community resources and supports, and how to support recovery and wellness through cultural competency and trauma-informed care (Foglesong, Knowles, et al., 2022; JSI Research & Training Institute, 2016; Money et al., 2011; National Association of Peer Supporters, 2019; SAMHSA, 2015, 2020). In addition to certification procedures, many states have established codes of ethics that peer recovery support specialists must follow. The codes of ethics vary across states, but generally address issues related to confidentiality and privacy of client information, informed consent, the release of information and mandatory disclosure (see National Association for Addiction Professionals, 2021). Although these areas of core values, competencies, and ethical codes are presented as critical to successfully becoming and performing as a PRSS, there is little to no understanding about how these attributes are directly related to program outcomes.

**Peer support and client engagement.** The potential benefits of peer support, broadly defined, are well supported in the literature (see Cohen et al., 2000; Cullen et al., 1999; Lin et al., 1986; White & Evans, 2013). Peer recovery support services and PRSSs are expected to improve program engagement by mentoring people through the process of recovery, sharing personal experience and knowledge to enhance engagement in treatment and other programs, and guiding the development of a recovery-based lifestyle in the community that is beneficial to oneself, friends, and family (White & Evans, 2013). Success is often measured by individual satisfaction, program engagement, alcohol/drug use, hospitalizations, jail time, housing, employment, and recidivism.

Peer support is linked to providing social and emotional supports that validate the client's feelings and experiences, reduce anxiety, provide comfort during times of crisis, inspire hope, and help facilitate recovery management (MacNeil & Mead, 2005; Pantridge et al., 2016; Reingle Gonzalez et al., 2019; Satinsky et al., 2020). Peer recovery support specialists have been effective in providing information and assisting others in navigating processes important to initiating recovery, promoting personal well-being, and monitoring and supervision (Pantridge et al., 2016). Relationships developed through peer support may also facilitate ongoing contact post-program and be used as a resource to sustain recovery (MacNeil & Mead, 2005; Nixon, 2020; Pantridge et al., 2016; Satinsky et al., 2020).

**Peer recovery support specialists' experiences.** PRSSs also report professional and personal benefits due to their role of working of with peers. In general, providing peer support helped to build confidence, created a sense of belonging, improved personal skills, and shifted the identity of a PRSS from addict to a person in recovery (du Plessis et al., 2020; Tracy et al., 2011). In addition, being peer support specialists reinforced abstinence, kept them engaged in the recovery process and in work, and improved their ability to build better social support networks (du Plessis et al., 2020; Tracy et al., 2011).

There are also challenges to participating in peer recovery work. PRSSs often report a lack

[2] Recovery Experience: 81 percent of states require recovery experience; 20.7 percent no time reported; 36.2 percent required at least 1 month; 41.3 percent required 12-24 months in recovery (SAMHSA, 2015). Research shows that those in recovery for 3-5 years are significantly less likely to return to use and be considered "recovered" (see White, 2007).

of clarity about their role and to whom they should report, resulting in confusion about responsibilities when interacting with staff and setting boundaries for clients (du Plessis et al., 2020; Gates & Akabas, 2007; Jones et al., 2019; Kuhn et al., 2015; Nixon, 2020). Lack of training and support also contributed to problems, especially when dealing with clients with more severe problems than they had personally experienced or felt comfortable managing without clinical staff's expertise and support (du Plessis et al., 2020). PRSSs may also experience emotional and psychological stress related to their role due to internalizing responsibility for clients who return to use, experience declining behavioral health issues, or deteriorate into crisis (du Plessis et al., 2020; Nixon, 2020). PRSSs also reported experiencing stigmatization, disenfranchisement, low pay, and the inability to move beyond the peer support role and into other professional positions (du Plessis et al., 2020; Foglesong, Knowles, et al., 2022; Jones et al., 2019; Nixon, 2020). Some traditional treatment models and work environments were not prepared to accept a shift to a recovery-oriented model, making it difficult for PRSSs to collaborate with clinicians or integrate into the traditional service environment (du Plessis et al., 2020).

**Peer support program outcomes.** Systematic reviews of peer support's influence on participant engagement and program outcomes suggest an overall positive effect appearing to be small to moderate in magnitude (Bassuk et al., 2016; Chinman et al., 2014; Eddie et al., 2019). In general, peer support appears to increase participant satisfaction and the likelihood that participants will engage in treatment and complete the process (Bassuk et al., 2016; Chinman et al., 2014). Peer support also appears to have positive effects on program outcomes by decreasing substance use-related hospitalizations, reducing recidivism, and reducing time spent in jail (Bassuk et al., 2016).

Few studies have been able to isolate the effects of peer support from the overall effect of the program in which it is embedded. However, Chinman and colleagues (2014) conducted a systematic review of peer support programs serving those with serious mental illness and co-occurring disorders and reported the outcomes for three types of program implementation: "peers added to traditional services (peers added), peers assuming a regular provider position (peers in existing roles), or peers delivering structured curricula (peers delivering curricula)" (Chinman et al., 2014, p. 4). Although there were moderate levels of evidence that all three delivery types had a positive effect on outcomes, Chinman et al. report that the "peers added" to traditional services and the "peers delivering curricula" models had the strongest effect on outcomes (see also Ramchand et al., 2017; White & Evans, 2013).

Unfortunately, systematic reviews in related fields such as mental health, substance use, and co-occurring disorders show that most studies of peer support are weakened by small sample size, short follow-up periods, mixed intervention types, poorly defined peer support roles, unknown or weak dosages, and the inability to isolate the effects of peer support from other treatment elements of the program (Bassuk et al., 2016; Eddie et al., 2019). Some studies also show treatment-as-usual performed as well as treatment with peer support. Therefore, it does not appear that peer support induces harmful effects, but it remains unclear what constitutes evidence-based practice in delivering peer support services and which peer support services strengthen program efficacy to improve participant engagement and program outcomes (Bassuk et al., 2016; Belenko et al., 2021; Eddie et al., 2019; Gesser et al., 2022). Similar findings are emerging in treatment courts that use peer recovery support specialists.

### *Peer Recovery Support Specialists in Adult Drug Treatment Courts*

Peer recovery support is being implemented in treatment courts across multiple systems (veterans administration, child welfare, mental health, and adult drug courts), yet there are few studies evaluating the process of implementation or outcomes of this approach in adult drug treatment courts (ADTC). Existing studies show how treatment courts structure the implementation of PRSSs into the model, describe the potential benefits of and challenges to using PRSSs, and show peer support to be a promising practice. A review of the extant literature suggests that treatment courts appear to use a parallel or integrated peer support service model, with some variation depending on the type of court.

**Adult drug treatment courts and PRSSs.** Only a small number of studies have attempted to evaluate the direct effects of peer support services and/or peer recovery support specialists on adult drug treatment court outcomes (Belenko et al., 2021; Pinals et al., 2019; Shaffer et al., 2022; Smelson et al., 2019). Overall, these studies show that peer support services tend to enhance outcomes when integrated into the treatment court model and are combined with other wrap-around services (Pinals et al., 2019; Shaffer et al., 2022; Smelson et al., 2019). However, a weak to no effect was revealed in a randomized control trial isolating the effects of peer recovery specialists on outcomes (Belenko et al., 2021).

**MISSION-CJ, wraparound service model.** Massachusetts has operationalized peer support through the MISSION-CJ framework structured to provide wraparound services within adult drug treatment courts (Smelson et al., 2019), an urban mental health court (Pinals et al., 2019), and a rural drug court (Shaffer et al., 2022). **Maintaining Independence and Sobriety through Systems of Integration, Outreach, and Networking-Criminal Justice** (MISSION-CJ) is a 12-month program delivered jointly by a case manager (CM) and a peer support specialist (PSS).[3] The program consists of several core components including Critical Time Intervention (CTI), Dual Recovery Therapy (DRT), peer support, vocational and educational supports, trauma-informed care, and Risk-Need-Responsivity (RNR) assessment (see Pinals et al., 2019; Shaffer et al., 2022; Smelson et al., 2019).

The CM-PSS teams are supervised by a licensed psychologist (adult and mental health court) or social worker (rural court) and the CM-PSS teams are purposefully designed to "provide case management that spans across the traditionally siloed behavioral health and criminal justice systems and act as 'boundary spanners' to bridge communication" (Pinals et al., 2019, p. 1045). The pairs are responsible for a caseload of 15 clients (Shaffer et al., 2022; Smelson et al., 2019). PSSs served as role models and delivered 11 recovery-oriented sessions from the perspective of individuals with lived experience in the areas of substance use, mental health and co-occurring disorders (mental health court), treatment experience, and criminal justice involvement (Pinals et al., 2019; Shaffer et al., 2022; Smelson et al., 2019). PSSs were also expected to aid participants in adjusting to new routines, avoiding triggers related to criminal behavior or substance use, stressing the importance of engaging with needed treatment (Smelson et al., 2019, p. 224), assisting with transportation, and accompanying participants to "positive

[3] The MISSION-CJ studies use Peer Support Specialist (PSS) compared to much of the literature that uses Peer Recovery Specialists (PRS), and Peer Recovery Support Specialists (PRSS) as used in the current study.

recovery-oriented events" in the community such as AA/NA (Shaffer et al., 2022).

Interestingly, Shaffer and colleagues (2022, p. 1051) reported additional information about the time spent (dosage) in the MISSION-CJ curriculum, noting that "programming and treatment referrals were titrated depending on the criminogenic risk level of the client." They also reported that the program "offered more intensive individual and group sessions per week for the first 4 months (approximately 2.5 hours weekly), which were reduced in frequency in months 5–9 (approximately 1 hour) and even further to twice per month during months 10 and 12" (Shaffer et al., 2022, p. 1051).

Each of the MISSION-CJ studies reported results based on a pre-post design, without a comparison group, and with a six-month follow-up. The outcomes were positive, showing significant reductions in nights spent in jail and decreases in illicit drug and/or alcohol use. Additional findings included reductions in the number of arrests (Shaffer et al., 2022), trauma symptoms (Pinals et al., 2019), and behavioral health symptoms (Pinals et al., 2019; Shaffer et al., 2022), as well as increases in employment (Shaffer et al., 2022; Smelson et al., 2019) and stable housing (Shaffer et al., 2022).

The findings produced by the MISSION-CJ framework across different types of adult treatment courts are promising. MISSION-CJ provided examples of how peer recovery support is being incorporated in an integrated model that specifically teams PRSSs with a CM while sharing the same caseload. MISSION-CJ also demonstrated the implementation of PRSSs independently delivering structured curricula. The integration of PRSSs into the overall program structure and the peer-delivered curricula approaches have been shown to enhance positive outcomes in peer support programs outside of the treatment court contexts (see Chinman et al., 2014). Thus, the MISSION-CJ approach to peer recovery support provides evidence that using PRSSs in treatment courts shows promise. Yet, due to the pre-post research design, the effects of peer recovery specialists on outcomes cannot be isolated from the overall effects of the programs. A recent randomized control trial, pilot study, attempts to fill this gap in existing research.

**Randomized control trial (RTC) with follow-up interviews.** Recently, Belenko and colleagues (2021) conducted a pilot study using a randomized control design of Peer Recovery Specialists (PRS) paired with Case Managers (CM) in the Philadelphia Treatment Court (PTC). Peer Recovery Specialists were specifically hired and trained for the study, required to be PTC graduates, be in recovery, and to be abstinent for at least one year (Belenko et al., 2021). The PTC is structured as a traditional, four-phase, 12-month post-adjudication (no contest plea) program, serving approximately 700 adult participants each year. Eight-to-ten case managers carry caseloads of approximately 50 clients each and are responsible for "facilitating access to social, behavioral, and legal services; meeting monthly or more if necessary; and regularly meeting with treatment facilities and recovery houses," as well as presenting monthly to the judge and completing administrative tasks (Belenko et al., 2021, p. 3). PRS held similar responsibilities as the CM with the additional responsibility of using their lived experience to "inform services, including sharing their personal story; providing additional support to clients who found court and/or treatment compliance challenging; and assisting clients with self-esteem enhancement, conflict resolution, assertiveness and other recovery skills" (Belenko et al., 2021, p. 3). PRS were also tasked with reporting to case management about clients' behavioral or health issues.[4] The study reported that PRS averaged 11.5 phone or in-person contacts (range 1-25) with their PTC clients and provided access to, on average, 5.1 different types of services (range 0-9).

Participants receiving Case Management with PRS services were compared to CM as usual to determine whether PRS services improve drug treatment court outcomes (Belenko et al., 2021). The findings showed that the CM-PRS model had no significant effects on any indicators of substance use recurrence measured by positive drug or missed screens and no significant differences for treatment engagement measured by the number of treatment sessions attended across all programs and the percent of missed sessions. The findings were mixed regarding effects on the drug court process and engagement. The CM-PRS group received significantly more incentives than the comparison group, but once other covariates were controlled, the PRS model did not significantly increase receiving an incentive or achieving the next phase level. The Case Manager-PRS model did have a significant but medium effect on reducing rearrests over a 9-month follow-up period and no significant effect on having a bench warrant issued (see Belenko et al., 2021, pp. 5–6).

A follow-up study to the Philadelphia Treatment Court randomized control trial included interviews of Peer Recovery Specialists (PRS), case managers, drug court team members, and participants (Gesser et al., 2022). Overall, drug court staff, PRS, and participants view PRS as making a positive difference for both clients and other staff members. Case managers reported benefits "including sharing their emotional stress with respect to high-risk clients, providing them with feedback about the program, and suggesting ways to interact with their clients" (Gesser et al., 2022, p. 32). Once again, the drawbacks identified by case managers, other team members, and participants were related to being unclear about how the role of PRS differed from case managers due to perceived overlap in their responsibilities. An additional point of tension was between PRS and the legal team about understanding how the PRS's role in maintaining confidentiality and advocating for clients may be violated by attending court hearings and reporting private information to the team. Other team members expressed a counter-narrative suggesting that PRS, having experience with the drug court and treatment program participation, may be better positioned to communicate the needs and perspective of the client to the team (Gesser et al., 2022). The authors were unable to determine if the Case Management with PRS services model or traditional CM model was better regarding whether the PRS should or should not report to the team (Gesser et al., 2022).

In summary, prior research shows that peer support is promising, but more research is needed to determine whether Peer Recovery Support Specialists working within the adult drug treatment court model rises to the level of being an evidence-based practice. A consistent observation across interdisciplinary

[4] Belenko et al. (2021, p. 3) reported that PRS were "also responsible for alerting the case management unit to any of their clients' current or potential behavioral or health related problems." Gesser et al. (2022, pp. 28–29) reported in a study based on the same court, that "The PRSs collaborated with case managers about mutual clients; however, they did not report recurrence of substance use to case managers to avoid mandatory reporting by case managers to the court, in order not to risk the trust established between PRSs and their clients." It may be that PRS reported to supervisors instead of case managers to avoid the mandatory reporting to the court required of case managers. Thus, between the two studies, the responsibility of PRS to report to case managers, supervisors, or the treatment court team is unclear.

studies, as well as treatment court-specific studies, is that there is great variation in how peer support is implemented across programs, thus making it difficult to establish how peer support *should* be formulated in ADTCs and "what works" to inform future evidence-based practice. Given that the examination of peer support in treatment courts is emerging as a focus of study, it is important to establish how often peer support is being used in treatment court settings, whether there are formal criteria used to establish the role and responsibilities of PRSSs, and how peer recovery support is being integrated by professionals in the field into the treatment court model. Thus, the current study attempts to fill this gap in the literature by answering the following questions:

**Q1.** How common is the use of peer recovery support specialists in adult drug treatment courts in the United States?

**Q2.** What criteria guide the hiring, training, and certification of peer recovery support specialists in adult drug treatment courts?

**Q3.** How is the peer recovery support specialist position being implemented within the adult drug treatment court model?

## Methodology

To address the research questions presented above, a survey instrument was developed by the authors to gather descriptive, baseline information regarding the use of peer recovery support specialists within adult drug treatment court programs in the United States and in United States Territories. The University of North Carolina Wilmington (UNCW) Institutional Review Board approved the study protocol.

The Qualtrics survey instrument was first emailed to 54 statewide/territory[5] drug court coordinators in November 2021, with a request that they forward the survey to all ADTC program coordinators in their respective jurisdictions. The survey included questions about the addition of PRSSs within the treatment court, rates of pay, hours worked, employer, level of involvement in the actual treatment court and staffing procedure, and state certification processes. Data collection began in November 2021 and initially ended on February 28, 2022. This wave of survey data collection resulted in 712 usable surveys. In August 2022 a second wave of survey requests was sent to states that did not respond to the first request. This targeted survey collection produced an additional 72 ADTCs. The final sample included 784 usable surveys received from 45 states/territories. As of December 31, 2021, a total of 1,728 ADTCs were operational within the U.S. Therefore, 45.3 percent of ADTC programs are represented in the study.

## Findings

These findings are organized to show (1) the prevalence of PRSSs in ADTCs, (2) the requirements and qualifications of PRSSs in ADTCs, and (3) how PRSSs are positioned to provide support services within the ADTC model.

### *Prevalence of PRSSs in ADTCs*

The use of PRSSs in adult drug treatment courts appears to be a fairly recent and growing practice. Of the 784 ADTCs represented in this study, 46.4 percent (n=364) reported having one or more peer recovery support specialists within their program. An additional 10 percent (n=78) reported that they did not currently have a PRSS but planned to add this role in the future. Finally, 43.6 percent (n=342) of respondents said they did not have and were not planning to add a PRSS to their ADTC. For those reporting having a PRSS (range was 1-28), 39.4 percent indicated having one PRSS, 41.4 percent reported having two to three, and 11 percent reported having four to five PRSSs involved with their program (see Figure 1, next page).

The survey results also show PRSS is a recent program feature within ADTCs. The earliest implementation occurring in the sample is reported as early as 2000. The practice slowly builds between 2006 to 2015, and then gains momentum beginning in 2016, with 80 percent of ADTCs with a PRSS formalizing this role between 2016 and 2022 (see Figure 2, next page).

### *Qualifications for PRSSs in Adult Drug Treatment Courts*

Respondents were asked about the required qualifications for PRSSs (see Figure 3, next page). Not surprisingly, over 70 percent indicated that the individual must have "lived experience."[6] Additionally, 82.7 percent reported that state certification was required. Far fewer respondents (13.3 percent) reported that the PRSS must be a graduate of the adult drug court, with the required amount of time separated from the ADTC program ranging from one month (33.3 percent) to 24 months (11.1 percent). The most common response among those selecting the "other" qualification category was that the qualifications were unknown because the PRSS was employed by an agency other than the ADTC.

### *Implementation of PRSS in Adult Drug Treatment Courts*

In addition to the PRSS qualifications, respondents were asked about features of the PRSS position such as employer, hourly pay, and hours worked each week. As shown in Figure 4, the majority (54.2 percent) of respondents reported that the PRSS was employed by a treatment provider organization, while only 15.4 percent reported that the PRSS was employed by the ADTC program. The remaining 30.4 percent of respondents indicated that their PRSS was employed by entities such as a non-profit, a recovery center, or a health department, among others.

The vast majority (79.3 percent) of respondents reported that the PRSS was a paid position. Hourly rates ranged from $10 to $90, with a mean of $17.71 and a median of $16.00. Over one-third (37.7 percent) of respondents reported an hourly rate between $13.00 and $15.99, while just over one-quarter (27.7 percent) indicated the PRSS positions are paid between $16.00 and $18.99. The hours worked per week ranged from 0 to 80.0 hours, with a mean of 19.6 and a median of 20.0 hours. The position was voluntary among 18.9 percent of respondents and was reported as both paid and voluntary by 1.8 percent of respondents.

The survey also explored questions related to the training, inclusion, and operational role of the PRSS within the treatment court program. As shown in Figure 5, around two-thirds (65.7 percent) of respondents reported that their PRSS received treatment court training before joining the program. However, only 36.6 percent of respondents indicated that the role and function of the PRSS is outlined in their drug treatment court team policies and procedures (operations) manual. Last, 65.2 percent indicated that the PRSS is an official member of the treatment court team.

Given the high rate of membership of PRSSs among the functioning treatment court team, it is interesting to further understand the duties assigned to the PRSS (see Figure 6). Among those courts indicating the PRSS was a member of the ADTC team, 97.7 percent indicated that the PRSS meets with participants, while 77.5 percent of programs reported that

[5] This includes all 50 states, the District of Columbia, Guam, Northern Mariana Islands, and Puerto Rico.

[6] "Lived experience" was not defined within the survey.

**FIGURE 1.**
**Number of PRSSs Involved with ADTCs (n=355)**

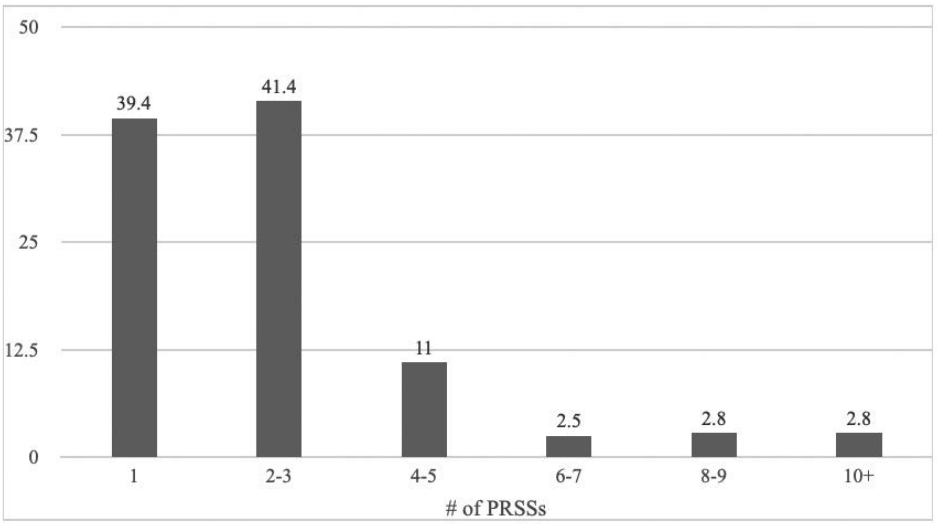



**FIGURE 2.**
**Year When ADTC Added PRSS Role (n=331)**

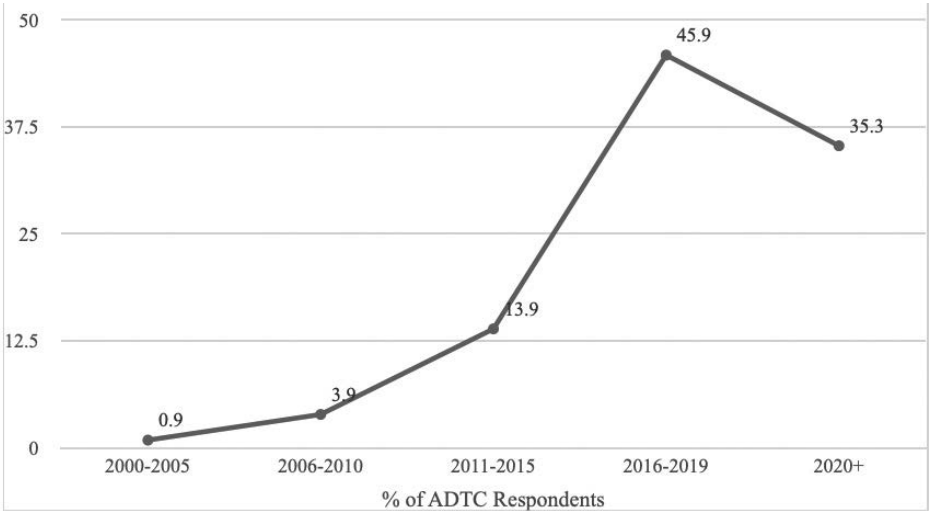
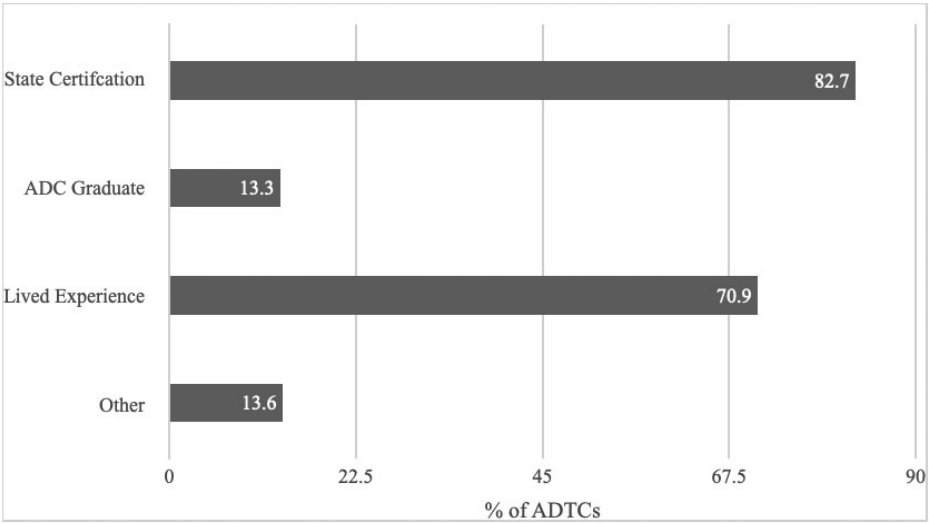



**FIGURE 3.**
**Qualifications for PRSS Involved with ADTCs (n=330)**




the PRSS coordinates programming. Just over two-thirds of respondents indicated that the PRSS provides transportation, and a similar percentage (68.4 percent) have a PRSS who attends drug treatment court team staffing meetings.

Respondents reporting that their PRSS attends drug treatment court team staffing meetings (n=201) were asked whether or not the PRSS provided input on various decisions. Figure 7 reveals that an overwhelming majority of respondents (83.6 percent) reported that the PRSS provides input in team decisions, changes to case management plans (80.3 percent), changes to treatment plans (73.5 percent), graduation and termination (79.8 percent), and incentives and sanctions (82.7 percent). (See Figure 7.)

Two-thirds (65.2 percent) of adult drug treatment courts with PRSSs described the PRSS as an official member of the team. Given the level of involvement in the staffing procedure and input afforded to PRSSs, we analyzed the similarities and differences among programs that reported the PRSS to be an official team member and programs reporting that the PRSS was not an official team member. A higher percentage of PRSSs categorized as official team members were in a paid position (86.0 percent), whereas 71.3 percent of non-official team members were paid. With regard to qualifications, a similar percentage of official and non-official PRSSs (84.5 vs. 81.7 percent respectively) required state certification (see Figure 8). Being a graduate of the program was required by 14.0 percent of programs with the PRSS as an official team member, as compared to 9.6 percent of programs where the PRSS was not an official team member. Based on chi-square analysis, a significant difference between the two groups was revealed with regard to lived experience being a requirement. Three-quarters (75.6 percent) of the respondents with a PRSS as an official team member must meet the requirement of having lived experience, whereas only 62.5 percent of ADTCs where the PRSS is not an official team member had to meet this requirement.

Significant differences between those ADTCs with a PRSS as an official team member and those who are not official team members were found when examining the roles and responsibilities of the PRSS (see Table 1). Based on chi-square analysis, a significantly higher percentage of programs with PRSSs as official team members reported having the roles and responsibilities of the

PRSS outlined in their policies and procedures (operations) manual, providing treatment court training for the PRSS, and having the PRSS coordinate programming. Not surprisingly, no significant differences between the two groups were found with regard to the PRSS providing transportation and the PRSS meeting with participants as part of their role/responsibilities.

There were also significant differences between team membership and attendance at pre-court staffing meetings based on chi-square analysis. For programs with a PRSS serving as an official team member, 88.2 percent reported that the PRSS attends pre-court team staffing meetings, whereas in only 28.6 percent of programs where the PRSS was not an official team member did the PRSS attend pre-court team staffing meetings ($p<.001$) (see Figure 9).

Interestingly, significant differences were found when examining the areas about which the PRSS provides input during the case staffing meetings. With the exception of input regarding changes to treatment plans, programs with a PRSS serving as an official team member were significantly more likely to report that their PRSS provided input on multiple areas based on chi-square analysis. For example, 85.4 percent of programs with an official team member reported PRSS input on issues related to incentives and sanctions, while only 65.4 percent of the other programs indicated that. Similarly, 87.7 percent of programs with an official team member allowed PRSS input into team decisions (e.g., voting), and only 57.5 percent of those programs without an official team member reported this type of input from the PRSS. (See Figure 10.)

## Discussion

This study is the first attempt to gather descriptive data about the extent of PRSS involvement across the ADTC model. The addition of PRSSs suggests that drug treatment court professionals remain innovative in exploring how to enhance the experiences of participants while simultaneously improving outcomes. It is important to know whether peer recovery support remains a practice of mutual aid informally exchanged between participants or whether it is formally constructed, clearly defined, and qualifies as a new category of promising practice. The results of this survey, combined with a careful review of the literature, yield four key findings that ADTCs should consider when exploring the development and addition of PRSS

**FIGURE 4.**
**Agency Employing PRSSs Involved with ADTCs (n=299)**

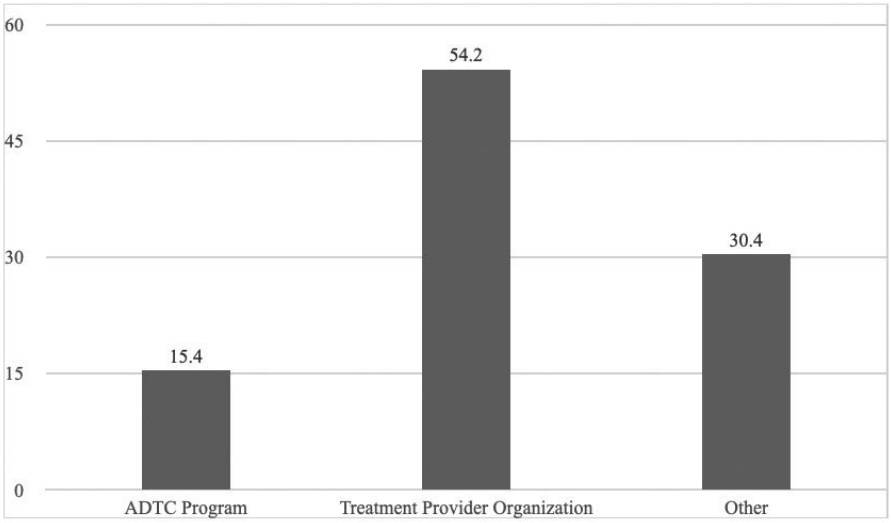



**FIGURE 5.**
**Integration of PRSS into ADTC Team (n=299)**

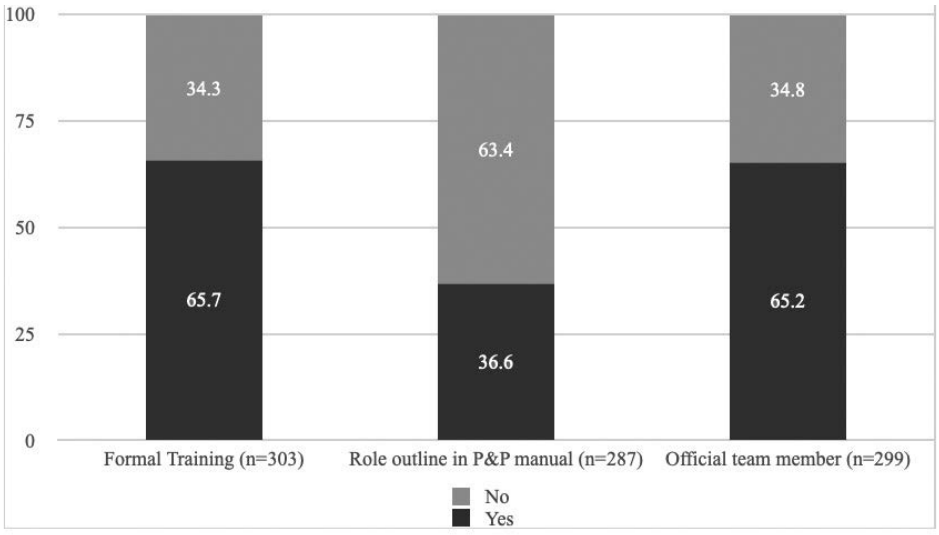
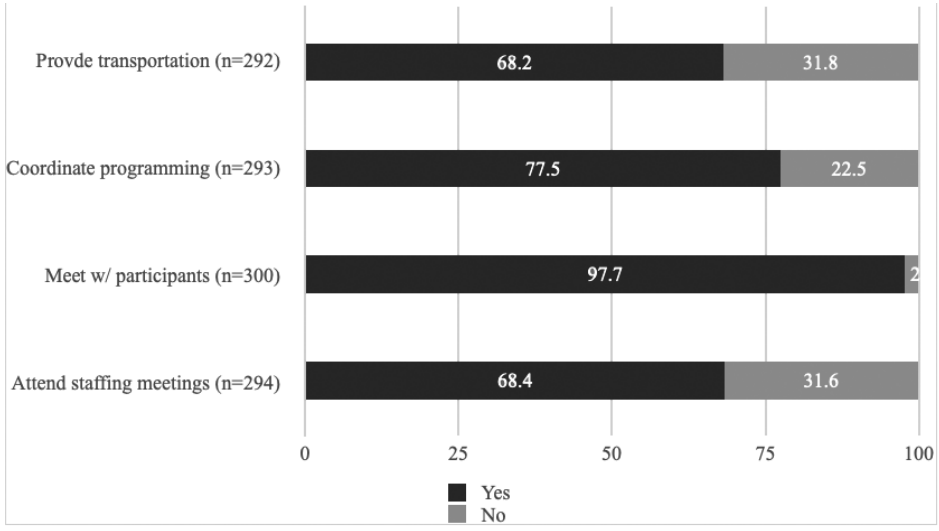



**FIGURE 6.**
**Roles & Responsibilities of PRSS Involved with ADTCs**



positions.

**First, PRSS in the ADTC model is a rapidly expanding practice.** Close to half (46 percent) of the survey respondents reported having one or more PRSS positions within their treatment court, with the large majority of these programs (80 percent) operating with between one and three PRSS positions.

**FIGURE 7.**
**Topics for which PRSSs in ADTCs Provide Input During Pre-Court Staffing Meetings**

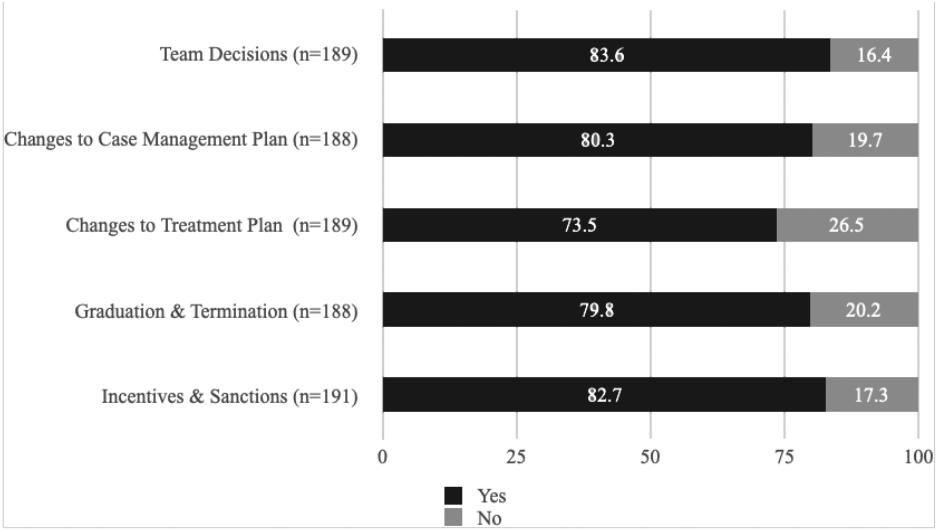



**FIGURE 8.**
**Comparison of PRSS Qualifications Across ADTCs Classifying the PRSS Role as Official/Not Official Team Member (n=297)**

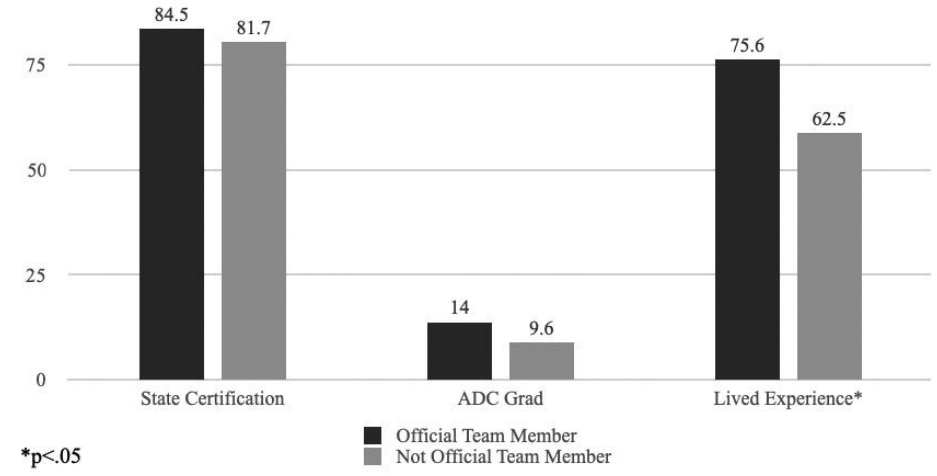



**TABLE 1.**
**Comparison of PRSS Roles/Responsibilities Across ADTCs Classifying the PRSS Role as Official/Not Official Team Member**

| | Official Team Member | Not Official Team Member |
|---|---|---|
| Role outline in policy & procedures (operations) manual** | 47.6 | 15.2 |
| Formal training** | 77.3 | 43.1 |
| Provide transportation | 70.2 | 64.0 |
| Coordinate programming** | 82.8 | 66.3 |
| Meet with participants | 97.9 | 97.1 |

**p<.001

The addition of PRSS is a new phenomenon, with most positions added to the program between 2016 and 2019. It is unknown why the addition of PRSS to the ADTC model slowed after 2019, but it is likely due to the COVID-19 pandemic that began in 2020. The increased use of PRSSs may also be a reflection of increased evidence of effectiveness in other models (e.g., substance use, mental health, and co-occurring disorders), federal and state investment in the general field of peer recovery support, and professionalization of the field.

This practice, however, is not fully embraced by all ADTC programs, as 43.6 percent of respondents reported that they had no intention of adding this position to the team. While this survey did not explore this decision, prior research points to some unique challenges that could be influencing the addition of PRSSs, including role confusion, duplication of effort, and ensuring confidentiality (see du Plessis et al., 2020; Gates & Akabas, 2007; Gesser et al., 2022; Jones et al., 2019; Kuhn et al., 2015; Nixon, 2020). Classic challenges to the treatment court model, such as a lack of resources, insufficient training, or no PRSS program/certification process may also inhibit inclusion and operation.

**Second, formal certifications and a code of ethics are foundational to PRSS implementation within the ADTC model.** With expansion comes a need to create standards to determine critical qualifications and to set professional expectations of PRSS implementation. The availability of a high level of training and certification, combined with ongoing clinical supervision, is a significant benefit for PRSSs. The code of ethics outlined by National Association for Addiction Professionals (NAADAC) provides a delineated set of duties and boundaries that must be adhered to in order to properly preserve the client-peer relationship (2021). However, the results of this survey, combined with the review of available literature, reveals a set of mixed practices that must be addressed within the treatment court process. A positive finding is that 82 percent of respondents in this study reported that PRSS state certification is a requirement to work within the adult drug treatment court program.

Certification of the field allows for PRSSs to learn valuable skills related to communication, resource connection, building a collaborative and caring relationship, setting boundaries, and addressing ethical dilemmas (Foglesong, Knowles, et al., 2022; JSI Research & Training

Institute, 2016; National Association of Peer Supporters, 2019; SAMHSA, 2015, 2020). Embedded within many state and national certification standards is a PRSS code of ethics. The NAADAC Code of Ethics for certified PRSS states (in summary) that the PRSS will work under supervision and complete sessions with a clinical supervisor, remain free from substances, and maintain their own outside supports for their recovery (2021).

The PRSS code of ethics also requires that they adhere to "federal confidentiality, HIPAA laws, local jurisdiction and state laws." They must also disclose any "pre-existing professional, social or personal relationships with the person(s) served" (National Association for Addiction Professionals, 2021). This may be of particular concern for former ADTC participants becoming peer recovery support specialists in the program from which they just graduated. The intersection of peer recovery support specialist's ethics, confidentiality requirements, and HIPAA regulations may create a professional conundrum for the PRSS when balancing working with individual participants and the ADTC team. For example, the PRSS may have had a prior relationship with clients, may have access to peers' official files, and may be asked to provide input on such decisions as sanctions for individuals who until recently were peers seeking mutual benefit. Thus, it is disconcerting that 20 percent of ADTC programs with a PRSS do not require formal certification and adherence to a professional code of ethics. It is critical that PRSSs be required to become certified in order to protect the efficacy of the PRSS role and the integrity of the ADTC model.

**Third, strengthening program efficacy through structural fidelity is important to the inclusion of PRSS positions in the ADTC model.** Prior research in related fields identified three structural models of peer support, including the sequential model, parallel models, and integrated models (see White & Evans, 2013). The current study suggests that ADTC programs are primarily implementing parallel models, with 54.2 percent of ADTC programs reporting that the PRSSs are employed by a treatment provider organization and another 30.4 percent reporting they are employed by non-profit organizations, recovery centers, health departments, etc. In addition, ADTCs that include the PRSS as an official team member are also adhering to an integrated model where treatment services and recovery support services are delivered by the same organization or highly coordinated multiagency teams.

Confounded within these structural models just noted are the structured roles that PRSSs serve, such as being a peer added to existing roles, peers serving within existing roles, and peers delivering curriculum (see Chinman et al., 2014). Several studies suggest that "peer added" and "peer delivering curricula" may be most likely to significantly enhance participant engagement in the process and increase positive outcomes in mental health, substance use, and co-occurring disorder-focused programs, as well as in treatment court settings (see Chinman et al., 2014; Pinals et al., 2019; Ramchand et al., 2017; Shaffer et al., 2022; Smelson et al., 2019; White & Evans, 2013). The current study shows that over half of ADTCs align with a "peer added" model, given that these peers are employed outside of the ADTC program. In addition, over three-quarters of ADTCs with PRSSs reported that they help to coordinate programing. While the current study did not ask about whether the PRSS directly delivered programming, the

**FIGURE 9.**
**Comparison of Whether PRSS Attends Pre-Court Staffing Meetings Across ADTCs Classifying the PRSS Role as Official/Not Official Team Member**

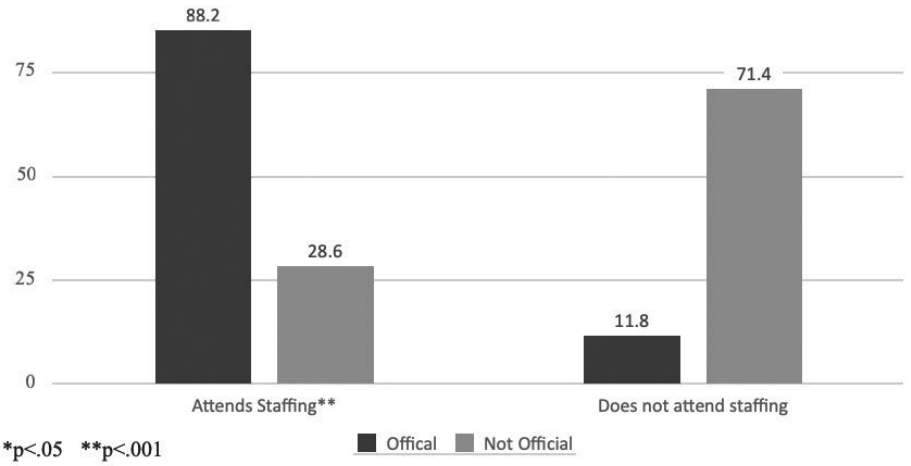
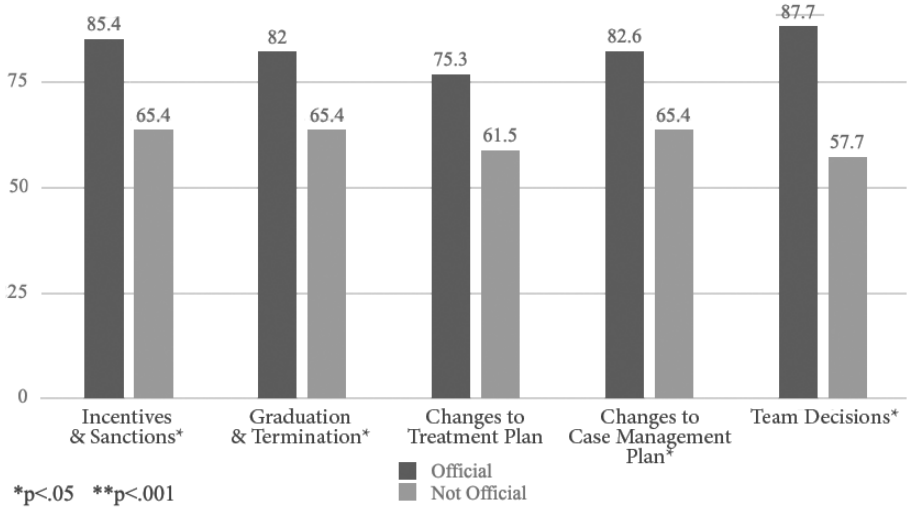



**FIGURE 10.**
**Topics for which PRSSs in ADTCs Provide Input During Pre-Court Staffing Meetings Comparison Across ADTCs Classifying the PRSS Role as Official/Not Official Team Member**



results show that PRSSs are at least affiliated with the programming and treatment process within the existing model. These results suggest that PRSS model structure and roles are in alignment with promising practices found in related fields.

Possibly the most concerning result of this study related to program efficacy is the nearly 30 percent of courts reporting that "lived experience" is not a stated requirement to serve as a PRSS. An important consideration to be made by ADTC professionals responsible for hiring PRSS workers is lived experience specific to recovery. Lived experience is critical to having unique knowledge about how to navigate the structural, emotional, and psychological recovery from substance use and co-occurring disorders, as well as experience with the drug treatment court process or the complex and fragmented systems of the criminal, health, and human service systems. One may argue that without lived experience there is no "peer" in peer support, as it is fundamentally based on personal experience and providing unique types of support based on mutual trust and understanding (Bassuk et al., 2016; Mead et al., 2001; SAMHSA, 2015; Taylor, 2014; White & Evans, 2013). Thus, it is surprising that only 70 percent of ADTCs in this study required lived experience to qualify as a PRSS.[7] Therefore, approximately one-third of ADTCs implementing PRSS are violating the basic premise of the peer recovery support model and what is theoretically and practically considered necessary to maintain program integrity.

**Finally, this study shows that operationalization and placement of the PRSS within the ADTC model is mixed and may be in conflict with the original tenets of peer support being located separate from clinical and professionalized relationships.** Although ADTCs are designed to provide access to treatment and recovery support services, they still retain the coercive leverage of the criminal justice system (see Lutze & van Wormer, 2007). Courts must decide whether PRSS services should be aligned with criminal justice practices or be aligned with navigating treatment practices as originally conceptualized by the peer support movement. For example, in line with navigating treatment practices, over 50 percent of ADTC respondents reported that the PRSS was employed by the treatment provider, and another 30 percent were employed by some type of non-profit, public health department, or recovery center. This is an important finding as the NAADAC code of ethics requires clinical supervision of the PRSS, and this most likely cannot be afforded if the PRSS is working directly under the ADTC program or judge. Much like the duties outlined by NAADAC, the PRSS within the treatment court engaged in many standard PRSS duties. This included meeting with clients, coordinating services and programming efforts (resource connection), and providing transportation. Thus, the PRSS in these courts were mostly aligned with the support, programing, and treatment components of ADTCs.

Yet, mission creep becomes a legitimate concern, with 62.5 percent of ADTCs reporting that the PRSS has been added as an "official" member of the ADTC team and have direct input on team decisions around incentives and sanctions, changes to treatment plans, and even graduation and termination. This context provides opportunities for PRSSs to participate in coercive action that may directly conflict with support and violate the mutual trust, rapport, and client-driven pursuit of program goals ensconced in the PRSS-peer client relationship. Some research shows that PRSSs may drift away from the peer support mission and closer to the professional identities of those with whom they primarily work (Foglesong, Spagnolo, et al., 2022). Therefore, PRSSs directly working with the ADTC team may begin to view their professional role as geared toward observation and surveillance on behalf of the team. Given state certification processes and national and state codes of ethics, it is important that ADTC teams do not place the PRSS in a position of violating their stated ethical codes. As White and Evans (2013, p. 9) stated, "care must be taken in the integration process not to de-professionalize clinical services or professionalize peer support relationships." The peer relationship is built on a foundation of trust, shared experience, care, and support (see Bassuk et al., 2016; du Plessis et al., 2020; Mead et al., 2001; White, 2007; White & Evans, 2013). Once the PRSS is expected to share confidential information or bring concerns (or even progress) directly to the team, it places the PRSS in a potential position of ethical violation.

Of further concern about the PRSS possibly drifting toward alignment with the coercive leverage of the criminal justice system is that only 36 percent (n=103) of ADTCs reported that the roles and responsibilities of the PRSS were outlined in the program's policies and procedures (operations) manual. This lack of clarity regarding the PRSS role creates opportunities for mission creep and confusion among ADTC team members as to the role of PRSSs. Thus, as White and Evans (2013) warn in relation to preventing any unintended harmful effects of peer recovery support, "Given the long record of harm in the name of help within the history of clinical and social interventions into AOD problems, it is incumbent on behavioral health leaders to ask whether any inadvertent injuries could flow from the implementation of PRSS" (p. 10).

### *Limitations of the Study*

Although the current study accomplished its goal of describing how PRSSs have been implemented within existing ADTCs, there are some limitations that will need to be addressed through future research. First, prior research shows that direct supervision of PRSSs by a case manager or treatment professional is critical to maintaining the integrity of the PRSS role. The current study asked where existing PRSS positions were situated but did not ask who is responsible for supervising individuals in PRSS positions. Second, research focusing on peer recovery support delivery models in related fields revealed that peer curriculum delivery by PRSSs significantly strengthens peer support model outcomes. Unfortunately, the current study asked about program coordination, but did not ask about the delivery of direct program/curriculum by PRSSs in the ADTC model. Third, data regarding the amount of time and the quality of the interaction between ADTC participants and PRSSs are important to determining the overall impact of peer recovery support on specific outcomes (e.g., program retention). Although the current study asked about the number of hours PRSSs worked in a typical week, as well as specific roles and responsibilities, data were not collected regarding the amount of time PRSSs spent with participants nor the quality of this interaction. Thus, the optimal "dosage" of emotional, psychological, and functional support provided by PRSSs is unknown. Finally, it should be noted that ADTC participation in the current study was voluntary and, thus,

[7] Interestingly, in SAMHSA's (2015) review of state requirements for peer recovery specialists, only 81 percent of states required recovery experience. SAMHSA also found that, when lived experience was required, it ranged from 36.2 percent of states requiring as little as one month to 41.3 percent of programs requiring 12-24 months in recovery. This finding is similar to the current study.

the findings are only representative of those ADTCs that elected to participate.

## Conclusion

A considerable body of empirical research over the past 30 years has demonstrated that treatment court programs (when implemented with fidelity to the model) are successful in reducing recidivism and facilitating recovery from substance use disorders among participants. Even though proven successful in their current configuration, treatment courts continue to build upon evidence-based practices and to evolve by testing promising new approaches that may improve the process and enhance targeted outcomes (see All Rise at https://allrise.org/; Treatment Court Institute [TCI] at https://allrise.org/about/division/treatment-court-institute/). The current study shows that peer recovery support is a recent innovation within the field that is quickly being integrated into the adult drug treatment court (ADTC) model. Peer recovery support specialists (PRSSs) are being used to collaborate with ADTC teams and serve a critical role by supporting the emotional, psychological, and functional needs of adult drug treatment court participants.

Common features of PRSS implementation across ADTC models is 1) requiring training and state- and national-level certification, 2) integrating the PRSS role into the drug court team, and 3) expecting PRSSs to meet with participants, attend pre-court staffing meetings, coordinate programming, and provide transportation. A majority of ADTCs with PRSSs allowed them to participate in team decisions related to incentives and sanctions, graduation and termination, and modifying treatment and case management plans. Thus, these ADTCs appear to have taken great strides toward fully integrating PRSSs into the team model.

This study also found that there are common models of peer support emerging in ADTCs nationally. PRSSs tend to be implemented in collaboration with organizations on which ADTCs rely to provide treatment and recovery support services. Similar to other related disciplines, to date, ADTCs have used a peer-added and peer-organized service delivery approach. Evidence from related fields such as substance use disorder, mental health, and co-occurring disorders reveals that there is value-added for the use of PRSSs within these systems. This also appears to be true in the few studies conducted on the effects of peer support used in the ADTC model.

The addition of PRSSs within the treatment court model, however, must be cautiously approached and managed in relationship to certification requirements and codes of ethics. Based on existing literature and the results of the current study, there are essentially two models of operation aligned with state certification requirements and codes of ethics that ADTCs should consider when using PRSS positions. The "intermediary team advisor model" ensures a stronger barrier between the participant, peer, and ADTC team by requiring that PRSSs report directly to a clinical supervisor who serves as an intermediary between the PRSS and the ADTC team. Thus, any concerns that the PRSS might have about a participant are shared in a clinical setting, HIPAA compliance is ensured, and information is only shared at a "general" level with the ADTC team through standard treatment reports. In this model, the PRSS does not attend pre-court staffing meetings and is not asked direct questions about individual participants' progress or concerns.

Within the "embedded team advisor model," PRSSs attend pre-court staffing meetings, but do not divulge private or confidential information about participants. They also do not engage in decisions about incentives/sanctions, graduation/termination, treatment plans, nor case management plans. Pertinent case-specific information is shared with the team by the clinical supervisor. Attendance at pre-court staffing meetings may assist PRSSs in working with participants to prioritize issues with the greatest likelihood to sabotage success while protecting the PRSS from violating their ethical and professional responsibilities.

It should be noted that in both the "intermediary team advisor" and "embedded team advisor" models, PRSSs do not provide information regarding specific participants to members of the ADTC team. Rather, PRSSs can provide team members with information from the perspective of a peer with lived experience to inform team discussions. If PRSSs participate as "voting" members of an ADTC team, then they are not honoring the participant's voice. Rather, they are injecting their own voice and thereby creating a power differential. The peer journey is one of participants defining the relationship and exercising self-determination. It is the role of the PRSS to support these efforts and to remain a neutral party. Until further research is conducted regarding this issue, ADTC teams are encouraged to carefully review state and national standards, as well as codes of ethics, to ensure that they are not asking PRSSs to violate their ethical duty to protect, care for, and support ADTC participants in their work.

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