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Designing and implementing an intervention for returning citizens living with substance use disorder: discovering the benefits of peer recovery coach involvement in pilot clinical trial decision-making

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Abstract

Peer-facilitated services in behavioral health care remain underutilized within criminal justice-involved community organizations, and there is little guidance for how to best involve peer workers in behavioral health-focused research activities. This paper described lessons learned regarding implementation of peer recovery coaches (PRCs) as part of development and pilot research on Substance Use Programming for Person-Oriented Recovery and Treatment (SUPPORT), a peer-facilitated substance use disorder (SUD) intervention for returning citizens. Qualitative data were collected from learning meetings with key stakeholders and group interviews with SUPPORT clinical trial participants and PRCs. Transcripts were analyzed to identify key decisions made impacting the development, implementation, and/or revision of the SUPPORT intervention and pilot clinical trial protocols. Analysis demonstrated that PRC involvement drove many of the decisions made regarding modifications to the original intervention and trial protocols, while benefitting client-level interactions and by influencing the non-profit agency and its connection to stakeholders. Moreover, PRCs improved the research design by refining the incentive structure and data collection plans. PRC involvement also contributed to the development of more recovery-oriented resources and catering support services to the unique

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needs of justice-involved individuals. Discussed were the implications for the role of PRCs in justice-involved behavioral health research and treatment.

Introduction

Peer support providers are current or former consumers of behavioral health services who often go by titles such as peer provider, peer support specialist, and peer recovery coach (PRC). Despite noted benefits of peer supports related to criminal recidivism, few peer interventions discussed in academic literature focus explicitly on justice-involved individuals who are returning to the community (Reingle Gonzalez et al., 2019; Salem et al., 2017; Simmons et al., 2017), and even less include PRCs in the creation and implementation of such interventions (Marlow et al., 2015). Substance Use Programming for Person-Oriented Recovery and Treatment (SUPPORT) is a peer support intervention targeting returning citizens with substance use disorder (SUD) that was developed in an attempt to expand this literature. The ultimate goal of SUPPORT's lead researchers is to carry out an explanatory trial of the intervention. A first step in this process was to conduct a pilot randomized trial accompanied with qualitative feedback mechanisms to document strategic decisions and real-time adaptations impacting SUPPORT that were made in response to challenges faced. This paper focuses on analysis of data pertaining to the qualitative component of this work to ensure a proper detailed accounting of the intervention exists within the published research record.

SUPPORT is a PRC-facilitated intervention. PRCs are paraprofessionals tasked with helping clients develop and traverse their personal substance use disorder (SUD) recovery pathways (White, 2009). PRC services have been expanding over the past 20 years (Gagne et al., 2018; Kelly et al., 2019), and most states currently have a PRC certification process in place. PRC's entry into the SUD field coincides a shift from an acute care approach to a recovery-oriented, chronic disease model focused on long-term services and supports (Humphreys & Tucker, 2002; Institute of Medicine, 2006; Laudet & Humphreys, 2013; W. White et al., 2003; White, 2009). The oft-stated benefit of employing PRCs and other peer positions as part of a behavioral health services team is their ability to establish rapport and build trust with clients, thus allowing them to act as a bridge between clinicians and service consumers (White, 2009). There is early and promising evidence for peer services in general, as previous research has linked them with positive outcomes, such as increased adherence to SUD treatment and reduced hospitalization and criminal recidivism (Boisvert et al., 2008; Cos et al., 2019; Min et al., 2007; O'Connell et al., 2017; Reingle Gonzalez, 2019; Rowe et al., 2007; Tracy et al., 2011). However, systematic reviews have pointed to a lack of rigorous designs and missing or incomplete descriptions of the actual interventions/services being tested in prior peer support research (Bassuk et al., 2016; Eddie et al., 2019; Reif et al., 2007).

Although all individuals struggling with a SUD might benefit from PRC services, those who are justice-involved are confronted with unique obstacles including employment, housing, unmet healthcare needs, and isolation from the social support networks (Carson & Sabol, 2012; Khan & Epperson, 2012; Travis et al., 2003; Visher et al., 2004). These challenges,

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along with discrimination and the stress of anticipated stigma (LeBel, 2008, 2012; LeBel et al., 2014; Pager, 2003; Winnick & Bodkin, 2008), contribute to poor treatment retention outcomes that can result in high post-release morbidity and mortality (Mallik-Kane & Visher, 2008; Morenoff & Harding, 2014). This process of reintegrating back into a community after being incarcerated is often difficult, and by yearend 2011, community reentry impacted over 700,000 adults who are released from prison, and an additional 9 million adults released from jail (Carson & Sabol, 2012; Visher et al., 2008). Many of these persons are surveilled by community supervision agents (probation or parole) for an extended period of time following release, and the misconduct reported by these agents is primary reason for a return to incarceration (The Council of State Governments, 2019). Additionally, given the criminalization of substance use in the United States, many individuals with SUD are re-incarcerated because of relapse events that result from the disorder (Chamberlain et al., 2019; Håkansson & Berglund, 2012). The criminalization of SUD in the US has recently (i.e., since 2011) been demonstrated by legislators introducing a host of punitive measures related to fentanyl analogues; including, mandatory minimum sentencing guidelines, homicide charges, involuntary commitment, and broadened prosecutorial discretion, among others (S.1622 Stopping Overdoses of Fentanyl Analogues Act) (Johnson, 2019). In addition, the criminalization of non-prescribed buprenorphine use has expanded in criminal justice and other settings due to concerns of diversion despite the relatively low risk and high safety profile associated with buprenorphine misuse (Doernberg et al., 2019).

As part of the SUPPORT intervention and clinical trial's internal development and quality control process, researchers captured data through an ongoing learning mechanism (described below) on the contributions of PRC in this process but also on how the final intervention was perceived by clients who received SUPPORT services. This paper described lessons learned from this process, addressing noted critiques of prior peer support research by explicating the rational that underpinned decisions that shaped various aspects of the clinical trial and intervention protocols (Bassuk et al., 2016; Eddie et al., 2019; Reif et al., 2007). This is particularly important as it applies to working with justice-involved individuals at re-entry, due to the lack of focused consideration of this population in prior peer support intervention research.

Methods

The overall SUPPORT study design blended developmental and learning evaluation approaches to tailor and support the intervention and trial protocols. Developmental evaluation approaches are appropriate for complex interventions such as SUPPORT that require additional refinements before they can be formatively assessed and when scalability is a future goal (Patton, 2011; Quinn Patton, 1994). It is a utilization-focused approach (i.e., carried out with the end user in mind) that fosters learning through detailed documentation of an intervention's development coupled with rapid response to facilitate strategic decision-making (Patton, 2011). Learning evaluation is a complementary approach that uses continuous data collection and rapid-response cycles to facilitate ongoing quality improvement of a developing intervention (Balasubramanian et al., 2015). This process is facilitated by plan, do, study, action (PDSA) cycles, which involve continuous reflection and

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adjustments to the program model through regular meetings—called "*learning meetings*"—involving members of the development team (Balasubramanian et al., 2015). Thus, the process the study followed required continuous data collection and analysis with real-time feedback to inform continuous improvement of both intervention and clinical trial protocols. A more detailed description of the specific pilot trial component of the study has been published elsewhere (Watson et al., 2017).

Intervention and research setting

SUPPORT was conceived as a 12-month-long intervention to deliver flexible, comprehensive, and client-centered recovery services. At the outset of the clinical trial, there were three primary components through which SUPPORT was predicted to accomplish its goals: (1) services delivered by a certified PRC, (2) recovery-focused treatment plans developed around each client's personal goals, and (3) $700 in voucher funding clients can use to access supportive services to meet their state goals. The rational underlying these components was based on an evaluation of a prior program that identified them as driving positive outcomes, including reduced recidivism (Buchanan et al., 2013; Ray et al., 2017).

The research setting, Public Advocates in Community re-entry (PACE), is an Indianapolis, IN-based nonprofit that has been serving returning citizens for over 55 years. It provides services to approximately 1,500 returning citizens annually. These services are divided into four distinct categories: transitional, employment, addiction, and pre-release services. PACE had no experience with peer services prior to the SUPPORT study.

Description of the data

Primary data come from audio recorded learning meetings described above. These meetings occurred between 1/11/2017 and 3/1/2020, were approximately 90 minutes each, with an average of 8 attendees (range of 5–10) at each meeting. Attendees included researchers, PACE staff, and coalition members) attended each meeting. Supplemental data were collected from clients between June 27, 2019 and November 6, 2019 to better understand how decisions made in learning meetings played out and were received by clients. The original goal was to conduct group interviews with clients; however, due to difficulties reaching them as a result of incarceration, general attrition at follow-up, or unfortunately death, only two group interviews (with 2 and 3 clients respectively) and one individual interview were completed. Interviews lasted approximately 45 minutes each, were audio recorded, and participants received an incentive of $30. Further, a PRC group interview was held on January 15, 2020 and lasted approximately one hour. Supplemental data collection and the resulting analysis describe below were led by the first author (GV): the lead researchers (DPW and BR) requested he led collection as an observer without prior participation in the study, making his views less susceptible to pre-existing biases that could blind him to potentially important themes.

Data analysis

The first author (GV) led the analysis with assistance from the second author (ES). They followed a combined deductive-inductive analysis approach using an initial list of a priori codes derived from the research literature (e.g., intervention modifications) and issues of

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importance identified by the lead researchers and then identifying additional data-driven codes (e.g., service vouchers) inductively through an initial round of open coding (Elo & Kyngäs, 2008; Hsieh & Shannon, 2005; Kuckartz, 2014). All coding and theme development was guided by the primary goals of understanding study challenges, responses, and participant and staff perceptions (Thomas, 2006). In successive transcript readings, the team used the constant comparative method (Mathison, 2005) to compare the existing codes with data in additional transcripts to improve and re-categorize the codes, the codes definitions, and developed sub-codes. Assessment of interrater reliability among 5 of the transcripts demonstrated 80% agreement between the two coders (Burla et al., 2008). Thematic saturation was determined at the point when continuous back-and-forth between developing themes and the data yielded no new insights (Eisenhardt, 1989; Glaser & Strauss, 2009). Results where then organized and summarized for presentation by theme. All data analysis was carried out in NVIVO-12 qualitative data analysis software (AlYahmady & Alabri, 2013; QSR, International Pty, Ltd., 2020).

Results

The analysis identified two overarching themes and several sub-themes. The first major theme was that PRCs input drove most modifications made to the original intervention and trial design, and this developed largely from the learning meeting data. The second major theme developed from the client focus group data demonstrated how it was that the PRCs that set the SUPPORT program apart from alternative services in the community.

PRC input as a drive of research and intervention-related decisions

Analysis demonstrated learning meetings were, as planned, a venue where all key stakeholders could share ideas, resources, and differencing viewpoints. However, PRCs were the stakeholders with the most substantial input in terms of the adaptations made to the design of the intervention and implementation of both intervention and research protocols. While a proportion of their concerns and input were related to minor issues, such as conducting community outreach and organizing a daily internal workflow among PRCs, three significant topics PRCs brought to light that were the provision of research incentives, vouchers provided to those participants assigned to receive the SUPPORT intervention, and the provision of a “safe space” for SUPPORT clients to congregate.

Research incentives

The most salient issues PRCs brought to light were related to research incentives provided to participants of the clinical trial. The initial concern was that study ineligible clients were learning about the research incentives provided to participants and were requesting to be part of the “program with the gift cards” as a result. This was quickly solved by informing PRCs to simply inform any clients who inquired about being part of the study that the procedures for the selection of research participants was controlled exclusively by the researchers and staff were not allowed to enroll anyone into the study.

A second and more difficult to address PRC incentive concern was that the value of the incentive for completing baseline data collection ($60) was perceived to be too much.

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Initially, participants were to receive $30 each for two separate interviews, one to collect demographic and recovery outcome data and another one to collect social network data. The interviews were originally supposed to occur on separate days because the research team was concerned about participant fatigue. However, due PACE's workflow and space availability, the interviews were combined to occur at a single time point. As such, clients were receiving $60 on one day, which PRCs found troubling:

> "The other thing that came up [information relayed to by PRCs] is we're giving [research participants] a pretty big gift card when we first meet them, and most of them are actively using. So, we're pretty much giving them the okay to go get high with that much money. And so, [the PRC] was like, the question was, can we give them a little less in the beginning…?" (Learning meeting, November 8, 2017)

This concern led to an ethical discussion regarding research participants' right to spend money considering the risks associated with a potential drug use binge, including potential overdose. Based on additional PRC input obtained after the meeting, the research team decided the best solution was to split the incentive so participants would receive $30 from the researcher after the first interview and the other $30 would be provided by a PACE staff member after the second interview (which still occurred immediately after the first interview) was completed. This allowed PRCs space to have a clinical discussion with clients to identify and mitigate any potential risks of drug use resulting from the incentive (usually by employing appropriate harm reduction strategies) (Collins et al., 2017; Koffarnus et al., 2013; Tidey, 2012).

Discussions regarding incentives continued in future meetings, reflecting that solutions were working well. One example that demonstrated how this new approach was leading to more honest and open discussions about substance use occurred when a SUPPORT participant had told his PRC he was going to spend his research incentive on heroin:

> "[The participant] had the gift card and that was going to help him be able to use because he had been a few hours since that time [his last use]. We talked about treatment, the possibility of [it] – [he said] "not right now." [He was] real clear with that…It was so honest and so clear you just had to respect him for saying it." (Learning meeting; January 3, 2018)

This discussion and others around incentives helped PACE to recognize the risk for all their clients who use opioids (not just study participants) and facilitated organization-level implementation of education and distribution of naloxone (the opioid overdose-reversing medication).

Service vouchers

During program design, there was consternation among PRCs and other PACE staff that participants assigned to the SUPPORT arm might misappropriate voucher funds provided, as is a common concern when working with marginalized groups, such as those with SUD (D'Angelo et al., 2016; Festinger & Dugosh, 2012). As a result, PRCs decided it was best to not inform clients of voucher funding at all, but to identify places they could assist clients by

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using the funding in ways that were in-line with their stated recovery goals *(Learning meeting; November 8, 2017).*

This was pushed back on by the research team because the original goal was to let clients know about the vouchers in order to foster a sense of personal agency related to their recovery. A compromise was reached where PRCs would withhold information about the vouchers until the participant was further along in their services and had demonstrated they were progressing in relation to their recovery goals.

The original assumptions of the researchers were validated in the focus groups with SUPPORT participants, as they indicated the PRCs should have been more transparent regarding the voucher funding: "*I think that should be discussed at some point, you know? And like, I would let people know. If they're engaging in treatment and they're doing well, what can do, like financially, maybe to help you. Like, in lieu of it…being a secret*" (*SUPPORT participant interview; June 27, 2019*). Another client who was unaware of the vouchers pointed to a way they could have used the funds to help a legal issue they were facing:

> "I need more legal advocacy…I'm going to try and compile my achievements and asked the court for modification. That's going to cost me money. I don't know if I'll have it and I don't know how long it'll take me to get it." (SUPPORT participant interview; November 16, 2019)

In many cases, the importance of the voucher funding was valued by clients as it provided them the opportunity to pay for critical prescription medication, which was highlighted by one client below:

> "But I think the big thing about this program that sets [it] aside from anything else is the funding [voucher]. That's there. And the availability for it. Like, it's helped me in, for instance, paying for my suboxone. I mean, that has been, that really helped me out. That kept me clean right there. You know what I mean? Being able to have that in a pinch, like that really helped me." (SUPPORT participant interview; June 27, 2019)

Providing a "safe space"

During a learning meeting, one of the PRCs stressed the importance of developing a "safe space", where SUPPORT clients could feel comfortable spending time outside of the context of a visit with their PRC.

> "…I really think it would benefit us to set up something where people are not just here for the across the desk "how are you doing today, when's the last time you used", but here's a place to sit and have a cup of coffee. Other recovering people are in the space. It's a drop-in place for them…I may feel safe coming to sit here and have a cup of coffee, but I don't necessarily want to have a 10 AM appointment with [my PRC] because I just finished using…" (Learning meeting; January 3, 2018)

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This discussion resulted in the a "drop-in" space being allocated outside of the PRC's office. The "drop-in" space later evolved into a full recovery resource center when state funding became available:

> "[What I'm trying to figure out] looking at [the] true mission [of the recovery resource center] and how that is well defined…[I am] borrowing from SUPPORT policies [and] I have some amazing recovery community organization toolkits…It's easy working on that policy and procedure [manual], blending what SUPPORT has given us, because that is our program [we started with], and adding these [new] things." (Learning meeting; November 14, 2018)

As demonstrated by the above selection, SUPPORT not only prepared PACE to take on this new project, but as also provided the framework for the PRCs to develop the Center's policies and procedures. As such, SUPPORT and the resource center became two separate but synchronistic initiatives at PACE.

PRC requirements

It was also recommended that there be more direct supervision of PRCs in addition to a minimum sobriety length of three years, as one PRC experienced a relapse in their recovery during program implementation. One PRC reflected on their beliefs as it related to the requisite length of sobriety needed to effectively operate as a PRC:

> "So, and I kind of play hardball in the longevity of recovery because as a peer I think it's super important that, peers that have that living experience or they come from the background of being a recovery person themselves that they are actively involved in their own recovery because how can I pass on what I'm not doing myself? I hear so many people [aspiring PRCs] they have 30 days or 90 days [sobriety], I want to be a peer recovery coach…But if you don't have that foundation, because foundation is monumental, and sometimes what peers will do is they think just because I'm sharing with you that I'm working on my recovery, no that is incorrect…I think it's very important that as a peer, you know, that I absolutely am engaged in my own recovery, so that I can take care of myself as well and then it works out, I think, best. So, I get very nervous when people are being peers when they're like, oh I've got a year [sobriety], and I'm like wow. When I was a year, I was still kind of crazy. You know, which I still am, but you know, not as much as I was before." (PRC interview; January 15, 2020)

Additionally, discussions regarding future modifications to the PRC requirements focused on the need to incorporate a clinical supervision protocol. The discussions on clinical supervision also highlighted the potential to better incorporate harm reduction training to the PRCs, and to act as a potential safeguard against PRC burnout and relapse. One PRC commented on the role of clinical supervision by saying the following:

> "I think we probably could have used someone who was meeting with [PRCs] on a weekly basis to do clinical [supervision]. And having a clinical supervisor would have really helped to just be able to talk to that point person to better understand what [PRC name] or [PRC name], [or] others were doing so that then it didn't feel so personal." (PRC interview; January 15, 2020)

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The work of PRCs set SUPPORT apart from alternative interventions and services

While not all of the PRC-recommended modifications the original study plans might have been viewed as beneficial by researchers and clients, the second major theme demonstrates how it was truly work of the PRCs that set SUPPORT apart from similar services for returning citizens that existed in the community. This is because the strengths of SUPPORT pointed to by clients were PRCs criminal justice relationships and knowledge and the supports clients received.

PRCs criminal justice relationships and knowledge

SUPPORT client interviewees stated the PRCs had established relationships with agencies that were relevant to the needs of justice-involved individuals throughout the community, such as with clients' correctional officers, which aided in the creation of a supportive recovery network. This highlighted the importance of the PRCs knowledge of the criminal justice system, and the non-profit agency's nearly 55-year working relationship with criminal justice stakeholders, that aided clients' navigation of their recovery within the context of the unique challenges faced for those in recovery at community re-entry. For instance, a PRC summarized the benefits of the nexus of criminal justice experience among PRCs and strong relationships with criminal justice stakeholders:

> "So, our relationship with criminal justice [stakeholders], which is obviously how I met [PRC name] when he was in criminal justice, is they're very familiar with what we do. They trust us. So, if we have a client on home detention and we want them to come to groups as part of their recovery plan, we should get less pushback than the average agency would because we have a very good rapport and reputation with them. Let's say we had an individual who relapsed, we need to get him into treatment, we wouldn't necessarily have to tell their criminal justice officer that they relapsed and all this happened. We could say [to the criminal justice officer] we are really recommending this, are you on board with it and they would, for the most part, okay yes and go along with what we did…On the flipside, we had a client who relapsed and went to jail. So, because we have a relationship with the jail, we had the jail dialoging with us, yes she's here. We said, can you move her to the specialized medical care unit, yes we can. Can we come meet her, sure you can. So, we just have easier access in the different correctional facilities because of that strong relationship with the stakeholders (PRC interview; January 15, 2020)."

Clients considered PRCs to be adept at tailoring SUPPORT in a manner that conveyed an understanding of their recovery needs as they re-entered the community. They also indicated PRCs actively nurtured an open and supportive relationship, while also holding them accountable for their recovery through regular check-ins and continued efforts to engage clients.

> "To me, it's more catered to felons. 'Cause when they get out of jail, they have nowhere to go. We have nowhere to go. No one to turn to. Because we have to start all over. Because, before we went in jail, we had lives. When we come out of jail, we have nothing, not even jobs. [I] lost an apartment, after eight years, two jobs, so come to [non-profit agency] and I'm back on track again. Yeah, because I am a

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> felon now and my age and a lot of people do not want to hire a felon at my age… So, what [PRCs] did for me was get me a job, help me get a job and into a sober living house, but after that, I said I've got to do this. I have to do this, 'cause I'm used to being independent. Living by myself, by myself. So that's what Pace did for me, help me get a job (SUPPORT participant interview; July 9, 2019)."

Indeed, clients indicated that the PRCs were "very understanding" of their needs upon release from incarceration. Further, one participant indicated that the PRCs were knowledgeable in treating felons and that *"they all know what all comes behind that…. correction officers, probation officers, they know, they are aware of it, and they are professionals with that. They know how to handle that (SUPPORT participant interview; July 9, 2019)."*

Following community re-entry, PRC linkages provided access to services that allowed clients to regain their independence, and as a result, some clients indicated that they no longer had to engage in illegal activity to support themselves now that they have access to supportive resources – a key behavioral change for justice-involved individuals:

> "[the PRCs] held me accountable, provide me with services to where I didn't have to go back out and sell drugs, or steal, or rob or whatever. And just make sure I was doing okay, like if I needed anything, you know they were there to have my back (SUPPORT participant interview, June 27, 2019)."

The supportive nature of PRC services

Participants stated that the PRCs at the host agency were more effective than those they have experienced at other community providers. For example, at some providers, clients may not always engage with the same PRC, as is the case in the current program, which can limit the level of rapport and trust between client and PRC. One client reflected on her experience by saying the following:

> "They, I feel like they care. You know what I mean? They like hold you accountable, you know what I mean? More or less, like if I don't show up for a meeting, [PRC name] is going to call me. She's gonna be like, 'where you at, what happened?' You know what I mean? And even if I don't answer, she's going to leave a voicemail (SUPPORT participant interview; June 27, 2019)."

A PRC also expanded on this theme and the value of establishing a therapeutic alliance with clients by maintaining a consistent relationship between them and the clients they are working with:

> "I would say there is (sic) other peer programs, you know, in the community happening, but not like what's happening here. So, like, somebody was describing one the other day and they were like, you just show up and there's just peers there. So, yeah, there's a peer, but it's not the same peer. [My client] always knows where I've been. And so it's consistently [me working with this one client] and so I think that's also different. (SUPPORT participant interview; January 15, 2020)."

This same PRC then went on to explain how having a consistent relationship with a single peer was beneficial because of the history of trauma most clients have and how that can lead to difficulties forming trusting relationships:

> But what I'm saying is for the population we serve, there is a lot of trauma that has never been dealt with, there's a lot of just stuff that hasn't been dealt with and so if I don't develop that relationship with [a client],then I'm not really going to trust, I'm not really going to get the true value out of the peer relationship. In my experience this past year, once I make that instant connection, and I gain a little of that trust, then I see the client open up and then they open up more, and more and more, and then they give me the opportunity to then, well have you ever looked at this and have you ever looked at, oh that's that not working, how's that working for you. So, I think it's the connection. It is the connection and the intimacy that you can gain, not with every client, because every client is not going to open up. But the majority, once you gain that, you know trust and that intimacy then they start opening up (PRC interview; January 15, 2020)."

Discussion

Our findings demonstrate how the SUPPORT intervention and clinical trial protocols were impacted by the inclusion of PRCs in learning meetings that guided development and quality assurance and how the PRC-based intervention was received by justice-involved clients. Overall, this highlights the value of involving peers in early stage research, and this is consistent with prior literature highlighting the value of involving members of vulnerable populations in research concerning them (Marshall et al., 2015). Moreover, there is relatively little guidance in the greater PRC literature on how peers who work with justice-involved individuals can best be involved in research; therefore, it was necessary to examine lessons learned and formulate best practices for PRCs' involvement in research projects – with attention to justice involved populations.

Focus groups and learning meeting discussions yielded important PRC-initiated changes to both the research process (e.g., research incentives and data collection system) and the intervention (e.g., development of a safe space and resource center for clients) that would likely not have occurred without PRC engagement. The process by which these changes emerged—in discussions with a diverse group of community stakeholders and researchers—and the nature of these changes—adaptive programming grounded in the lived experiences of PRCs and clients—align with previously identified approaches for improving SUD peer involvement in research processes (Viswanathan et al., 2004; Wallerstein & Duran, 2006).

PRCs were integrated into the learning meetings as soon as possible and this integration included ongoing feedback, thus maximizing the mutual benefit of the partnership. The findings demonstrated that PRCs' expertise as peers and service providers was immediately solicited and valued, and their suggestions for changes carried considerable weight in shaping research and intervention decisions. The current findings have been supported by existing literature that suggests peer supports contribute to research through their knowledge of community norms, understanding the values and needs of clients, skills related to

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organizing, and positioning as cultural brokers and outlets for dissemination (McConnell et al., 2018).

In turn, the team members benefited from research professionally, through expanded networks (i.e., researchers and other providers), social support, and an increased understanding and skills related to research (e.g., grant writing) (Spector, 2012). The importance of PRCs was demonstrated by their role in synchronizing the ongoing efforts of PACE with the new study protocol within SUPPORT – including the development of a recovery resource center. PRCs advised on policies and procedures that could be sustainable in the context of community-engaged practice. That is, often in an agency setting there is a benefit to adaptability, as agency demands may pivot in new directions if opportunities for sustainability present themselves during the study period. Therefore, it was in the best interest of the PACE staff, the PRCs, and the clients that the services are viable at the conclusion of the research study. From a researcher perspective, there was likely a mutual desire that the program could be sustained long-term, but it should also be stated that the denial of new opportunities that may alter the course of the research study would be unethical (Mikesell et al., 2013). To note, this malleability was written into the framing of the SUPPORT intervention, as a 12-month-long intervention that delivered flexible, comprehensive, and client-centered recovery services (Watson et al., 2017).

Behavioral health research is often fraught with ethical challenges that are complicated by the different moral viewpoints of various stakeholder groups (Gordon et al., 2018) and the current research that integrating PRC perspectives demonstrated respect for their experience and expertise, which can lead to improved design and implementation of interventions and the associated research protocols. And critically, the benefits of including peer supports in the research design process has been endorsed by prior research – insofar as enhancing the intervention quality and resulting in a stronger overall impact on client lives (Amirav et al., 2017; Domecq et al., 2014; Gordon et al., 2018; Jagosh et al., 2012; Marshall et al., 2015; Viswanathan et al., 2004). Per clients' reporting, the PRC-initiated changes to the intervention – in concert with PACE's ongoing services – had demonstratable implications to their experiences of the program. That is, themes emerged within the clients' focus group data that indicated clients' primarily positive reflection on the capacity of the intervention to address the needs of a re-entry population. The PRCs in the current study had personal involvement with criminal justice settings and had received training to provide coaching and mentoring along the continuum of criminal justice involvement. In addition to the PRCs assistance throughout the re-entry process – aiding individuals exiting jails to transition to the community by supporting their recovery needs – they also had intimate knowledge of specialty courts, jail-based processes, probation officers, and established relationships within these systems which was viewed as facilitating more appropriate referrals and care to their clients.

The findings in the current study extend a growing body of literature that has provided a compelling case for greater peer support involvement in the criminal justice system (Bond & Drake, 2014; Davidson & Rowe, 2008; Portillo et al., 2017; Rowe et al., 2007). Integration of PRCs in research has strong potential for improving the development and delivery of behavioral health interventions, and the peer engagement approach outlined in this paper

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may be feasibly adapted to other community-based behavioral health programs. For instance, studies of justice-involved individuals indicate a high prevalence of trauma exposure among this population group, which includes interpersonal trauma (e.g., domestic violence, battery, assault) (Gunter et al., 2012), and systemic- and economically-driven violent trauma related to drug use (Copes et al., 2015; Victor & Staton, 2020). A tenet of trauma-informed care focuses on creating opportunities for individuals to regain a sense of control (Hopper et al., 2010), which may be a critical component of recovery for justice-involved individuals, many of whom are actively balancing reoccurring traumatic exposure and the strain associated with community re-entry. Therefore, it is plausible to hypothesize that peer engagement which forges partnerships across systems during the re-entry process and supports clients' recovery goals may adapt well to trauma-informed care and increase clients' resiliency against chronic re-offending, worsening of trauma-related symptomology, and challenges related to recovery.

However, there are several limitations. These data presented in this study are from a single non-profit organization in a Midwestern state; therefore, the generalizability of the current findings is limited. In addition, given the limited number of PRC staff and clientele, and the longstanding involvement of the non-profit agency with criminal justice stakeholders, it is unclear how the current findings would compare to a larger PRC cohort with or without robust support from a non-profit agency. Future research should continue to explore implementation outcomes related to feasibility and acceptance of PRC integration into jails or prisons, with the aim of understanding how well these individuals coordinate care for vulnerable population groups with behavioral health concerns. In addition, future research should explore how the degree of familial and kinship support infrastructure is associated with individuals' barriers and facilitators to a successful community re-entry. Given that African American males make up a large proportion of the US correctional population, it is recommended that researchers understand these social support systems that may be unique to this population group.

Conclusion

PRCs are considered an asset in the development of research policies and protocols and in the recovery planning among a justice-involved re-entry population. Thus, this study has added novel data on how organizations and academic researchers can collaborate with PRCs on how to best integrate PRC services into their organizational structure and research processes. This study also supported the notion that PRCs do play an important role at the point of community re-entry among justice-involved individuals with SUD – in large part due to rapport-building and the humanistic PRC approach. Although the current findings are promising, and the general peer literature base demonstrates positive outcomes for SUD concerns, the role of peer services at re-entry has not been rigorously investigated. To that end, future research should investigate whether the characteristics of PRCs impact outcomes and assess the potential benefit of peer deliverers with criminal justice experiences working with justice-involved clients.

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