

What Peer Support Can and Cannot Promise: An Honest Evidence Review, 2026

The short version

- Peer recovery support has the best evidence for **getting people into treatment and keeping them there** (engagement, linkage, retention). Several recent reviews agree on this [1][2].
- Evidence that it improves **substance use itself** is described by the reviewers as preliminary, inconsistent or inconclusive [1][2]. Evidence on overdose and mortality is inconsistent [2].
- Most of the research was done with people already in treatment, in emergency departments or in justice settings. We found no study of peer coaching for employed adults who are not in treatment.
- So Still Standing Recovery promises a process (a fast human reply, a plan for paying for care, the same coach) and does not promise an outcome. Still Standing has no clients yet and makes no outcome claims.
- Still Standing will measure itself with short, standard tools and will publish what it finds, including results that are poor.

1. What the studies measure, and how strong they are

“Peer recovery support” covers many things: a person with lived experience of recovery who meets someone in a hospital bed, runs a recovery center, makes weekly calls or helps someone book care. The research reflects that. Before the results, here is what kind of evidence each source is.

Source	What it is	Design strength
Eddie et al., 2025 [1]	Systematic review update: 28 multi-group studies, 12,601 participants; searches to December 2024	Review of studies with more than one group
Duan et al., 2026 [2]	Systematic review: 53 studies, 2003 to 2026	Systematic review; our notes do not break down the designs
Chardavoyne et al., 2026 [3]	Review of 9 studies comparing peer-led and other emergency department approaches, 14,883 participants	Review of comparative studies
Kelly et al., 2025 [4]	Review of 7 studies of recovery community centers; none had a comparison group	Observational only
Castedo de Martell et al., 2025 [5]	Review of the policy and payment landscape and research gaps	Describes gaps; not an outcome study
Eddie et al., 2019 [7]	Earlier review of peer services	Review; authors note “many null findings” and methodological limits
Beaudoin et al., 2022 [8]	Randomized trial in emergency departments, 648 people	Randomized
Watson et al., 2024 [9]	Pragmatic randomized trial in emergency departments, 243 people	Randomized
AmeriCorps-funded evaluation, 2024 [6]	Evaluation of 11 recovery coaching organizations	Program evaluation; our notes do not record its design

A review is only as good as the studies inside it. The two emergency department trials below compared peers with another form of help, not with no help. The recovery community center studies were observational, and people chose to take part, which matters below.

2. What peer support has shown

Engagement and retention in treatment. This is the most consistent result. The 2025 review of 28 studies concluded that the evidence “has coalesced to indicate the capacity of” peer recovery support services “to improve” treatment engagement and retention [1]. The 2026 review of 53 studies found the evidence most favorable for treatment linkage and engagement [2]. The earlier 2019 review also reported better retention and satisfaction, and better relationships with providers and supports [7].

Which programs did better. In the 2026 review, programs with favorable outcomes more often had “sustained navigation, practical assistance, and repeated peer contact” [2]. That is an association across studies, not a tested recipe. It is the reason Still Standing’s design is built around navigation and repeat contact. A separate AmeriCorps-funded evaluation of 11 recovery coaching organizations found lived experience important for building rapport [6]. That is a finding about trust, not about outcomes.

Substance use. The 2019 review found positive results on reduced use and return to use, alongside “many null findings” [7]. The 2025 review calls the evidence on substance use outcomes “preliminary but inconclusive” [1]. The 2026 review calls findings on substance use inconsistent [2].

Recovery capital and functioning. In seven recovery community center studies, participation went along with better substance use, recovery capital and functioning [4]. None of those studies had a comparison group, so this is a correlation.

Related models that are not peer-specific. Two designs that inform Still Standing’s step-down contact are not described in our notes as peer-delivered:

- Recovery Management Checkups (regular check-ins with re-linkage to treatment). In a randomized study, the primary outcome was any treatment over 12 months, with an adjusted odds ratio of 3.85. Days of treatment and days abstinent were secondary outcomes [10]. Our notes do not give a result for abstinence days, and we do not state one.
- Telephone continuing care. Randomized trials measured any alcohol use, heavy use and percent days abstinent, with 79.9% assessed at 18 months [11]. Our notes record how outcomes were measured, not the results, so we make no claim about them.

Family support. CRAFT is a training approach for family members and other concerned people, not peer support. A review of 14 studies (691 family members) found it about twice as effective as comparison conditions at getting the loved one into treatment. Treatment entry was highest with combined individual and group delivery (77% and 86%) and lower with a self-directed workbook (13.3% to 40%) [12]. This is about entry into treatment, not about recovery.

Cost. We can say little. The 2026 review reports limited economic data [2], and the 2025 policy review names peer-workforce and economic-evaluation research as major gaps, even though peer services are reimbursed by Medicaid in almost every state [5]. We found no reliable cost-per-outcome figure for peer support and do not offer one.

3. What peer support has not shown

It has not shown a reliable effect on deaths or overdose. The 2026 review found results on overdose and mortality inconsistent [2]. We cannot say peer support prevents either.

Peers did not beat other help in the two emergency department trials we reviewed.

- In the Navigator trial (648 people), 32% of the peer arm and 30% of the social-worker arm received treatment within 30 days. That difference was not statistically significant. Outcomes came from linked statewide records [8].

- In the POINT trial (243 people), there were no significant differences on return to the emergency department for overdose, linkage to medication treatment and other outcomes [9].
- A 2026 review of 9 comparative emergency department studies found mixed results and no clear superiority [3].

These comparisons were against another trained worker, not against no help. They tell us peers are not reliably better than a social worker at short-term linkage in a high-risk setting. They do not tell us peers are no better than nothing.

It has not shown long-term abstinence. We found no figure in our sources for sustained abstinence attributable to peer support. The 2025 authors say more work is needed on “when, where, and over what duration” and “for whom” [1].

It has not been tested for people outside treatment. Nationally, 3.5% of people with a substance use disorder (1.6 million) received services from a peer support specialist or recovery coach in 2025, and 92.4% of those also received treatment [13]. Peer support in the data is mostly an add-on to treatment. We found no outcome study of peer coaching for employed adults outside treatment settings.

Weaknesses that apply across the field.

- **Self-selection.** People who join a program or a recovery center may already be more motivated. The community center studies cannot separate the effect of the center from the type of person who goes [4].
- **Short follow-up.** Many studies track people for months, not years. The Recovery Management Checkups study interviewed people at 3, 6, 9 and 12 months [10].
- **Heterogeneity.** “Peer support” ranges from a one-off hospital visit to years of weekly calls. Pooling these can hide what works.
- **Fidelity.** How closely a program follows its design matters. The CRAFT review found that comprehensiveness, training and fidelity predicted success [12]. We have not seen the same tested for peer support, so we cannot say how faithfully the programs in these reviews were delivered.
- **Who is in the studies.** Mostly emergency department, treatment and justice populations [1][2][3].

4. What this means for promises

A promise should be something we control. We control how fast we answer, whether we make a plan, and whether the same person follows up. We do not control what happens in someone’s life.

What we can promise	What we will not promise
A human reply within one business day	That anyone will stop or cut back
A one-page plan in your own words by the end of week one, including how care could be paid for	Abstinence, cure or recovery
Help booking: a three-way call, or a script you can use	That treatment will be offered, available or covered
The same coach follows up, with a named backup who has read your notes	That coaching will work better than treatment or another kind of help
Check-ins on the schedule you choose, and an offer of help if you return to use	That use will stop, or never return
Contact only through the channel and rules you set	Any result for your health, job, family or finances
A plain statement of what we found, published after the first months of service	Safety in every situation; coaches are not emergency services

Returning to use is treated as information, not as failure. A coach will offer to help re-connect you with care.

5. How Still Standing will measure itself

Still Standing has no clients yet. The numbers below do not exist. We will publish them after the first months of service, and we will publish them whether they look good or poor. We have not set outcome targets in this paper and we will not retrofit any.

Process measures (what we promised): whether a human replied within one business day, time to first conversation, whether a coverage pathway was identified in week one, whether an appointment was booked among people who wanted treatment, and how many people are still in contact at 30, 90 and 180 days.

Instruments. All are self-report and short. None is a diagnosis. Scores are conversation starters, not labels.

- **BARC-10** (Brief Assessment of Recovery Capital): 10 items, validated against the 50-item version. A cut-off of 47 was associated with sustained remission in the validation samples [14]. That is evidence about the scale, not about our service. Used at intake, 90 days and 6 months.
- **AUDIT-C**: 3 questions about drinking. In one study in VA primary care, it identified heavy drinking with an area under the curve of 0.891 [15].
- **NIDA single drug-use question**: asks how many times in the past year a person used an illegal drug or misused a prescription medication. In one study it was 100% sensitive and 73.5% specific for a drug use disorder [16].
- **Columbia suicide screener (C-SSRS)**: used for safety at intake and when distress shows up in a check-in. It is free for community use and can be asked without mental health training [17]. It is a safety tool, not an outcome.
- **SUPRT-C** (SAMHSA's client self-report tool): short sections that people can skip, offered as an optional, one-tap "help keep this free" step, never a condition of service [18].

The accuracy figures for AUDIT-C and the NIDA question come from other settings and older studies. They show the tools can detect use, not that they will detect change in our setting.

Outcomes we will report: change in BARC-10 over time, self-reported drinking or days of use, treatment status, and whether people are still employed at 90 and 180 days. Employment is not an outcome other programs report much, and we will say so when we publish.

The model. Still Standing's coaching is called Navigate and Stay.

- **Navigate (week one)**. A coach helps the person check coverage, shortlist options and book help, and writes the one-page plan with them. Contact is short and frequent in the first four weeks.
- **Stay (step-down check-ins)**. Check-ins ease from weekly to every two weeks to monthly, then quarterly checkups to 24 months, at a pace the person can change. Extra contact falls around risk points, such as the day before treatment starts and the first week after any discharge or back at work. A return to use leads to prompt re-linkage.
- **Family track**. Family members and other concerned people get their own track, informed by CRAFT [12]. We never pass on to the loved one what a family member tells us.

This design draws on what the reviews associate with better results (sustained navigation, practical help, repeated contact [2]) and on the check-in models above [10][11]. It has not been tested as a package, and it has not been tested with employed adults who are not in treatment.

6. Limits of this review

- We read summaries of these studies compiled in our research notes. We did not re-analyze the original papers or any underlying data.
- We did not search every database. This is not a formal systematic review, and it was not independently peer-reviewed.
- Our notes do not give pooled effect sizes or confidence intervals for the reviews. We report only the numbers the notes record. Where a number is missing, we say what is missing.

- The 2026 reviews are very recent. Their authors' own full texts may add caveats we have not seen.
- Study populations, definitions of “peer support” and outcome measures differ. Comparing across studies is rough.
- Peer support was studied mostly alongside treatment, so the results may not carry over to a free coaching service for people who have not entered treatment.

7. What this means for Still Standing’s work

Still Standing’s claim is **access and engagement**: helping people reach and stay connected to care, and helping families take a first step. It is not a claim to reduce return to use. The evidence supports the first much better than the second. Because the evidence for people like those we serve is thin, Still Standing will publish its own results.

What we could not verify

- **Effect sizes and confidence intervals** for the 2025 and 2026 reviews are not in our notes. We did not state any.
- **The Duan 2026 abstract.** We tried to retrieve it from PubMed for headline numbers. The page was blocked by a cookie wall, so we rely on the summary in our notes.
- **Results of the telephone continuing care trials** and the abstinence results of Recovery Management Checkups: our notes record the outcomes measured, not the findings.
- **Studies by Reif and Bassuk** that were suggested for this review are not in our research notes. We did not cite them.
- **Cost-effectiveness** of peer support: no reliable figure found.
- **Any study of peer coaching for employed adults outside treatment:** none found.
- The AmeriCorps evaluation (2024, 11 organizations) is summarized in our notes only as finding lived experience important for rapport; we cite it for nothing else; we did not see its design or sample details.

Sources

1. Eddie et al., “Peer recovery support services: systematic review update,” Current Addiction Reports, 2025. <https://link.springer.com/article/10.1007/s40429-025-00645-8> (PMID 41551498; <https://pubmed.ncbi.nlm.nih.gov/41551498/>)
2. Duan et al., peer recovery support systematic review (53 studies), Drug and Alcohol Dependence, 2026. <https://pubmed.ncbi.nlm.nih.gov/42570534/>
3. Chardavoyne et al., peer support in emergency departments (9 comparative studies), Substance Abuse and Rehabilitation, 2026. <https://pubmed.ncbi.nlm.nih.gov/42367672/>
4. Kelly et al., recovery community centers (7 studies), Journal of Substance Use and Addiction Treatment, 2025. <https://pubmed.ncbi.nlm.nih.gov/40447107/>
5. Castedo de Martell et al., peer recovery support policy and research gaps, Substance Use & Addiction Journal (Subst Use Addctn J), 2025. <https://pubmed.ncbi.nlm.nih.gov/39323370/>
6. AmeriCorps, recovery coaching evaluation evidence snapshot (11 organizations), 2024. https://americorps.gov/sites/default/files/document/Recovery_Coaching_Final_Report_Evidence%20Snapshot.pdf
7. Eddie et al., review of peer recovery support, Frontiers in Psychology, 2019. <https://pmc.ncbi.nlm.nih.gov/articles/PMC6585590/>
8. Beaudoin et al., Navigator randomized trial, 2022. <https://pubmed.ncbi.nlm.nih.gov/35943744/>
9. Watson et al., POINT pragmatic trial, 2024. <https://pubmed.ncbi.nlm.nih.gov/38258819/>
10. Scott et al., Recovery Management Checkups, 2023. <https://pubmed.ncbi.nlm.nih.gov/37864532/>
11. McKay et al., telephone continuing care, 2010. <https://pubmed.ncbi.nlm.nih.gov/20873894/>
12. Archer et al., CRAFT systematic review, Addiction, 2020. <https://pubmed.ncbi.nlm.nih.gov/31770469/>

13. SAMHSA, 2025 National Survey on Drug Use and Health annual national report, released 27 Jul 2026.
<https://www.samhsa.gov/data/sites/default/files/reports/rpt57150/2025-nsduh-annual-national-html/2025-nsduh-annual-national.htm>
14. Vilsaint et al., BARC-10 validation, Drug and Alcohol Dependence, 2017.
<https://pubmed.ncbi.nlm.nih.gov/28578224/>
15. Bush et al., AUDIT-C, Archives of Internal Medicine, 1998. <https://pubmed.ncbi.nlm.nih.gov/9738608/>
16. Smith et al., single-question drug screen, Archives of Internal Medicine, 2010.
<https://pubmed.ncbi.nlm.nih.gov/20625025/>
17. Columbia Lighthouse Project, Columbia Suicide Severity Rating Scale. <https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/about-the-scale/>
18. SAMHSA, SUPRT-C adult baseline tool, 2025. <https://www.samhsa.gov/sites/default/files/gpra-suprt-c-adult-baseline-tool.pdf>

About Still Standing. Still Standing Recovery is a California charity offering free, confidential coaching from credentialed peer recovery coaches who have been through recovery, for working adults worried about drinking or drugs.

Version and date. v1.0, 17 October 2026. We update papers when new data are released. General information, not legal, medical or insurance advice.