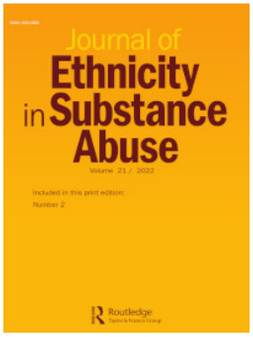

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Rethinking Recovery: A Qualitative Study of American Indian Perspectives on Peer Recovery Support

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ABSTRACT

Objectives: This qualitative evaluation was guided by two questions: 1) How does peer recovery support (PRS) support American Indian (AI) people in recovery from substance use disorders? and 2) What makes PRS effective?

Methods: We utilized a descriptive qualitative study design to explore the essence of PRS. Semi-structured interviews were conducted with six AI peers to explore the perceptions and lived experiences of recovery from one urban Montana location. Data analysis involved coding all the transcripts using the priori codes developed, then identifying key themes from the coded data.

Results: Themes and interview data helped us explore how PRS supports recovery and potential reasons why it is effective for AI populations. Peers indicated that the program helped them maintain their recovery, and the role of peer mentors was critical to their success. Themes of belonging, connection, and compassion were common among peers interviewed. They also felt that recovery is a spiritual process. The peers had limited recommendations for improving the program, except the need for funding sustainability.

Conclusions: Understanding how people recover is the first step in addressing the current substance misuse epidemic facing our nation. This evaluation outlined the qualitative impacts of PRS, the spiritual nature of PRS, the context of PRS, and recommendations from peers involved in the program. More work is needed to explore how to sustain PRS programs and integrate PRS into existing community-based settings, like churches, social services, urban AI centers, and other locations.

KEYWORDS

American Indian; peer recovery support; recovery

Introduction

American Indians (AIs) experience disproportionate impacts from drugs and alcohol. Despite advances in evidence-based prevention, treatment, and recovery support in the US and beyond, AIs have the highest rates of past-month drug use (17.4%), past-month binge drinking (25%), and

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methamphetamine use (Substance Abuse & Mental Health Services Administration [SAMHSA], 2019). Stressors like poverty, institutional and systemic racism, neglect, physical abuse, emotional abuse, household instability, trauma, exposure to family members with addiction, mental illness, or incarceration can contribute to an elevated risk for substance misuse in AI populations (U.S. Department of Health and Human Services (HHS) & Office of the Surgeon General, 2016).

There is limited research on how AI people with substance use disorders (SUD) recover. What we know about recovery comes from the US general population, publications, and reports. An estimated 22 million people in the US are in recovery from an alcohol or other drug problem (Kelley, 2022; Kelly et al., 2017). In 2018, the US Surgeon General reported that up to 50% of adults with previous SUD are in stable remission (more than one year) (2018). Theories about how the general population recovers from SUD range from readiness and stages of change (Prochaska & Norcross, 2001) to the learning model of addiction (Lewis, 2015). Other theories stress the importance of social environments (Alexander et al., 1981) or promote the disease model of addiction, which views addiction as a disease of the brain that requires clinical treatment like any other chronic disease (Pickard, 2017). All these theories have been tested and published, but when applied to individuals in recovery, they do not always fit, as there is not one theory that is affectatious for all individuals with SUD. A key issue with Western behavioral health theories and treatment models is that they are developed based on a general population profile and lack cultural specificity or context when applied to unique populations like AIs. Among AI populations, researchers have found that support from family and friends, culture, spirituality, and involvement in voluntary self-help groups facilitate recovery (Kelley et al., 2017). Others report that enhancing self-efficacy, coping skills, motivation, and social network changes (Kelly et al., 2009) support recovery. This finding was also echoed in the US Surgeon General's synthesis of evidence to address drugs and alcohol, where research demonstrates the effectiveness of 12-step mutual aid groups and 12-step facilitated interventions (2018).

An emerging body of research on evidence-based approaches for Peer Recovery Support (PRS) demonstrates that it is a promising approach and potentially effective (Eddie et al., 2019; Kelley et al., 2015; White, 2012). However, previous studies on PRS have been criticized because they lack methodological rigor (Cos et al., 2020; Reif et al., 2014). Critics of PRS call attention to small samples, inconsistent definitions of peer workers and recovery coaches, lack of comparison groups, and inability to isolate PRS from other forms of support received. One of the most significant challenges with published PRS studies is that they are written by

researchers, from the lens of western clinical models of treatment and recovery, utilizing standardized instruments (such as the GAD-7 or PHQ-9) that measure quantitative recovery outcomes (Cos et al., 2020). Studies may include individuals with the lived experience of recovery in different aspects of a study, but the data used to document effectiveness is often curated by researchers. The use of western models and instruments to assess recovery introduces a bias that fails to recognize the contextual and cultural aspects of recovery in AI populations (Kelley, 2022). In sum, there is a plethora of data about high rates of SUD in AI populations; however, there is limited data on recovery for this population (Rieckmann et al., 2012). This study fills a knowledge gap by documenting the actual experiences of peers involved in a PRS program and focuses on the context of recovery, PRS program impacts, spiritual aspects of recovery, and recommendations using qualitative methods.

Peer recovery support (PRS)

In the last five years, community-based PRS services have emerged as a key element in helping communities and individuals address high rates of substance abuse and limited recovery support resources (Kelley, 2022). PRS is unlike traditional treatment approaches because it is non-clinical, where individuals with the lived experience of recovery help other individuals in recovery (Reif et al., 2014). PRS is multi-faceted to include mentoring, education, and support services provided by individuals with the lived experience of recovery to individuals with SUD or co-occurring substance use and mental disorders (Reif et al., 2014). While there are many definitions of recovery, the Substance Abuse Mental Health Services Administration (SAMHSA) defines recovery as a process of change where people seek to improve their health and wellness and strive to live a life that reflects their full potential (Substance Abuse & Mental Health Services Administration & Center for Behavioral Health Statistics & Quality, 2012a). Peers and peer mentors take collaborative actions to improve four major wellness domains: health, home, purpose, and community (Substance Abuse & Mental Health Services Administration & Center for Behavioral Health Statistics & Quality, 2012a). To foster the success of the peer's recovery journey, the peer mentor relationship is guided by key recovery principles, including hope, person-driven, diverse pathways, holistic, peer-supported, relational, culturally relevant, trauma-informed, respectful, and strength-based (Substance Abuse & Mental Health Services Administration & Center for Behavioral Health Statistics & Quality, 2012b).

Peer mentors (also called Peer Support Specialists, Peer Recovery Support Specialists, Peer Navigators, or Peer Coaches) are now common positions

in social service offices, prisons, churches, schools, clinics, treatment facilities, and other community-based organizations. In certain populations, PRS is preferred over self-help groups like Alcoholics Anonymous or counseling (Kelley, 2022; Kelley et al., 2015; 2021). This perspective is based on the concept that PRS provides a new path to recovery that is individually driven, culturally responsive, and often community supported.

PRS in AI populations has been helpful in addressing negative perspectives, stigma, and experiences within the Western behavioral health model and system –some feel the model is colonial, Eurocentric, discriminatory, and culturally inept (Kelley et al., 2015). These views are rooted in real experience and have resulted in barriers to treatment and limited participation in recovery settings among AI people. The US Surgeon General's Report (US Surgeon General, 2018) found that PRS and recovery support organizations are instrumental in promoting recovery but cited insufficient evidence to support widespread adoption and use. However, a greater understanding of how people recover and common themes in their experiences could be used to inform general recovery approaches and peer recovery support programs (Kelley, 2022). In this paper, we summarize key themes from qualitative data collected from AI individuals with substance use disorders enrolled in a 6-month peer recovery support pilot program in Montana.

About the project

The PRS project was facilitated by a tribal consortium located in an urban area of Montana. The consortium is led by elected tribal officials and serves 11 tribes in Montana, Wyoming, and Idaho. The consortium serves more than 80,000 AIs in rural and urban settings. The PRS target population was 400 AI people over the age of 18 who live in Montana and Wyoming and are in recovery. The consortium partnered with tribal Chemical Dependency Program Directors and tribal leaders to identify communities that would be willing to pilot and implement the PRS project. A culturally tailored, tribal-specific PRS project resulted from these discussions, and this was important because many recovery programs are based on a Pan-Native American Recovery approach that often fails to recognize the unique traditions, language, and history of a given tribe (Owen, 2014). The goals of the PRS project were to decrease substance use and relapse (Kelley et al., 2021). Peer mentors (coaches) were trained extensively to provide PRS in partner communities. Peer mentors are diverse and can be cultural leaders, elders, youths, healers, advisors, and spiritual teachers. A community advisory board supported the program and included community representatives from substance abuse/recovery

supporting organizations, cultural programs, traditional knowledge keepers and elders, public and tribal schools, social service organizations, law enforcement, juvenile justice, community-based organizations, and others.

This qualitative study was guided by two questions: 1) How does PRS support AI people in recovery from substance use disorders? And 2) What makes PRS effective?

Methods

Evaluation study design

We utilized a descriptive qualitative study design to explore the essence of PRS. Consistent with qualitative study designs, our approach was grounded in an interpretivist position, meaning we are most concerned about the experience of recovery and understanding peer perspectives about PRS (Astalin, 2013). The case study approach was appropriate because we are interested in the phenomenon of PRS based on real-life contexts (Yin, 2003).

Participants

Key informants were selected by the lead peer mentor using convenience sampling methods (Etikan et al., 2016). Inclusion criteria for the selection of informants was participation in the program for at least 6-months, evidence that they utilized PRS services provided, and willingness to voluntarily complete the interviews. Evidence was determined based on completing program intake and participating in weekly activities with a peer mentor. All were AI people from tribes located in Montana. Other demographic information was not collected due to the sensitive nature of PRS, and the small number of peers interviewed. No participants were excluded from the interview process if they met the inclusion criteria and were willing to participate in the interviews.

Data collection

Qualitative semi-structured interviews were conducted with six AI peers to explore the perceptions and lived experiences of recovery from one urban Montana location. Before interviews started, the evaluator met with the peer and provided training in qualitative data collection techniques and how to conduct interviews. Consistent with an empowerment-focused evaluation, the evaluator paid the peer an equitable stipend for their work. Peers were interviewed by the peer. The peer conducting the interviews was an individual receiving PRS services from the program. Interviews

began with peers providing verbal consent to participate in the interview. Responses were transcribed using a pen and paper. All participants received a $50 gift card to compensate them for their time. Peer interviews served as the primary data source for this qualitative study. IRB review and approval of this evaluation was conducted prior to data collection.

Together the peer mentor, peer, and evaluator formulated an interview guide (see Appendix). Interview guides covered a variety of topics about recovery and involvement in the program. Questions were designed to answer the two evaluation questions that focused on how PRS supports recovery and what makes PRS effective. The peer conducting the interviews was instructed to follow up on responses when additional information was required, or to clarify responses provided.

Data analysis

Interview data were transcribed into Microsoft Word from handwritten notes and text messages (used to provide clarification or additional information from the interview). Transcribed notes were sent to the evaluator. All identifying information that could be linked to participants was removed and replaced with a unique identification number (#1-6). Data extraction for this evaluation involved selecting and coding all text-based on interview questions. The coding structure was developed a priori by the evaluator.

One person coded the initial transcripts. Codes were reviewed by both authors. Data analysis involved coding all of the transcripts using the a priori codes developed, then identifying key themes from the coded data (Yin, 2003). Themes were reviewed by both authors to ensure they were appropriate based on context and evaluation questions (Kelley, 2018; 2020). Validation of the results occurred by sharing the results with individuals and peers involved in the program, and those with the lived experience of recovery, comparing results with existing literature, and consensus of results through verbal agreement of authors.

Results

Interview data from six peers helped us explore how PRS supports recovery and potential explanations about what makes it effective for AI populations. A priori themes used to code data include the context of recovery, program impacts, spiritual aspects of recovery, and recommendations.

Context of recovery

Peer experiences and their recovery varied. Peers indicated that the program helped them maintain their recovery, and the role of peer mentors was critical

to their success. One peer said, "I am a recovering meth addict. I used meth almost every day for 10 plus years so you could say I was a hard-core meth addict for over a third of my lifetime; wasted years I will never get back."

Other peers talked about their struggles with maintaining recovery and the importance of family.

> Every day was a struggle for me to stay positive for my family, and every day, more and more, I wanted to give up and give in and get high cause I thought if I got high, I wouldn't be so stressed and life wouldn't be so hard but every day there was my peer mentor or someone I met through this program. I would see someone, and I would make it another day sober. This went on every day for five, almost six months. Within that time, our pickup was stolen; thankfully we got it back minus everything that was stolen or broken. There were nights we had to sleep in our cars; nights we slept in holy tents. There were days and nights my boyfriend, and I wouldn't eat so our kids would get enough. Running out of gas became normal. Having to re-wear your least dirty outfit was okay after a while. Being harassed by family and DFS a few times a week and forcing a smile for the kids almost killed me… every time.

Another said, "I was literally falling apart and dying inside full of fear knowing at any moment I might just walk out the door get high and never look back but then here would come someone or something familiar to me from my recovery would save me and my sobriety for another day."

Gratitude was also noted within the context of recovery. Praise for the program and peer mentorship demonstrate peer experiences.

> And as I am sitting here today with tears running down my face feeling so grateful for amazing people like my amazing mentor and programs and groups like this for saving my life. It's been 15 days since we are no longer homeless, and through it all, I kept my sobriety thanks to my blessing from my journey in recovery.

The program helped peers maintain their sobriety. Most felt the support they received from peers, and attending weekly talking circle groups, and support groups helped them maintain their sobriety. One peer said, "To maintain my sobriety, I attend meetings, try to get involved in things, and share with my peers." Another said, "I attend self-help meetings, smudge, pray, talk to my sponsor/mentor, and work on my steps to maintain my sobriety."

Relapse

A common contextual theme found in the interviews was related to relapse. Peers talked about stressful life events, homelessness, relationship breakups, federal agencies wanting to take away their children, and not having enough money to meet their basic needs. Without the program, many peers felt they would have relapsed during these stressful times. Because of the program, peers knew how to ask for help and support, and this support carried them through difficult times.

> If it wasn't for her and this program, I probably would have relapsed. On May 30th of this year, my boyfriend, myself, and our four kids became homeless; at first, it wasn't so bad. We all looked at it as a vacation till we found a place to rent; we went to swimming pools and restaurants, ordering room service, chilling, and enjoying life. Weeks went by, and we still hadn't found a place to rent. Motels were getting old and feeling crowded. Our bank accounts getting lower and lower, and it didn't feel like a vacation anymore. I was getting more and more stressed and worried as days would go by, and that's when the urge to get high began, so I would call or text my mentor and visit her. She always reassured me, and between her and the programs, I was never alone and would be okay.

Perceived positive impacts

PRS has positive impacts on peers. Themes of belonging, connection, and compassion were common among peers interviewed. These statements from peers underscore the importance of PRS programming and support. One peer said, "I found a mentor, and I'm still sober because of it." Another reflected, "All the info from the program has helped me feel part of the community." Peers also reflected on the types of support they received that had the most significant impacts, "…my support group with my peer mentor, the transportation to and from places [helped me]. It has been very encouraging and supportive". Another peer discussed PRS impacting community involvement, "Socially by getting me involved in the community, pushing myself to challenge myself to run, volunteer for events, expressing myself and helping me to find new things to do in recovery." Other peers also discussed community involvement and feeling important, "The support and involvement in the community helped [me] during my struggle, feeling safe…and finding new things to do that did not involve alcohol or drugs. I felt compassion from my peer, important, listened to, and safe".

We wanted to know if our peers achieved their goals due to the program. At the beginning of the program, peers developed goals for their recovery in partnership with their peer mentor. Goals varied from getting a house, getting children back that had been taken away, enrolling in school or job training programs. All peers were able to achieve at least one goal due to participating in the program. Peers talked about their goals during the interviews and ways to become more involved in recovery meetings. Peers also reflected on personal growth resulting from PRS. This included being able to deal with anxiety and stress, finding employment, finishing prerelease, and finding sober housing. One peer reflected, "My goals to achieve were to become a giving person. The program helped me to realize my life is worth sharing. To give my testimonies in recovery groups means that I am giving others help by being involved at recovery meetings. My peer mentor was wonderful". Another peer shared how PRS

helped them overcome anxiety and reach spiritual goals of prayer and participation in ceremony. Peers unanimously agreed that PRS helped them maintain their recovery, "…to stay sober, to keep working through tough times, to talk with group members and stay accountable to them, find housing in sober living and help work through issues and help solve issues [these were the goals achieved]".

A spiritual process

Peers talked about recovery as a spiritual process. Peers renewed their spiritual strength through meetings, prayer, smudging, and seeking out guidance when needed. Some felt the program reconnected them to their spirituality; one peer said, "I take a spiritual way on my sobriety, and I have the program to thank for that." Other peers talked about attending church and seeking out God as a higher power to teach them how to live. "If I stay accountable to my group members, myself, write (journal), meditate, pray and exercise [I maintain my recovery]. Get involved in the community, meetings, and church." Others wrote, "I am seeking out a higher power, God… to teach me how to live."

Recommendations

Peers did not have any recommendations on how to make the program better, but a common theme among peers, peer mentors, and our partners is the need for continued funding of the program. Because the program was grant-funded, it ended in September 2019. The facilitating organization was unable to continue to provide services, and this left a huge gap in the availability of culturally responsive peer recovery support services in the urban area.

Discussion

This qualitative evaluation explored two questions: 1) How does PRS support AI people in recovery from substance use disorders? And 2) What makes PRS effective? Themes demonstrate the effectiveness of PRS and provide insight into which aspects of PRS facilitate recovery from substance use disorders.

How does PRS support recovery? In this study, we found that the context of recovery varies. This is consistent with previous research that found recovery is based on an individual's lived experience, the kinds of support they have, self-efficacy, motivation, and involvement in voluntary activities and groups (Kelly et al., 2009). In the present evaluation, we identified

homelessness, fear of relapse, and the importance of social support as contextual factors that support recovery. This is consistent with previous studies in this population where social support and housing were facilitated through PRS services (Kelley et al., 2017). At the same time, this evaluation pointed to the importance of grant-funded programs and their flexibility compared with other PRS programs that require extensive paperwork to meet third-party billing requirements. Some felt that PRS offered in this context was even more effective than traditional PRS models because it was implemented by a tribal consortium, with flexibility and attentiveness to culture.

Peers reported positive impacts from being involved in the program. Impacts related to reaching their recovery goals, achieving and maintaining sobriety, social connections, and community involvement. This is similar to previous research from the White Bison Wellbriety movement that indicates that civic leadership and social support are critical for addressing high addiction rates in AI communities using peer recovery support models (Moore & Coyhis, 2010). PRS may have a greater impact in urban AI locations where many people do not have access to kinship systems, cultural activities, and support available in a peer's tribal nation.

What makes PRS effective? Recovery is a spiritual process, and PRS helps facilitate the process of peers seeking a higher power to help them in their recovery. Peers talked about their belief in a higher power: "seeking out higher power in God to teach me how to live" and "smudging, prayer, and praying for guidance." The program connected peers to talking circles, smudging, prayer, and a group of people in a community that would support them in their recovery—this is the foundation of recovery and healing. Previous studies link spirituality to cultural resilience, which supports recovery (Elm et al., 2016); others describe addiction as a crisis of the spirit (Lowery, 1998). Addiction and, therefore, recovery is based on the concept that healing occurs by reclaiming the spirit (Deloria, 1999).

Peers maintain their sobriety in different ways. All peers mentioned some form of support; some received this by attending weekly talking circles; others said being with their peer mentor and getting involved in activities in the community. This is consistent with previous research by Kelly and colleagues, which found that 45% of people in recovery in the US attend self—help groups, and 17% access recovery support services such as faith-based or community recovery centers (2017).

Although recommendations for future programs were limited, all peers wanted the program to continue. Because the program was grant-funded, peers knew that they would no longer have access to a peer mentor employed by the program. Implications from this study apply to clinical

education, practice, and supervision. First, it is imperative that providers working in a clinical setting recognize that they do not hold the keys to recovery and do not determine who recovers and who does not (Kelley, 2022). PRS is a viable and preferred approach to supporting AI people in recovery. Second, ways in which people recover from substance use disorders vary, but social support, spiritual practices, and involvement in community activities help. Recovery initiatives must incorporate these factors into engagement, treatment, and recovery models of care. Third, accessing recovery supports is not equal or equitable, and AI populations continue to experience high rates of substance use disorders and limited recovery resources (Kelley, 2022). Clinicians, educators, and supervisors involved in various aspects of recovery must work relentlessly to build equity and improve access and reduce discrimination, racism, and acultural models of PRS with AI populations.

Limitations

This evaluation included a small sample of AI peers involved in a PRS program; their experiences and recommendations do not represent all people or all experiences, only their own. Bias related to social desirability should also be considered (Leggett et al., 2003). The convenience sampling method used is subject to bias (Etikan et al., 2016). Still, given the limited amount of time, resources, and the transient nature of the population, this was the only viable approach for sampling. The method used to record interviews varied; due to limited access to computers and familiarity with technology, some of the interviews were typed in a text message on a cellphone and later transcribed. This may have resulted in abbreviated text or not documenting the entire response due to the nature of text messaging as a qualitative data collection method. Despite these limitations, this evaluation provides unique insight into the lived experiences of peers involved in a PRS program. These experiences and impacts can be used as a basis for funding additional PRS efforts in AI populations who may not access traditional Western treatment and recovery resources.

Conclusions

Understanding how people recover is the first step in addressing the current substance misuse epidemic facing our nation. Reaching people where they are at in their recovery is critical, and peer mentors with the lived experience of recovery can do this. This evaluation highlights the continued need for PRS programs that serve AI people in recovery.

Evaluation findings underscore the impacts of PRS, the spiritual nature of recovery and PRS, the context of PRS, and recommendations from peers involved in the program. More work is needed to explore how to sustain PRS programs and integrate PRS into existing community-based settings, like churches, social services, urban AI centers, and other locations. Future research should explore the amount and duration of PRS required to sustain recovery. Although this may be difficult to capture because PRS does not occur within a clinical setting, and PRS services provided are not always captured or quantified.

Recovery is a process, and PRS assists individuals by providing critical support when they need it most. Findings support the continued use of PRS as a viable approach to maintain recovery and underscore the need for change at the individual, community, and nation level. PRS has the potential to revamp how traditional models of recovery support are developed, determining who is qualified to provide PRS to individuals in recovery and in what context. This study recognizes the benefits of PRS and outlines the potential of PRS to heal individuals and communities who experience high rates of SUD. It is imperative to explore viable pathways toward building recovery capacity among AI populations with limited recovery resources available. This evaluation provides key thematic elements needed for AI peer recovery support and recovery generation.

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