Peer Health Navigation Experiences Before and After Prison Release Among People With Opioid Use Disorder

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Objective: Recently incarcerated people with opioid use disorder are at high risk of overdose and adverse outcomes as a result of biopsychosocial risk factors. Peer support models aiming to improve these outcomes have expanded in recent years. This qualitative study aimed to document participants' experiences with peer health navigation before and after prison release, examine participants' perspectives on the role of peer health navigators, and understand participants' views on service improvements.

Methods: The authors conducted in-depth, semistructured interviews with 39 recipients of peer health navigation at release, 30 of whom also completed a follow-up interview 3 months later. Interviews were analyzed via cross-case analysis.

Results: Interviewees differently valued the various types of support they received. Participants appreciated working with someone with shared lived experience with whom they could establish a trusting relationship. Nevertheless, structural and policy barriers meant that certain key needs—such as housing and employment—could not always be met.

Conclusions: Peer health navigators can connect participants to evidence-based treatment and help them address their psychosocial needs and develop skills to support long-term wellness. Further research is needed to assess the impact of peer health navigation on participant outcomes, such as overdose reduction, treatment engagement, and sustained recovery.

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Individuals with substance use disorders are overrepresented in the criminal legal system. More than half of those incarcerated in state prisons have been diagnosed as having a substance use disorder, and 15%–20% of state prisoners regularly used heroin or other opioids in the year before incarceration (1). When transitioning from incarceration to the community, these individuals are at extremely high risk of overdose, in part because of the loss of drug tolerance while incarcerated and the high risk of relapse after release (2, 3). Many studies have shown high rates of mortality among former prisoners after release (3), with the risk of a fatal drug overdose in the 2 weeks after release being as much as 129 times that among the general population (2). People with substance use disorders leaving prisons may experience numerous barriers to recovery and community reintegration, including unstable living arrangements (4); unemployment (5); limited social support for meeting food, housing, and recovery needs; and lack of access to timely treatment and support for comorbid general medical and mental health conditions (6, 7).

Meeting the complex needs of individuals recently released from incarceration requires a comprehensive approach that addresses multiple aspects of recovery and holistically addresses social determinants that undermine community reintegration (8, 9). Individuals returning to the

HIGHLIGHTS

- Recently incarcerated people with opioid use disorder are at high risk of overdose and adverse outcomes as a result of multiple biopsychosocial risk factors, and peer support models aiming to improve these outcomes have expanded in recent years.
- Interviews with recently incarcerated people suggest that recipients of peer navigation services value the support and the opportunity to have a trusting relationship with someone with similar life experiences.
- Peer health navigators can connect participants to evidence-based treatment, help them address their psychosocial needs, and help them develop skills that support long-term wellness, but barriers to recovery and community reintegration remain.

community after long periods of incarceration may have difficulty navigating complex health care and social services systems because of stigmatizing practices (10). Recognizing these challenges, some organizations have established peer navigation services—programs that employ individuals with lived experience in common with those they are serving—to aid individuals with the prison-to-community transition (11).

Many implementation models exist (12–15), but peer support services generally refer to nonclinical support services delivered by peers either independent from or in conjunction with professional treatment (11). Research on the effectiveness of peer support in carceral settings has shown promising reductions in criminal legal system recidivism (13, 16), increased engagement in psychiatric or substance use treatment (14), improved self-rated health (15), and HIV-specific health improvements (17, 18). Peer support may also play an integral role in addressing inadequacies in the substance use disorder system of care (19), but systematic reviews have identified a need for further rigorous research (20, 21).

Few studies have examined the role of peer services specifically at the intersection of incarceration and substance use disorders (12–15, 17, 22, 23), yet such programs are expanding rapidly as peers' ability to support community integration and long-term recovery is recognized. In substance use and mental health care, peer support services—also referred to as peer navigation or peer mentoring—have implemented a recovery model for substance use disorder treatment, which calls for a person-centered, strengths-based wellness approach (24, 25). Some research has examined the experiences of peer health navigators (PHNs) working in such settings (26, 27), but only a few studies have examined the importance of their specific relationships with people exiting incarceration (28, 29); no studies have thoroughly examined recently incarcerated people's longitudinal perspectives on peer relationships in the context of community reentry, a crucial aspect of providing this person-centered, strengths-based support.

Understanding participant perspectives on peer services is critical, because participants can help identify successful program aspects and areas that need improvement, which can lead to a better understanding of effective peer-participant relationships. This qualitative study explored participant experiences with PHN services during the transition from prison to the community and had three aims: first, to describe participants' views (in their own words) on the supports and services they received from their PHN and which of these they perceived to be most valuable; second, to examine participants' perspectives on the unique role of PHNs working in this context and their most important qualities; and third, to understand participants' views on unmet needs and opportunities for service improvements.

METHODS

An extended methodological description is available as an online supplement to this article. Key elements are described in the following sections.

Study Setting

This study used data collected from participants in the Rutgers University Behavioral Health Care Intensive Recovery Treatment Support (IRTS) program, which provides team-based support to people with opioid use disorder incarcerated in New Jersey. The program provides 3–6 months of prerelease and 12 months of postrelease engagement with PHNs. PHNs have direct experience with incarceration, substance use disorders, or mental health challenges and act as empowerment catalysts; they identify needed action steps that help program participants take charge of their own lives. During the prerelease phase, PHNs use a person-centered planning process to identify participants' strengths and develop plans for participants to achieve their goals after release (30). After release, the team provides peer support, facilitates linkages to services and resources in the community, and helps participants build the skills necessary for successful community tenure and relapse prevention. The focus of this article is on the relationship between a participant and their primary PHN, but each IRTS team includes a nurse, two case managers, and 10 PHNs from whom participants receive support.

Sample and Recruitment

We recruited participants by using utilization-focused convenience sampling (31). Participants had to be individuals recently released from New Jersey state prisons who were age 18 years or older, English speaking, diagnosed as having opioid use disorder, and currently or previously enrolled in the IRTS program. Of the 355 individuals released during the study period (July 2020–April 2021), 300 participants were approached by PHNs, who distributed study flyers and provided the research team's contact information. Participants had the option to contact the team via preaddressed letter, text, telephone, or e-mail. Informed consent was obtained after the procedures had been fully explained to participants. Participants were invited to complete an initial (release) interview and a second (follow-up) interview 3–4 months later, regardless of program enrollment status. We interviewed a total of 39 participants shortly after release, of whom 30 also completed the follow-up interview.

Data Collection

Demographic information was obtained from program records and gathered through participant self-identification. Guided by the consolidated framework for implementation research (32) and with input from service providers and a program funder, we developed two semistructured interview guides that assessed participants' experiences. The release interview guide contained items pertaining to the

TABLE 1. Summary of findings and exemplary quotations from participants recently released from prison (N=39), organized by theme

Summary of findings	Exemplary quotations
Theme 1: important program elements: services and support	
Emotional support (someone to talk to, relapse prevention, discussion of challenges), appraisal support (assistance with goal setting and developing action plans, feedback for self-monitoring, encouragement), informational support (guidance, suggestions, information on resources to support recovery and reintegration), and instrumental support (linkage to general medical, mental health, substance use disorder, and recovery support services; transportation; mobile phone; material needs, including clothing and food)	"The fact that they gave me somebody who cares, again, and it's not just him, either. It's the nurse. It's the secretary. It's the whole crew. I could just call, and they'll immediately help with no problems. I never have any back and forth, any begging, nothing. They're just there for whatever." (participant 1516) "Any time in my time of weakness and I reach out to any one of them, even if it's not my peer navigator, they're there for me to talk to and guide me in the right direction." (participant 1932) "She gives me all these resources, like, 'If you want to go to a meeting, I could get one for you,' and stuff like that." (participant 1216) "She's always there for me. You know what I'm saying? I know that she's there and that's a good feeling, that you can call her, reach out to somebody to get assistance." (participant 1329) "They already helped me with filling out [forms] for my Medicaid. I'm waiting for the arrival of that, maybe this week. They helped me with the welfare situation to apply for that. They helped me with mental health." (participant 1613) "My navigator, he called me all the time. He talked to me about my situation if I had problems. I felt comfortable sharing with him. He would stop by my house. We would talk and everything. He was like a friend." (participant 1608) "He helped me get into a shelter when I first got out. And then he helped me go to social services. . . . He brought me to social services and started the work on my housing and my [temporary rental assistance], which is how I got the place I'm at now." (participant 1936) "They always tell me about food banks and places I can go for shops if I need it, or whatever. . . . If I need clothes, I can always go to them. They'll tell me where to go to get clothes." (participant 1516) "They've gone over and above to make sure that I have my medications that I need, to make sure I'm in touch with the right counselors or psychiatrists." (participant 1932)
Theme 2: important qualities of peer health navigators	
Shared lived experience, trustworthy, empathetic, understanding, nonjudgmental, supportive, motivational, honest, genuine, transparent, open minded, good listener, person centered, resourceful, informative	"Somebody who doesn't have that experience or ever had those drug problems or whatever, they don't, they can't compare with us. They don't understand the struggles we go through and the struggles we've had and where we've been." (participant 1511) "It shows that people can change. . . . When I see people doing better and that [have] experienced the same thing I've experienced, it's like, 'Well, if he could do it, I can do it.'" (participant 1516) "To be honest, I liked the fact that the people that you send out are people who have actually experienced drug use or [have] family members that do drugs, someone who's actually been through it. Because when you're talking to somebody who has never really experienced it, it's like you can't really relate because what they're saying, they don't see eye to eye where you're coming from." (participant 1516) "They don't even have to have been there. Maybe somebody with just an empathetic personality or a soul. I would say character, empathetic character." (participant 1932) "Someone who's willing to help, but not force certain things on you. Somebody that is willing to not be rigid, but to have a plan, but be willing to change their plan to serve you the best way you need to be helped." (participant 1936) "In the past, I've been a procrastinator and not really motivated to do much. And he's got this, I don't know, this spirit about him, where it's like I want to do good." (participant 1951) "She looks for any information that can help in any situation, going to meetings, helping, looking for housing. I mean, she's just there for all that." (participant 1511)

continued

TABLE 1, *continued*

Summary of findings	Exemplary quotations
Theme 3: unmet needs and opportunities for improvement	
Unmet needs (housing and employment), opportunities for improvement (more hands-on assistance, extended prerelease engagement period, opportunities for recreational activities, additional material assistance, increased capacity)	"I know they definitely have been trying to help, but like housing—they couldn't get me no housing at all. . . . Just saying, because of my charges, I'm not eligible for basically anything. . . . He was trying, I know that much, he was trying to call everybody, but in the county on that, they don't seem like . . . I don't know, if you got any kind of drug offenses of any kind of nature, they don't want to give you nothing here." (participant 1985) "When I went to social services, he wasn't even allowed to come in with me, and I had to go in by myself. . . . So I had nobody there that was going to be able to back me up or help me out, and it didn't really work out quite well. I mean, the situation ended up working out overall, but if he was there and was able to help me, I think it would have been a different situation than it was." (participant 1936) "Just being honest when given a request from a participant, whether or not this request can be achieved or done or not. As opposed to having someone believe that I can do this or I can make sure this happens, just being straight up and not just being like, as you say, like a people pleaser by just saying things." (participant 1760) "The ball should start rolling prior to the person being released. I think it would behoove [Intensive Recovery Treatment Support] to figure out how they can link up with the Department of Corrections and begin that ball at least a few months prior to an individual's release." (participant 1677) "A lot of us are coming out of those situations, our people have moved away. Our family members have moved away and stuff like that. We're coming out here to start all over. We're coming out here to nothing. Housing placement I think will be one of the main services that could really improve this program." (participant 1265) "Oh, I always think you should be better with helping people, being more hands-on with different businesses, like housing, shelters, [Supplemental Security Income]. I think they should be more hands-on with them. Doctors, psychiatrists being able to . . . they don't see me. They don't have enough . . . what word could I use? She can't call my doctors or anything, and she can only give me the numbers and tell me to call. I think they should [be] more hands-on with the whole setup. Everything, everybody should communicate with each other and know what this one person is doing, and what's happening, and what's going on with this one person. Everybody should be on the same page." (participant 1801) "I think they could help me more with working with people. Doing different activities, helping people out with jobs and stuff like that." (participant 1087)

participants' experiences in the early weeks after release and their goals for recovery and reintegration. The follow-up interview guide focused on IRTS services received in the community. In both interviews, participants were asked for their perspectives on working with PHNs and what they perceived to be the program's strengths and areas for improvement (see online supplement for interview guides). Interviewees were compensated with $25 gift cards for completing each interview and $5 for verifying their contact information 1 month after the first interview.

Interviewers were an experienced graduate-level qualitative researcher (P.T.) and two graduate student trainees who received ongoing training and supervision. Interviews averaged 30 minutes in length and were done by telephone between July 2020 and April 2021. Strategies used to preserve participant confidentiality are described in the online supplement.

Analysis

We initially created a codebook that reflected the sensitizing concepts, or themes identified by the study team before analysis, from the interview guides. Throughout the coding process, we added codes as needed, which were discussed and retroactively applied to previously coded transcripts. Three independent graduate-level qualitative researchers coded the first three interviews to establish a consistent coding style and to ensure that the codebook accurately reflected interview content. The remaining interviews were coded by one of three graduate-level staff members or graduate students, and each was audited by one of two senior team members. Discrepancies or inconsistencies that arose during this process were addressed at recurring team meetings. To manage potential bias among research team members, personal reflexivity was addressed at these team meetings, as described in the online supplement. Three

members of the research team then conducted cross-case analysis to identify patterns and deviant cases (31). Study data were managed, coded, and analyzed with Dedoose software, version 9.0. All study procedures were approved by the Rutgers University Institutional Review Board.

RESULTS

Of the 39 participants, 35 (90%) were men; 17 (44%) were non-Hispanic White, 13 (33%) were non-Hispanic Black, and nine (23%) were Hispanic of any race. Median participant age was 39 years (range 24–61). Of the 30 individuals who completed the follow-up interview, five were no longer participating in the IRTS program. We present the findings in sections corresponding to study aims. Additional quotations pertaining to each study aim are provided in Table 1.

Important Program Elements: Services and Support

IRTS participants described forms of support as emotional (provision of care or empathy), instrumental (provision of tangible goods or aid), informational (information provided during a time of stress), or appraisal (information that is useful for self-evaluation) (33, 34). Individuals emphasized different types of support, with some placing greater value on emotional and appraisal support and others preferring more tangible supports to which PHNs connected them.

Participants consistently highlighted that having a PHN who was there for them "no matter what" (participant 1249)—and whom participants could call at any time as the need arose—was the most important aspect of the program. They shared that knowing that the PHN was always there to help gave them a sense of security: "Whatever problem I have, whatever situation, whatever, it's like, she's there" (participant 1249). Participants reported that PHNs listened, talked through challenges, and shared their own experiences to support participants' recovery.

> If I need something, I just call them up, even if it's something simple, just someone to talk to . . . and that seems hard nowadays, just to get somebody to listen to you. . . . They made me feel like . . . the whole world is not against [me]. (participant 1233)

Several individuals spoke about how conversations with PHNs were especially important when they felt at risk of relapse: "If I want to relapse, I can always just call and maybe they'll talk me out of it or take me out to eat or something. . . . Just have a great conversation with positive people" (participant 1516).

Interactions with PHNs also provided appraisal support, which facilitated goal setting, self-evaluation, and continued self-improvement. Although many interviewees did not engage with staff during the prerelease phase (because of COVID-19 restrictions), those who did discussed how valuable prerelease engagement was for setting recovery goals. "He was talking to me about how I was doing in jail and how things were progressing with my sobriety and what my plans were for when I was getting released, how he could help me with reintegrating once I got out" (participant 1936).

Many participants viewed PHNs as role models because they had overcome similar challenges related to addiction, incarceration, or both. "I do know that he is [in] recovery. . . . And just to see he's still clean, he's still working, and stuff like that . . . that's [a] positive influence, so it's good to see that" (participant 1988).

Many participants emphasized the informational support they received through IRTS services—that is, guidance, suggestions, and information about resources that could support their recovery. As one person shared, "She was very helpful with giving me information on certain other things that could all lead to getting a job or some training" (participant 1265). One participant added that even when the PHN was unsure of how to help them, "They'll send me a link to something or they'll point me to the right person I should talk to that would know more about it" (participant 1955).

Participants described the critical role PHNs played in following through on instrumental or tangible supports, most often by linking participants to health services. Most participants had started medications for opioid use disorder before release. They described how PHNs were critical to navigating obstacles to community-based treatment: "She got me into the place. She set up the transportation and everything and got involved with my insurance. She's just there with me, a hundred percent" (participant 1249). Respondents also received help with applying for benefits, without which it would have been difficult to access needed health services. PHNs, in conjunction with other IRTS staff, also connected participants to housing, employment, education, and government benefits, as well as to clothing, food, childcare, or home furniture.

Important Qualities of PHNs

When asked which PHN qualities were most important to them, many participants highlighted the value of shared lived experience, which helped PHNs understand what participants were going through and fostered trust. "The peer support is, for me, it was very critical. Because as I mentioned about my trust issues and my apprehension about just new people saying things and not producing" (participant 1760). A few respondents said it would not have mattered whether the PHN had lived experience, reporting other qualities that helped to create a strong relationship: "I'm pretty sure a regular person could help, too. We're all regular people" (participant 1216).

Most participants felt it was important that PHNs be empathetic, understanding, nonjudgmental, and supportive because, as one respondent said, "People look at ex-convicts as being at the bottom of the list" (participant 1453). Respondents valued PHNs who showed that they were "compassionate about another person's situation" (participant 1265). Participants felt it was important for PHNs to be supportive and motivational and to genuinely show that they "want you to win" (participant 1955). Several participants used words such as *honest, trustworthy, genuine,* and *real* when describing important PHN qualities. Participants

could sense when a PHN "really wants to help you other than just somebody who looks at it as a job" (participant 1516). Interviewees shared that they valued when PHNs were transparent and did not "sell you a dream" (participant 1516).

Effective PHNs were also described as open minded, good listeners, and person centered. Several respondents felt that it was important that their PHN follow their lead rather than tell them what to do and be adaptable to changing needs and circumstances. One participant said, "She's very, she can be mindful of how I see things . . . someone who listens to you and doesn't just try to tell you what to do but actually works with you to come up with something together" (participant 1216).

Although a majority of participants appreciated their individual PHN's interaction style, some wished for a different approach, including more "tough love": "It's about being stern. . . . Sometimes putting your foot down. Like okay, they don't want to hear it, then it's time to go. . . . Show tough love sometimes" (participant 1329). Another participant felt this kind of approach would demonstrate that the PHN "knew what he was doing" and was not someone "that I could just manipulate or get [one] over on" (participant 1913).

Unmet Needs and Opportunities for Improvement

In discussing their experiences with the IRTS program, participants identified recovery needs that were not fully met. Most prominently highlighted were barriers to housing and employment, especially for individuals with a conviction for drug distribution charges, which precludes access to resources in both areas. Among interviewees who described unmet needs, the most common (identified by 10 respondents) pertained to housing. Others also shared that they would have liked more direct employment assistance, including "job placement or job readiness" (participant 1265). However, it is worth noting that for many participants, successful connections to employment and housing support were program highlights.

A few participants wanted the PHN to play a more active, hands-on role in connecting them to services, or at least to more clearly understand, describe, and guide participants through the process of applying for social services and other resources. One individual who expressed this sentiment acknowledged the limits imposed by COVID-19: "With this COVID-19 thing going on . . . I think they could do more if you were more hands-on other than phone calls and separation" (participant 1453). One participant perceived the social services system to be fragmented and poorly coordinated.

The interpersonal nature of recovery coaching with PHNs meant that not every PHN-participant interaction went smoothly. A few interviewees highlighted communication or interpersonal challenges between themselves and PHNs:

> So my peer navigator went on vacation, and she gave another navigator my number, and the guy like . . . kind of weirded me out. I go to work. I wake up at 5:00 in the morning to go to work, and he wanted to meet me real bad. He was so persistent about it. (participant 1932)

This quotation exemplifies how PHNs at times went above and beyond to make sure they connected with their clients. Whereas others may have appreciated this level of effort, this individual found it overbearing.

One of the most significant changes to the IRTS program resulting from COVID-19 was the inability for PHNs to physically meet with participants in prison before release because of pandemic restrictions. A few participants who enrolled in the program after March 2020 felt the program should have started while they were still incarcerated, as initially designed. In a few cases (primarily following New Jersey's COVID-19–related large-scale prison release, during which more than 2,000 individuals were released in a single day) (35), participants said they felt staff were "overwhelmed" and that "the caseworkers needed a lighter load" (participant 1688).

It is worth noting that of the five participants who discontinued IRTS enrollment, three did so because they moved out of state. One reported a desire to continue with the program but found it difficult because they were homeless. The remaining individual had positive things to say about the program but ultimately discontinued "because I was, I still am currently being pulled in so many directions" (participant 1613), suggesting that this person did not believe the program provided critical support in the face of their challenges.

DISCUSSION

This article describes participants' experiences with the services and supports they received from PHNs, perspectives on the unique role and important qualities of PHNs, and ongoing barriers and needs that were not fully addressed through peer navigation. PHNs were nearly universally viewed by participants as providing valuable support for recovery and community reintegration. Aspects that participants perceived to be most important included having a PHN available should any needs arise, empathetic and genuine emotional support during challenging times and when risk of relapse is high, informational support, and tangible assistance through linkage to health services and other resources to support recovery and reintegration.

The diverse forms of support valued by interviewees highlight the importance of a holistic, whole-person approach that addresses individuals' health and wellness goals and is also attentive to social determinants that undermine recovery. Prior research with justice-involved populations and those with substance use disorders has similarly found that PHNs provide these varied forms of support (26, 36), which is especially important considering that studies have shown that logistical challenges and the time and effort associated with meeting basic needs can act as barriers to treatment maintenance and recovery (37).

Participants differently emphasized instrumental and tangible versus emotional and appraisal forms of support, demonstrating the need for flexible, person-centered implementation models that are responsive to individual needs and preferences. Participants came home to a complex service delivery system, and having a knowledgeable PHN to act as a resource broker was important (26). Even if not all participants needed continuous assistance from IRTS staff, knowing that they were available gave participants a sense of support in navigating postrelease challenges.

Interviewees spoke to the unique role of PHNs, and many (but not all) felt that working with someone with shared lived experience facilitated a strong and trusting connection. Other studies have similarly found that well-trained peer workers can more easily establish credibility and demonstrate understanding than can nonpeer workers (27, 38, 39). Participants viewed PHNs as successful role models who could inspire their own recovery, which has also been found in previous studies (28, 40, 41). Qualities of PHNs that participants perceived to be important were consistent with prior research on peer services for related populations and included being nonjudgmental and honest (26, 42–45). Our finding that some participants held varying perspectives on desired qualities of effective PHNs could suggest pairing service recipients with PHNs who possess desired qualities; participants and peers could be aligned along shared demographic characteristics or substance use experience. However, other research has suggested that the most important shared experience in a peer relationship is incarceration, regardless of other factors (46). Differences in desired PHN qualities more pragmatically illustrate the importance of training and support for PHNs to encourage collaborative approaches that center client preferences in the treatment course (47), especially because a systematic review of community case management has shown that these interpersonal interactions must center the client, be responsive to their practical needs, and be sensitive to the local context (29). With the wide range of training for peer services (48), future programming should ensure meaningful implementation of this perspective.

Our finding that housing and employment were the most commonly reported unmet needs is consistent with prior literature showing that these are among the most significant needs reported by individuals returning to the community from prison (6), and this finding reflects broader and longstanding social and structural barriers to reentry (7). Opportunities to access housing, government benefits, and employment are limited by policies that bar individuals convicted of certain charges from accessing certain resources (4, 5, 49, 50). Despite this barrier, participants still wanted additional assistance from PHNs in these areas; some approaches that may help participants access limited resources include adequate prerelease planning, formalized goal setting (51), identification of available housing vacancies, direct linkage to employers on release, and more robust job training programs that focus on careers in which a high demand for workers exists. Although this problem is systemic, some specific programmatic changes or training in addressing these needs, such as individual placement and support for employment (52) or modified peer housing support, could be helpful (53).

Our findings should be interpreted with several limitations in mind. First, they are based on a convenience sample of individuals who volunteered to complete interviews and may not reflect the broader population served by the IRTS program. This point is especially important given that a majority of IRTS participants chose not to complete an interview. Recruitment occurred through PHNs, which could have introduced bias if staff avoided distributing recruitment material to participants likely to report negative experiences with the program. Findings may be further biased as a result of incongruence between interviewer positionality and participant background. Approximately 25% (N=9) of participants were lost to follow-up, and those who completed the follow-up interview likely were more successful in the program and had better experiences than those who lost contact with the study team. The study is also limited to the perspectives of program participants and does not incorporate the experiences of PHNs, other IRTS staff, or other reentry service providers. Most interviews were completed when in-person prerelease services were suspended because of COVID-19 restrictions, so the current study primarily reports on postrelease services and prerelease services that were delivered virtually.

Although this study provides evidence of the benefits and limitations of peer services for individuals with substance use disorders recently released from incarceration, additional research is needed to examine the impacts of PHN on intended outcomes, such as development of self-care and wellness skills for long-term recovery, avoidance of overdose and recidivism, and utilization of recovery and health services. Future research should also identify the optimal role for PHNs working with individuals with substance use disorders and justice system involvement—that is, maintaining a peer role that is distinct from other professional roles (e.g., therapist, case manager) and draws on the unique strengths and expertise of peers. It will also be important to develop and test program adaptations that better meet housing, employment, and other unmet needs of service recipients, such as a specific role for housing and employment navigators or direct linkage to transitional housing and employers. In addition, focusing on the role of PHNs in bolstering self-care skills for sustained recovery will be important, because these key habits and routines create and sustain long-term recovery.

CONCLUSIONS

Peer services for individuals with substance use disorders exiting incarceration are expanding rapidly as their promise for supporting community reintegration and long-term recovery is increasingly recognized. In this study, we found that participants perceived such services to have great value,

in that they provided diverse forms of support for recovery and community reentry. Participants felt that working with a PHN with shared lived experience facilitated relationship building and trust, and they highlighted empathy, understanding, and compassion as key qualities of PHNs. Despite the many helpful elements of peer health navigation, certain key needs such as housing and employment were not always met, often because of policy and structural barriers. Future research should rigorously examine the impact of peer services on participant outcomes.

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