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**NATIONAL HUMAN TRAFFICKING
TRAINING AND TECHNICAL
ASSISTANCE CENTER**



Peer-Led Support Groups: Overview of the Empirical Research and Implications for Individuals Who Have Experienced Trafficking and Substance Use Disorder

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TABLE OF CONTENTS

Acknowledgments	2
Introduction	4
<i>Organization of This Report</i>	5
<i>Summary of the Literature Review Approach</i>	6
Overview of Peer Support Groups	6
<i>Substance Use</i>	7
<i>Trauma and Substance Use</i>	14
<i>Individuals Who Have Experienced Crime</i>	16
Peer Support Outcomes	17
<i>Substance Use</i>	19
<i>Mental Health</i>	20
<i>Coping</i>	20
<i>Quality of Life</i>	21
<i>Support Networks</i>	22
<i>Outcomes Summary</i>	23
Summary And Recommendations	26
References	31

INTRODUCTION

In 2018, approximately 20.3 million people in the United States had a substance use disorder (SUD), 9.2 million had a co-occurring SUD and any mental illness, and 3.2 million had a co-occurring SUD and a serious mental illness; however, only 51 percent of adults and 66 percent of adolescents with a co-occurring SUD and a mental illness received treatment (Substance Abuse and Mental Health Services Administration [SAMHSA], 2019). Individuals with co-occurring SUD and posttraumatic stress disorder (PTSD) are more likely to experience more severe substance use (Amaro, Chernoff, Brown, Arévalo, & Gatz., 2007) and, without treatment, face increased risk of homelessness (Palepu et al., 2013), unemployment (Henkel, 2011), and incarceration (Nowotny, Belknap, Lynch, & DeHart, 2014). Substance use is both a risk factor and a coping mechanism for individuals who have experienced crime (e.g., intimate partner violence, sexual assault, human trafficking). For example, studies show women who have experienced abuse tend to use more alcohol than women who have not experienced abuse (García-Moreno, Pallitto, Devries, Stöckl, Watts, & Abrahams, 2013).

Individuals who have experienced human trafficking also experience a wide range of physical and mental health consequences, including substance use, depression, anxiety, PTSD, and co-occurring disorders (Zimmerman et al., 2006). Substance use among individuals who have experienced trafficking is complex. Some individuals were at risk of trafficking because of prior substance use. Many individuals were coerced to use alcohol or drugs during their trafficking experience (e.g., as a mechanism of control) and/or used alcohol or drugs to cope with trauma associated with their trafficking experience (Baldwin, Fehrenbacher, & Eisenman, 2015; Lederer & Wetzel, 2014). Based on a survey of 100 individuals who have experienced domestic sex trafficking, 84 percent used alcohol, marijuana, cocaine, or heroin during their exploitation; 98 percent experienced psychological symptoms (e.g., depression, anxiety, shame, guilt); and 55 percent experienced PTSD (Lederer & Wetzel, 2014). Hopper and Gonzalez (2018) found similar prevalence estimates of mental illness among their sample of individuals who have experienced sex and labor trafficking: 61 percent experienced PTSD and 71 percent experienced depression.

Researchers and practitioners recommend providing specialized treatment to meet the complex needs of individuals who have experienced trafficking (Powell, Asbill, Louis, & Stoklosa, 2018; Salami, Gordon, Coverdale, & Nguyen, 2018). One option is to adapt existing treatments used with individuals with substance use issues or survivors of crime (e.g., interpersonal violence, sexual abuse, torture) to individuals who have experienced trafficking, but it is unclear which specific approaches may be most beneficial (e.g., Salami et al., 2018). Individuals who have experienced trafficking face a variety of barriers to accessing services. Mental health and substance use services are often short term, fragmented, and expensive and require insurance, U.S. citizenship, or T visas. In addition, many service providers lack the capacity to serve the unique needs of individuals who have experienced trafficking (e.g., Powell et al., 2018).

Some individuals with lived and professional experience with trafficking recommend using peer support programs to assist individuals who have experienced trafficking (NHTTAC, 2018, 2019; Rajaram & Tidball, 2016). Peer support is provided and received by individuals who share similar life

Terminology

- *Substance use disorder:* Individuals who are dependent on or abuse alcohol or illicit drugs
- *Co-occurring substance use disorder:* Individuals with both a mental disorder and a substance use disorder
- *Serious mental illness:* Individuals with a mental, behavioral, or emotional disorder that interferes with or limits major life activities

(SAMHSA, 2019)

Peer-Led Support Groups: Overview of the Empirical Research and Implications for Individuals Who Have Experienced Trafficking and Substance Use Disorder

experiences (e.g., substance use, trauma, abuse, mental illness). The individual identifies who they consider to be a peer and how they want to obtain peer support (e.g., support groups, one-on-one interaction). The goal is to build mutually supportive and compassionate relationships among equals, share knowledge and information, and work toward recovery. Peer support is part of a system of care for individuals who are in recovery, supplements other services and forms of treatment, and is free and widely accessible (Blanch, Filson, Penney, & Cave, 2012; U.S. Department of Health and Human Services, 2015; White, 2009). Research suggests peer support groups help individuals reduce or abstain from substance use, reduce symptoms of trauma and other mental illness, increase coping skills, and expand supportive networks (Crisanti, Murray-Krezan, & Reno, 2019; Kelly, 2017; Kelly, Abry, Ferri, & Humphreys, 2020; Money et al., 2011).

Peer support groups may be a good option for individuals who have experienced trafficking who cannot access or are not ready to access formal treatment and other services, need long-term support, or want to build a supportive network with others who share similar experiences. The National Human Trafficking Training and Technical Assistance Center's (NHTTAC) Human Trafficking Leadership Academy (HTLA) Class 2 fellows surveyed 41 individuals who have experienced trafficking and found 88 percent of the sample said a peer support group would have been helpful during their recovery. The HTLA Class 2 fellows recommended exploring how peer support groups could be used to (1) provide a safe, nurturing, and empowering space for individuals with co-occurring disorders who have experienced trafficking; (2) recognize and meet the unique needs of individuals who have experienced trafficking; (3) reduce feelings of isolation and social exclusion; and (4) expand networks and support systems for individuals who have experienced trafficking.

They also recommended exploring whether 12-step peer support models can be used to support individuals who have experienced trafficking because these models are widely available and may be easily adaptable (NHTTAC, 2018). However, a variety of other types of peer support groups for substance use and individuals who have experienced crime should also be explored. A large body of literature suggests that peer support groups are associated with positive outcomes for individuals with SUD. Individuals who have experienced trafficking and SUD have needs similar to individuals who have not experienced trafficking and may benefit from the same types of peer support groups.

The goal of this literature review is to (1) provide an overview of peer support groups and associated outcomes for individuals who have experienced trafficking and SUD; (2) explore how existing peer support group models can benefit individuals with co-occurring disorders who have experienced trafficking; and (3) discuss recommendations for leveraging promising strategies that align with the needs of individuals who have experienced trafficking. Limited research has been published on the use of peer support groups with individuals who have experienced trafficking, thus this literature review focuses on the ways peer support groups have been used with different populations who have experienced substance use and victimization.

Human Trafficking Leadership Academy

- Co-facilitated by NHTTAC and Coro
- Offers a combination of in-person leadership seminars and virtual collaboration over a 4- to 6- month period
- Fellows collaboratively develop recommendations, tools, and other resources to help OTIP and the anti-trafficking field deliver survivor-informed services

Organization of This Report

This report is organized to include:

- An overview of peer support groups
- A discussion of peer support groups for individuals with substance use disorders and individuals who have experienced crime, including research on participants' satisfaction with each peer

Peer-Led Support Groups: Overview of the Empirical Research and Implications for Individuals Who Have Experienced Trafficking and Substance Use Disorder

support group model

- A synthesis of the empirical research on outcomes associated with the identified peer support group programs for substance use disorders and individuals who have experienced crime
- A summary and recommendations

Summary of the Literature Review Approach

The goal of this literature review is to explore how peer support research, resources, and programs can inform efforts to support individuals with co-occurring disorders who have experienced trafficking. The research questions addressed in this literature review are:

- What are the different types of peer support models?
- How are peer support models used for individuals with SUD?
- How are peer support group models used for individuals who have experienced crime (e.g., intimate partner violence, sexual assault, trafficking)?
- What are the findings, strengths, and limitations of the research on peer support groups?
- How can peer support groups help individuals who have experienced trafficking?
- What are some recommendations to further advance the research and evidence base of peer support models for individuals who have experienced trafficking?

Google Scholar and EBSCOhost were used to search for peer-reviewed journal articles and reports. Web content from a variety of sources, including federal and state agencies and nongovernmental organizations, was also reviewed. Searches included the following key terms: Peer support models, 12-Step, Seeking Safety, SMART Recovery, Women for Sobriety, LifeRing for Secular Sobriety, trafficking and peer support, victimization and peer support, interpersonal violence and peer support, sexual assault and peer support.

OVERVIEW OF PEER SUPPORT GROUPS

Peer support is a “process through which people who share common experiences or face similar challenges come together as equals to give and receive help based on the knowledge that comes through shared experiences” (Penney, 2018, p. 1). Peers share demographic or social characteristics such as psychiatric, alcohol, and/or other drug-related problems (Tracy & Wallace, 2016) as well as trauma, abuse, or illness (Blanch et al., 2012). Support reflects authentic empathy and encouragement offered to one another in a reciprocal relationship that can only be derived from a shared experience. The shared experience is the most critical component of peer support, but individuals define what it means to be a “peer” differently (e.g., type of recovery, gender, race, ethnicity, age, history of incarceration) (White, 2009). These shared experiences help individuals build trust and support networks, share knowledge and coping strategies, seek validation in their experiences, and begin to heal (Blanch et al., 2012; Solomon, 2004; Tracy & Wallace, 2016; White, 2009). There are eight underlying principles of peer support. Peer support must be voluntary (not mandatory) to facilitate relationship building. Peers should be nonjudgmental, empathetic, respectful, and honest and direct during their interactions. Each peer should be mutually responsible for sharing their needs and hearing others’ needs without feeling pressure to solve others’ problems. Peer support should be nonhierarchical—each person shares power within the pairing or group and is equally responsible for

Principles of Peer Support

- Voluntary
- Nonjudgmental
- Empathetic
- Respectful
- Honest and direct communication
- Mutual responsibility
- Shared power
- Reciprocal

(Blanch et al., 2012)

Peer-Led Support Groups: Overview of the Empirical Research and Implications for Individuals Who Have Experienced Trafficking and Substance Use Disorder

making decisions and ensuring a positive group dynamic. Finally, peer support should be a reciprocal process of constantly giving and receiving help (Blanch et al., 2012).

Peer support is provided in a variety of ways and settings. In peer support groups, individuals discuss their experiences and engage in collaborative problem solving. Groups can be structured or unstructured and facilitated by a trained or untrained peer. There is a difference between support groups led by trained professionals (e.g., clinician, counselor, social worker, victim advocate) and peers without training. This distinction holds even if the trained professional has shared experiences with group members. Because trained facilitators offer a therapeutic component to the peer support group, it is different than how support groups were originally conceptualized. One-on-one peer support can be provided by a peer mentor or navigator. Peer mentors develop relationships with peers who have less recovery experience. They serve as a coach to help encourage and motivate other peers through their recovery. This may include collaboratively setting recovery goals, choosing a recovery pathway (e.g., peer support model, treatment), sharing information and resources, expanding peer support networks, and problem solving. It is important to note the peer mentor and mentee are still equals—the relationship is mutually supportive rather than hierarchical (SAMHSA, 2009). Peer navigators are more formal because they often are employed as case managers in organizations. They help individuals navigate systems (e.g., health care, criminal justice) and connect peers to services and other resources (Sheehan et al., 2018). One-on-one and group peer support can be offered in communities or organizations (e.g., behavioral health, criminal justice, medical, shelters); in out-patient or in-patient settings (White, 2009); and before, during, or after formal treatment. Peer support is intended to supplement other forms of treatment (SAMHSA, 2017).

Because of the many benefits of peer support groups, the HTLA fellows recommended exploring the feasibility of peer support groups to assist individuals who have experienced trafficking and substance use. Peer support groups are dynamic, flexible, and adaptable across multiple settings and stages of recovery (Blanch et al., 2012). Peer support is often free for participants, which provides options for individuals with limited financial resources. When used before beginning treatment, peer support can help individuals who are early in recovery find the best recovery approach to fit their needs, increasing the probability of the individual successfully completing and benefiting from the program (Tracy & Wallace, 2016). Research suggests participation in peer support groups decreases substance use (Kelly et al., 2020) and improves mental health (Wilcox, Pearson, & Tonigan, 2015), coping skills, quality of life (Najavits et al., 2014), and social support (Kendra, Weingardt, Cucciare, & Timko, 2015). Although research is limited on using peer support groups for individuals who have experienced trafficking or other crimes, there is a burgeoning research on peer support groups for individuals who have experienced trauma and substance use disorders. The following section provides an overview of peer support groups for individuals who have experienced substance use disorders and crime. Included in this discussion is an overview of participant satisfaction with participating in these groups. A summary of outcomes on peer support groups follows to inform recommendations and future research.

Substance Use

Individuals with substance use problems often use peer support groups as part of their recovery. Substance use peer support groups can be a supplement to formal treatment and source of continued support after completing formal substance use treatment (Tracy & Wallace, 2016; White, 2009). There a variety of peer support group models for substance use, but the four most well-known models are 12-step, SMART Recovery, Women for Sobriety, and LifeRing Secular Recovery (LifeRing) (LifeRing, n.d.; Zemore, Kaskutas, Mericle, & Hemberg, 2017). The table below provides a brief comparison of these models and the Seeking Safety model that addresses both trauma and addiction.

Peer-Led Support Groups: Overview of the Empirical Research and Implications for Individuals Who Have Experienced Trafficking and Substance Use Disorder

Comparison of Peer Support Group Models

Model	Focus	Philosophy/Format	Recovery Goal	Structure	Training	Scope
12-step	Mostly addiction, few groups for co-occurring disorders	<ul style="list-style-type: none"> 12 Steps Spiritual Uses labels (e.g., alcoholic, addict) 	Abstinence	<ul style="list-style-type: none"> Unstructured group meetings facilitated by a peer Individual interactions with a sponsor Working the 12 Steps 	No training required	<ul style="list-style-type: none"> 2 million+ members of Alcoholics Anonymous (AA) 120,000 AA peer support groups
SMART Recovery	Addiction	<ul style="list-style-type: none"> 4 points Uses cognitive behavioral therapy approaches and psychoeducation Secular Discourages labels (e.g., alcoholic, addict) 	Abstinence from alcohol and drugs	<ul style="list-style-type: none"> Structured group meetings facilitated by a peer or professional Working through SMART Recovery tools and exercises 	2-day training required	<ul style="list-style-type: none"> 1,445 U.S. peer support groups 1,098 international peer support groups 25 weekly online peer support groups
Women for Sobriety	Addiction	<ul style="list-style-type: none"> 13 acceptance statements 6 levels of recovery Secular Gender-specific 	Abstinence from alcohol and drugs	<ul style="list-style-type: none"> Unstructured group meetings facilitated by a peer 	No training required but members must fill out an application to become a Certified Moderator (i.e., meeting facilitator)	62 U.S. peer support groups
LifeRing	Addiction	<ul style="list-style-type: none"> 3-S philosophy (sobriety, secularity, self-help) 	Abstinence from alcohol and drugs	<ul style="list-style-type: none"> Unstructured group meetings facilitated by a peer Using the Recovery by Choice Workbook 	No training required	<ul style="list-style-type: none"> 163 U.S. peer support groups 35 international peer support groups
Seeking Safety	Addiction and trauma	<ul style="list-style-type: none"> Uses cognitive behavioral therapy approaches and psychoeducation Secular 	Abstinence or reduced alcohol and drug use	<ul style="list-style-type: none"> 25 structured sessions Individual or group Group meetings facilitated by a peer or professional 	Trainings are available but not required	Unknown

12-Step Programs

Alcoholics Anonymous (AA) and related 12-step recovery programs are the oldest and most prolific form of addiction peer support in the United States (Kelly et al., 2020). AA has been operating since 1939 (Alcoholics Anonymous, 2020), and its 12-step meetings are free, open to anyone who is interested in joining, and widely available throughout the United States (Donovan, Ingalsbe, Benbow, & Daley, 2013). There are more than 2 million AA members and 120,000 AA groups throughout the world (General Service Office of Alcoholics Anonymous, 2018). Narcotics Anonymous is the largest 12-step program for drug users (Bøg, Filges, Brännström, Jørgensen, & Fredriksson, 2017) with more than 22,803 members and 67,000 groups throughout the world (Monico, 2020). The 12-step model is based on a philosophy of “recovery, service, and unity,” and the goal is to achieve abstinence from the substance or problem behavior by working the 12 Steps, attending peer support meetings, working with and serving as a sponsor (e.g., a coach or mentor), and helping others through fellowship (Borkman, 2008). The 12 Steps provide guidelines for recovery. Individuals working the first three steps focus on admitting they are powerless over their addiction and turning their lives over to a higher power. Steps four through nine focus on addressing “defects of character” by taking a moral inventory, accepting blame, asking for help from a higher power, and making amends to others who were harmed during the course of the addiction. The final three steps focus on maintaining sobriety by continuing to take responsibility for actions, praying and appealing to a higher power for support, and practicing the 12 Steps (Borkman, 2008; Monico, 2020). 12-step meetings typically last 60–90 minutes and are usually held in local community spaces but can also be held online (Kelly & McCrady, 2008). See box below for AA’s 12 steps.

Examples of 12-Step Groups

- Alcoholics Anonymous
- Narcotics Anonymous
- Cocaine Anonymous
- Crystal Meth Anonymous
- Heroin Anonymous
- Double Trouble in Recovery
- Dual Disorders Anonymous
- Dual Recovery Anonymous
- Sex Addicts Anonymous
- Survivors of Incest Anonymous
- Gamblers Anonymous

Alcoholics Anonymous 12 Steps

1. We admitted we are powerless over alcohol—that our lives have become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to return to our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another person the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong, promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as a result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

(Alcoholics Anonymous, 2020)

Participant Perceptions of 12-Step Programs

Many members of 12-step peer support groups express satisfaction with their participation in the program. For example, they reported 12-step peer support group meetings met their needs, agreed with their goals, and helped with their problems (Kendra et al., 2015). 12-step members often report they appreciate the social support they receive through meetings and sponsorship (Penn, Brooke, Brooks, Gallagher, & Barnard, 2016; Tsutsumi, Timko, & Zemore, 2020). The wide availability of meetings also makes it easy to find a group to fit within busy schedules (Tsutsumi et al., 2020). Some studies found that increased satisfaction with a 12-step program predicted greater attendance at 12-step meetings, abstinence in both the short term (e.g., past 30 days) and long term (e.g., 1 year), and less severe psychiatric symptoms (Kendra et al., 2015). The empirical research on the relationship among 12-step programs, abstinence, and psychiatric symptoms are discussed in more detail in the outcomes section.

However, many individuals do not want to participate in a 12-step program because they disagree with the philosophical foundation of the program (Horvarth & Sokoloff, 2011; Kelly, Deane, & Baker, 2015). For example, some individuals do not like that 12-step programs are rooted in spirituality, requiring them to believe in and turn their lives over to “a higher power.” Others do not want to state they are powerless over addiction, label themselves as an addict or alcoholic, or commit to a lifetime of treatment or abstinence (Donovan et al., 2013; O’Sullivan, Blum, Watts, & Bates, 2015; Tsutsumi et al., 2020; Zemore et al., 2017). Meetings are typically unstructured, which can lead to a few people dominating the conversation and repetitive sharing of “war stories” that do not lead to problem solving (O’Sullivan et al., 2015; Penn et al., 2016). 12-step programs typically require participants to strive for total abstinence, which is difficult for individuals who take prescribed medications (e.g., Methadone, psychiatric medications, narcotics for pain) (O’Sullivan et al., 2015). 12-step meetings also tend to be dominated by men, lack racial and ethnic diversity, and make some people feel marginalized (e.g., LGBTQ, mentally ill) (Donovan et al., 2013; Najavits, de Haan, & Kok, 2015); however, other scholars disagree with this assessment (e.g., White, Galanter, & Humphreys, & Kelly, 2016).

Individuals with co-occurring SUD and mental health disorders often feel uncomfortable discussing mental illness and use of psychiatric medications in 12-step meetings since they primarily focus on substance use (e.g., AA, Narcotics Anonymous). Some members are criticized for talking about their use of psychiatric medications or mental health problems (Penn et al., 2016; Zweben & Ashbrook, 2012) and feel that 12-step meetings are too confrontational (Bogenschutz et al., 2014). Dual Disorders Anonymous, Dual Recovery Anonymous, and Double Trouble in Recovery are adaptations of the 12-step model for individuals with co-occurring disorders. Each dual diagnosis 12-step program encourages members to discuss their substance use, mental health, and use of medication without feeling ashamed (Matusow et al., 2013); however, these three programs are not widely available in the United States (Penn et al., 2016).

12-step programs are not designed to address both substance use and trauma and may be unappealing to individuals who have experienced crime. For example, individuals who have experienced crime often seek recovery through empowerment, but 12-step programs emphasize powerlessness. Several steps focus on acknowledging the role character defects played in substance use, harm inflicted on the self and others, and making amends to those who may have been harmed rather than focusing on traumatic experiences and the harm inflicted on the person in recovery. Sharing traumatic experiences in meetings may also be triggering for individuals who have experienced crime (Najavits et al., 2015). Individuals who do not agree with or believe in the 12-step model, are not religious, and are less motivated to change are more likely to stop participating in 12-step meetings (Kelly & Moos, 2003). Several alternatives to 12-step programs were developed to

Peer-Led Support Groups: Overview of the Empirical Research and Implications for Individuals Who Have Experienced Trafficking and Substance Use Disorder

address these challenges and appeal to a greater number of individuals who are experiencing substance use (Kelly et al., 2015; Zemore, Lui, Mericle, Hemberg, & Kaskutas, 2018).

SMART Recovery

Self-Management and Recovery Training (SMART Recovery) is a nonprofit organization offering a peer support model for individuals who are experiencing addiction (e.g., alcohol, drugs, gambling, sex, eating, spending, self-injury) (SMART Recovery, 2020). SMART Recovery was founded in 1994 (Horvath & Yeterian, 2012). As of 2017, there are 1,445 in-person SMART Recovery meetings in the United States; 1,098 international meetings; and 25 weekly online meetings. Most meetings are free and open to the public, except for SMART Recovery meetings held in private facilities or organizations (e.g., military, corrections, schools, hospitals) (SMART Recovery, 2017). It is unclear how many individuals participate in SMART Recovery support groups. SMART Recovery uses a four-point model grounded in therapeutic approaches (e.g., cognitive behavioral therapy and motivational interviewing) to help participants implement positive behavioral changes (Horvath & Yeterian, 2012; SMART Recovery, 2020). SMART Recovery was developed as an alternative to the 12-step models and intentionally avoids discussions of spirituality, labeling individuals as alcoholics or addicts who are powerless, and encouraging lifetime attendance (Horvath & Sokoloff, 2011; Horvath & Yeterian, 2012). The four points in this model can be addressed in the order most beneficial to the participant (Horvath & Yeterian, 2012).

SMART Recovery 4 Points

1. Building and maintaining motivation
 2. Coping with urges
 3. Managing thoughts, feelings, and behaviors
 4. Living a balanced life
- (SMART Recovery, 2020)

Individuals can attend in-person or online group meetings facilitated by a professional or nonprofessional volunteer with or without lived experience (Horvath & Yeterian, 2012). The group facilitator must first attend a 2-day training and can then use the SMART Recovery manual and a wide range of tools to facilitate group meetings (Kelly et al., 2017). SMART Recovery tools, worksheets, and exercises focus on (1) readiness for change; (2) the costs and benefits of addiction and recovery; (3) identifying and addressing cravings, irrational beliefs, and faulty thinking; and (4) identifying important personal values. Group members are encouraged to brainstorm solutions to problems and participate in group exercises (e.g., using tools, role-playing, and rehearsing constructive responses to difficult situations). The SMART Recovery model does not include sponsors (Horvath & Yeterian, 2012). Individuals can search the SMART Recovery website for in-person or online meetings and participate in a chat room that is open 24 hours a day, 7 days a week (SMART Recovery, 2020).

Participant Perceptions of SMART Recovery

Participants in SMART Recovery report they enjoy the facilitated group discussion in meetings because it provides opportunities to (1) form relationships with others in similar situations, (2) share their experiences and obtain feedback, (3) be held accountable for their actions, (4) learn from others, (5) help others through recovery, and (6) reduce isolation (Gray et al., 2020; Kelly et al., 2017; Penn et al., 2016). Participants in two studies believed the SMART Recovery tools and strategies were very helpful because they provided practical ways to achieve realistic goals without judging others for relapsing (Kelly et al., 2017; Milin, 2008). The cost benefit analysis, goal setting, and problem-solving tools ranked as the top three most helpful tools. Participants in SMART Recovery appreciate that SMART Recovery focuses on the present, avoids discussing past experiences with and justifications for addiction, and concentrates on actionable solutions (Kelly et al., 2017). When discussing areas for improvement, participants recommend expanding in-person

Peer-Led Support Groups: Overview of the Empirical Research and Implications for Individuals Who Have Experienced Trafficking and Substance Use Disorder

meeting locations, offering more meetings each week, and continuously adding and updating tools (Kelly et al., 2017). SMART Recovery participants also report meetings are sometimes repetitive and focus more on psychoeducation than social support. Some participants are disappointed there are no sponsors in SMART Recovery and a lack of milestones to be celebrated like there are in 12-step programs (Penn et al., 2016).

Women for Sobriety

Women for Sobriety's New Life Program was founded in 1975 as a secular, gender-specific alternative to 12-step peer support programs (Fenner & Gifford, 2012). In 2018, there were an estimated 62 peer-led Women for Sobriety groups in the United States (Zemore et al., 2017). There is no information available on the current number of Women for Sobriety members. Participants are encouraged to strive for abstinence, reflect on their substance use, and engage in group problem solving in a nonjudgmental and compassionate manner (Fenner & Gifford, 2012). The New Life Program uses a combination of 13 acceptance statements and 6 levels of recovery to help participants develop their recovery goals. Participants use the acceptance statements to let go of past experiences of victimization, commit to regaining control over their lives and happiness, and create a new life. The acceptance statements are not conceptualized as steps to be completed in a specific order, but rather in the order that best helps the individual.

The levels of recovery focus on (1) accepting that the individual has a problem with substance use and needs to strive for abstinence, (2) redirecting negative thinking and guilt into positive thinking and problem solving, (3) developing a "new self-image," (4) engaging in positive attitudes and behaviors, (5) improving relationships, and (6) setting new priorities for continued growth (Women for Sobriety, 2020). New Life Program participants use personal "roadmaps" by developing small and attainable goals over a specific time period best suited for their own unique needs (Kirkpatrick, 2018). The New Life Program uses peer support group meetings, online and phone support, a social media community, and a booklet of program materials to support the recovery process. New Life groups are held weekly and led by a Women for Sobriety certified moderator who is a peer (not a professional). To become a certified moderator, individuals must have achieved at least 1 year of continuous sobriety, read the New Life Program materials, demonstrated their knowledge of the New Life Program, filled out an application, and be approved by Women for Sobriety. In meetings, participants share their names, state "I am a competent woman," read the 13 acceptance statements, and then discuss their experiences. There is no pressure to participate in group discussions (Women for Sobriety, 2020). In an effort to promote empowerment and self-sufficiency, the New Life Program does not provide sponsors; instead, it provides a list of group members who are willing to support others in between meetings (Fenner & Gifford, 2012).

Peer-Led Support Groups: Overview of the Empirical Research and Implications for Individuals Who Have Experienced Trafficking and Substance Use Disorder

Women for Sobriety Statements of Acceptance

1. I have a life-threatening problem that once had me. *I now take charge of my life and my disease. I accept the responsibility.*
2. Negative thoughts destroy only myself. *My first conscious sober act must be to remove negativity from my life.*
3. Happiness is a habit I will develop. *Happiness is created, not waited for.*
4. Problems bother me only to the degree I permit them to. *I now better understand my problems and do not permit problems to overwhelm me.*
5. I am what I think. *I am a capable, competent, caring, compassionate woman.*
6. Life can be ordinary or it can be great. *Greatness is mine by a conscious effort.*
7. Love can change the course of my world. *Caring becomes all important.*
8. The fundamental object of life is emotional and spiritual growth. *Daily I put my life into a proper order, knowing which are the priorities.*
9. The past is gone forever. *No longer will I be victimized by the past. I am a new person.*
10. All love given returns. *I will learn to know that others love me.*
11. Enthusiasm is my daily exercise. *I treasure all moments of my new life.*
12. I am a competent woman and have much to give life. *This is what I am and I shall know it always.*
13. I am responsible for myself and for my actions. *I am in charge of my mind, my thoughts, and my life.*

(Women for Sobriety, 2020)

Participant Perceptions of Women for Sobriety

There is limited research available on satisfaction with Women for Sobriety, although membership surveys in 1991 and 2011 indicate participants appreciate the program's focus on making positive changes, improving self-esteem, problem solving, and personal accountability for achieving success. Participants also appreciated the support they received from other group members, participating in a group for women only, participating in online forums, and feeling that they could "speak freely." In terms of dissatisfaction, many women do not want to take the training required to become a certified moderator or establish and maintain the support group (Fenner & Gifford, 2012; Kaskutas, 1994).

LifeRing for Secular Sobriety

LifeRing was founded in 1999 as a peer support program for substance use emphasizing total abstinence from drugs and alcohol through a secular self-help approach (LifeRing, n.d.). As of 2018, there were 163 LifeRing meetings in the United States and 35 meetings outside the United States (Zemore et al., 2017). No information is available on the current number of LifeRing members. The LifeRing philosophy is built on the premise that recovery is an individualized journey. Participants must take personal responsibility for their recovery, rather than admit powerlessness over substance use. There is no pressure for participants to label themselves as an alcoholic or addict, but participants are welcome to use labels for themselves if they find it helpful. LifeRing is supportive of individuals who take prescribed medications, and participants are encouraged to create structured, individual recovery plans using the Recovery by Choice Workbook. The Workbook focuses on nine personal domains: (1) the body (e.g., physical

LifeRing 3-S Philosophy

- **Sobriety:** Maintaining complete abstinence from alcohol and drugs
- **Secularity:** Keeping religious beliefs private and taking personal responsibility for recovery rather than relying on "divine intervention".
- **Self-Help:** Using personal motivation and effort, with reinforcement from the support group, to maintain sobriety.

(LifeRing Secular Recovery, 2020)

Peer-Led Support Groups: Overview of the Empirical Research and Implications for Individuals Who Have Experienced Trafficking and Substance Use Disorder

self-care); (2) the immediate environment (e.g., identifying and coping with environmental triggers); (3) time and activities (e.g., creating and adhering to a daily schedule); (4) people (e.g., creating healthy relationships); (5) feelings (e.g., practicing emotional mindfulness to avoid relapse); (6) lifestyle (e.g., healing the parts of your life that have been harmed by SUD); (7) history (e.g., reconnecting with your pre-addiction self); (8) culture (e.g., identifying and engaging healthy community cultures); and (9) treatment and support groups (e.g., have realistic expectations and getting support) (Nicolaus, 2009).

Peers (called “conveners”) take turns volunteering to facilitate in-person and online meetings. Conveners must have six continuous months of sobriety and “be familiar with LifeRing literature.” They do not have to complete a training (LifeRing, n.d.), and each meeting begins with the reading of an opening statement and the question “How was your week?” One by one, each group member is invited to share their thoughts, get feedback from the rest of the group, and strategize how to overcome anticipated challenges in the next week. The goal is to focus on the present and avoid “war stories” that dwell on the past. Meetings are available in person and online (Nicolaus, 2009). The Recovery Toolbox provides a link to the Recovery by Choice Workbook and tips for enhancing recovery (LifeRing, n.d.).

Participant Perceptions of LifeRing

Limited research is available on satisfaction with LifeRing participation. One study found that 50 LifeRing participants felt supported, accepted, and not judged. They appreciated being able to discuss their experiences with their peers, learn from others with similar experiences, and share common goals. Several participants liked the flexible and secular approach of LifeRing. Some participants would prefer access to more meetings at different times and locations and have trained peers facilitate the meetings (Sotskova, 2014).

Trauma and Substance Use

Trauma is a significant public health concern with no socio-demographic boundaries; it is pervasive with far-reaching psychological, emotional, spiritual, social impacts. It is common among those with mental and substance use disorders (SAMHSA, 2014) and is frequently associated with the many consequences correlated with victimization, including interpersonal violence, sexual assault, and trafficking (Hanson, Sawyer, Begle, & Hubel, 2010). According to SAMHSA’s Trauma and Justice Strategic Initiative—a group of national experts that includes trauma survivors, practitioners, scholars, and policymakers—trauma “results from an event, series of events, or set of circumstances experienced by an individual as physically or emotionally harmful or life threatening with lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being” (SAMHSA, 2014, p. 5). One drawback for individuals who have experienced trafficking is that peer support group models often do not address both substance use and trauma. According to research conducted by Frisman, Ford, Lin, Mallon, and Chang (2008), peer support groups focused on substance use without simultaneously addressing trauma improved substance use outcomes; however, participants also experience a decrease in self-efficacy in facing their trauma. Seeking Safety is a structured intervention for addressing both substance use and trauma that has been adapted for use in peer support groups.

Seeking Safety

Seeking Safety was developed in 1992 to treat individuals with co-occurring symptoms of substance use and PTSD (Treatment Innovations, 2020). Over time, Seeking Safety broadened to support individuals with a history of either substance or trauma-related problems (i.e., individuals do not have

Peer-Led Support Groups: Overview of the Empirical Research and Implications for Individuals Who Have Experienced Trafficking and Substance Use Disorder

to experience both substance use and trauma at the same time to participate in the program) (Najavits et al., 2014). No information is available on the current number of Seeking Safety members. The Treatment Innovations (2020) website has a list of service providers that offer Seeking Safety, but this list is not comprehensive. Seeking Safety combines cognitive behavioral therapy with psychoeducation to teach clients about the relationship between substance use and trauma. Treatment focuses on the present (rather than dwelling on past experiences with substance use and trauma) and establishing “safety” is the first treatment priority. Safety is defined in a variety of ways, including reduced substance use, suicidality, and engagement in risky behaviors; leaving dangerous relationships; and improving coping skills. Seeking Safety allows clients to choose goals that work best for them, such as abstinence or decreased use. Clients learn how to establish safety by participating in 25 sessions that explore (1) coping skills, (2) asking for help from safe people, (3) trust, (4) self-compassion, (5) personalized types of recovery, (6) self-care, (7) relapse and safety planning, (8) commitment to recovery, (9) setting boundaries, and (10) healthy relationships (Najavits, 2002).

The program is flexible. Individuals can choose the format (individual or group), order of sessions, and setting (e.g., outpatient, inpatient, residential). Seeking Safety is a low-cost program originally designed to be facilitated by professionals through organizations or programs. Trainings are available (but not required) for professionals who want to facilitate Seeking Safety (Najavits, 2002). Seeking Safety has also recently been used as a peer-led model (Najavits et al., 2014; Crisanti et al., 2019) where peer guides can take turns leading the group. In one study, for example, Seeking Safety participants served as peer guides on a rotating 4-week schedule. Participants who also wanted to facilitate Seeking Safety group sessions as peer guides were required to be stable (e.g., not currently experiencing “behavioral problems”) and attend a 3-hour Seeking Safety training (Najavits et al., 2014). Facilitators can use a clinician guide and provide handouts to clients (Najavits, 2002). Seeking Safety encourages participants to broadly describe their past experiences in one or two sentences without sharing detailed descriptions of past substance use or trauma (e.g., “I was molested as a child,” “I used heroin for 20 years”). The goal is to focus on the present and avoid triggering other individuals who are participating in the group (Najavits et al., 2014). Seeking Safety participants are encouraged to choose a recovery goal that works best for them, whether that is abstinence or decreasing substance use (Treatment Innovations, 2020). Researchers recommend combining Seeking Safety with other types of treatment to maximize positive outcomes (Lenz, Henesy, & Callender, 2016; Najavits, 2002; Schäfer et al., 2019).

Participant Perceptions of Seeking Safety

Individuals who participated in peer-led Seeking Safety described the experience as empowering, respectful, nonjudgmental, comfortable, informative, and goal oriented. They felt supported by the group dynamic and looked forward to the group sessions. When asked whether they would make any changes to the peer-led model for Seeking Safety, all respondents stated modifications were not necessary (Najavits et al., 2014). In one study, participants reported it was helpful to be able to refer the Seeking Safety manual when they were experiencing triggers, cravings, or difficulty using coping strategies (Cook, Walser, Kane, Ruzek, & Woody, 2006). Participants in Seeking Safety programs that were not peer led also reported overall satisfaction with the program, stating they felt comfortable being open and honest about their experiences with trauma in a group setting (Wolff, Frueh, Shi, & Schumann, 2012). This finding suggests that regardless of what type of facilitator is leading the group, participants still feel empowered and comfortable talking about their experiences. However, it is still important to acknowledge the implicit power dynamic in peer support groups facilitated by a clinician rather than a peer.

Individuals Who Have Experienced Crime

Although peer support groups for individuals who have experienced crime are commonly offered, particularly for intimate partner violence and sexual assault, the extant research on their format and effectiveness is limited (Sullivan, 2012; Tutty, Ogden, Wylie, & Silverstone, 2017; Ven, 2020). Individuals who have experienced crime typically access peer support groups through organizations (e.g., domestic violence or sexual assault programs, shelters) (Blanch et al., 2012; Sullivan, 2012; Tutty et al., 2017). These groups can be facilitated by untrained peers, trained peers, or professionals who may or may not have lived experience (Tutty et al., 2017). Support groups for individuals who have experienced crime are often informal spaces where individuals can take turns leading the group, discuss their shared or lived experiences, share coping strategies, strategize safety plans, and share knowledge and information on community resources (Fearday & Cape, 2004; Sullivan, 2012; Tutty, Ogden, & Wylie, 2006). Some groups set agendas to discuss specific topics such as setting goals and boundaries, different definitions of abuse, parenting, and navigating conflict (Fearday & Cape, 2004). Thus, similar to peer support groups for substance use, peer support groups for individuals who have experienced crime are implemented in a variety of ways and settings.

While researchers rarely draw a distinction between peer-led and professional-led support groups for individuals who have experienced crime in their research, there are important differences (Tutty et al., 2017). Professional-led support groups for individuals who have experienced crime often are structured with the inclusion of facilitated discussions, psychoeducation, and skill building (Tutty et al., 2006). And while there are benefits to having a trained professional lead support groups if crisis intervention is needed, it can also create a power imbalance. Since individuals who have experienced intimate partner violence and sexual assault experience power imbalances during their abuse, power imbalances in a peer support group setting can implicitly perpetuate a power dynamic that can hinder healing. In contrast, peer-led support groups allow for shared leadership and may create a more equitable environment (Fearday & Cape, 2004). Some peer support groups are co-led by peers and professionals, where the peer has primary leadership responsibility with support from a professional who provides assistance if the peer facilitator or other group members become triggered (Fearday & Cape, 2004; Moses, Huntington, & D'Ambrosio, 2004; Tutty et al., 2006). Professionals may be selected to lead or co-lead a group because the peer support group is part of residential shelter services or other organizational programs and they are trained to facilitate support groups, respond to the complex manifestations of trauma, and provide referrals to services (Fearday & Cape, 2004). Providing training to peer facilitators may help bridge the gap between peer-led and professional-led peer support groups. Trained peer facilitators can receive instruction on how to manage group dynamics, engage in crisis intervention, connect group participants to resources, and lead without dominating the discussion. They can also be screened to ensure they are in a place in their recovery where they can handle difficult discussions without being triggered (Tutty et al., 2017). Research on satisfaction with peer support groups for individuals who have experienced crime is currently unavailable, although there are some reports that participants felt like they were able to discuss their experiences in a safe space without judgment (Alaggia, Michalski, & Vine, 1999; Cross, 2019; Gordy, 1983; McCormack & Katalinic, 2016). Being in the support group also validated their experiences (McCormack & Katalinic, 2016) and helped participants realize they “were not alone” (Alaggia et al., 1999).

PEER SUPPORT OUTCOMES

Anecdotally, participants identify peer support groups—regardless of whether the support group focuses on victimization, substance use, or some other shared experience—as an important resource in their recovery. Peer support creates opportunities for connections among others with similar shared experiences, which can help mitigate feelings of shame and self-blame (Helgeson & Gottlieb, 2000; Sullivan, 2012) and in turn increase the receptiveness to seek further supports to aid recovery (Money et al., 2011). As discussed in more detail below, the empirical literature generally supports positive outcomes—such as reductions in substance use, improved mental health, learned coping skills, enhanced quality of life, and strengthening of support networks and peer connection—of peer support group participation; however, several methodological limitations are associated with research on peer support programs. Peer support outcomes are difficult to assess because peer support is often combined with other types of treatment (e.g., psychotherapy, psychiatric medication, methadone maintenance, or other professional intervention). This makes it difficult to determine whether individuals are experiencing positive outcomes from their participation in a peer support program, other types of treatment, or both (Crisanti et al., 2019; Money et al., 2011; Najavits & Hien, 2013; Wilcox et al., 2015). One way to isolate the effects of treatment type is through a randomized control trial (RCT); however, an RCT is not always an appropriate research design for peer support groups. This is due to the inherent variability in how support groups are implemented and some of the ethical issues in denying or limiting treatment of some participants seeking services in favor of methodological rigor. Most of the research on peer support groups are not RCTs (Najavits & Hien, 2013); of those that are, they are primarily focused on outcomes associated with substance use. There are no RCT empirical studies examining the outcomes associated with peer support groups for individuals who have experienced crime or, more specifically, individuals who have experienced trafficking.

Randomized Control Trial

Considered the gold standard of research designs. This design randomly assigns participants into a control group or an experimental group. Randomization mitigates any population bias and isolates the effects of the outcomes of interest.

(Stanley, 2007)

Another methodological challenge with research designs examining peer support group outcomes is the difficulty in capturing long-term outcomes, which requires a longitudinal research design (Zemore et al., 2018). One concern with longitudinal design is attrition, or when participants leave the study or stop participating in treatment. While this always happens to some extent, attrition can become a serious issue if those who drop out of the treatment or study differ in some systematic way. When this happens, the results of the research study are no longer generalizable. Individuals who have experienced SUD might not stay in treatment long term or may differ from those who do stay in treatment long term, making it difficult for research to disentangle the sustainability of treatment effects over the long term (Bøg et al., 2017; Desai, Najavits, Harpaz-Rotem, & Rosenheck, 2009). The voluntary and fluid design of peer support groups (Crisanti et al., 2019) coupled with anonymity (Lange-Altman, Bergandi, Borders, & Frazier, 2017) also makes it difficult to track participants over the long term; for individuals who have experienced crime, safety and confidentiality (Office for Victims of Crime [OVC], 2013) compounds the challenges in documenting long-term change. For these reasons, very few studies examine the long-term impact of peer support groups (Zemore et al., 2018). This is problematic given the complex and long-term trajectory of healing for individuals who have experienced crime and maintaining or managing sobriety.

Peer-Led Support Groups: Overview of the Empirical Research and Implications for Individuals Who Have Experienced Trafficking and Substance Use Disorder

In addition to the methodological limitations of peer support research, the body of empirical research suffers from other limitations, making it difficult to come to a consensus on effectiveness. The bulk of research is on peer support programs for substance use, primarily 12-step programs (especially Alcoholics Anonymous) and to a lesser extent SMART Recovery and Seeking Safety. Far fewer studies¹ have focused on outcomes of peer support groups for individuals who have experienced crime and even less so for individuals who have experienced trafficking. While there is overlap between trafficking experiences and substance use, it is unknown whether positive outcomes associated with peer support groups for SUDs will carry over to peer support groups for individuals who have experienced trafficking. However, the limited support for positive outcomes associated with other individuals who have experienced crime (Guthrie, 2013; Tutty et al., 2006; Tutty et al., 2017) suggest this is a worthy avenue to pursue.

The dynamic, flexible, and adaptable nature of peer support group models, coupled with the variability in implementation, creates challenges for scholars to identify and study standardized measures (Gray et al., 2020). Even when similar concepts are included as outcome measures (e.g., decrease in substance use), the way these concepts are operationalized varies across studies. For example, researchers might operationalize a decrease in substance use as abstinence (Boden et al., 2012), whereas other researchers might operationalize it as a reduction and management of substance use (Zemore et al., 2018). Similarly, individuals who have experienced crime have individual needs and goals for seeking services that are diverse, dynamic, and can change over time during their healing journey (OVC, 2013; Sullivan, 2018); thus, standardized outcomes among this population can be difficult to have and might not reflect the reasons individuals participate in support groups. This is particularly an acute concern given the cultural and ethnic diversity of participants who attend support groups and research suggesting outcomes might vary by gender and ethnicity (Frisman et al., 2008; Kelly & Yeterian, 2011).

These limitations notwithstanding, research on peer support groups are, overall, encouraging. Using diverse research designs (including RCTs and qualitative research), the available body of empirical support for peer support groups coalesce around five primary outcomes: (1) substance use, including abstinence, severity of alcohol or drug use, and impact of alcohol or drug use; (2) mental health, including mood and anxiety disorders; (3) coping skills, including the application of a variety of adaptive techniques to detect and respond to stress and conflict; (4) quality of life, including measures of self-confidence/self-esteem, hope and optimism, validation, life satisfaction, and; (5) support network, including social capital and peer connections derived from participation in peer support groups. The research associated with these outcomes is discussed below. The following outcomes focus mainly on peer support groups for substance use because the extant empirical research on peer support for survivors of crime is scant. Outcomes for individuals who have experienced crime (and trafficking, specifically) are highlighted whenever possible.

Outcomes of Peer Support Groups

- Substance use
- Mental health
- Coping skills
- Quality of life
- Support networks and peer connections

¹ Although there is some research on support groups for individuals who have experienced crime, particularly for individuals who have experienced IPV, they are often led by trained facilitators or professionals and therefore fall outside the scope of a traditional peer-led group model, which is the emphasis of this literature review. These findings are not discussed here as it is possible there are differences in outcomes of groups led by peers and trained facilitators.

Substance Use

Researchers explored outcomes associated with substance use in a variety of ways, including abstinence and alcohol and drug severity or impact. Abstinence is typically measured by assessing whether the individual has used alcohol or drugs within a certain timeframe (e.g., in last 30 days, 6 months, a year). Alcohol or drug severity is often assessed by frequency of drug or alcohol use and whether drug or alcohol use is having a negative impact on the individual's life (e.g., medical, psychiatric, legal, employment, family). The largest body of research is on 12-step programs, especially Alcoholics Anonymous. There is also limited research on other substance use programs, including Seeking Safety, SMART Recovery, Women for Sobriety, and LifeRing. Collectively, these studies suggest participation in a peer support group can result in positive outcomes regarding substance use behaviors.

Research consistently finds a correlation between participation in Alcoholics Anonymous and abstinence as well as a reduction in the intensity of drinking, cravings, and alcohol-related consequences (see Kelly et al., 2020). Few studies examine outcomes associated with participation in 12-step programs for drug or narcotic use (DeLucia et al., 2016; Hatch-Maillette et al., 2016); however, preliminary evidence suggests participation in 12-step programs for drug use (e.g., Narcotics Anonymous) is associated with sustained abstinence (Galanter, Dermatis, Post, & Santucci, 2013; Gossop, Stewart, & Marsden, 2008). The research also suggests dosage is an important contributor to success. Individuals who frequently and consistently attended 12-step meetings (Kaskutas, 2009; Tonigan & Rice, 2010), served as and received help from a sponsor, completed step-work, and participated in group activities experienced better substance use outcomes, especially if they participated in professional treatment and 12-step simultaneously (Humphreys & Moos, 2007; Tonigan & Rice, 2010).

These findings are consistent with the research examining the effectiveness of Seeking Safety and SMART Recovery. Crisanti and colleagues (2019) found cravings for drugs or alcohol and addiction severity significantly decreased over the course of a peer-led Seeking Safety program. Najavits et al. (2014) also examined a peer-led Seeking Safety program but were unable to measure outcomes associated with substance use because their program was hosted at a residential care facility where participants were unable to use substances. However, several studies (Boden et al., 2012; Cook et al., 2006; Najavits, Gallop, & Weiss, 2006; Najavits, Weiss, Shaw, & Muenz, 1998) assessing outcomes of non-peer-led Seeking Safety found increased abstinence and support the findings of Crisanti and colleagues (2019). One study found Seeking Safety participants reduced substance use in the first 6 months of the program, but a small sample of participants reported increased substance use at the 12-month follow-up period (Desai, Harpaz-Rotem, Najavits, & Rosenheck, 2008). However, increased substance at follow-up may be due to individuals' "selective dropout from the study" and, given the high attrition rate of the sample, these findings should be interpreted with caution (Desai et al., 2009). SMART Recovery participants also self-reported a reduction in the number of drinks per day, increased abstinence, and fewer alcohol-related problems (Brooks & Penn, 2003; Hester, Lenberg, Campbell, & Delaney, 2013).

Zenmore and colleagues (2017; 2018) conducted a longitudinal study to compare outcomes of participation in Women for Sobriety, LifeRing, SMART Recovery, and 12-step peer support programs. There was a correlation between program participation and alcohol outcomes across all four programs. More specifically, higher program participation (e.g., meeting attendance, working with a close friend or sponsor, doing service work) reduced alcohol use and severity for participants. However, SMART Recovery and LifeRing participants were less likely to be abstinent and have no alcohol problems at a 12-month follow-up compared to 12-step participants. This may reflect differences in recovery goals. For example, participants in 12-Step and Women may strive to

Peer-Led Support Groups: Overview of the Empirical Research and Implications for Individuals Who Have Experienced Trafficking and Substance Use Disorder

completely stop using alcohol or drugs (i.e., abstinence) while SMART Recovery and LifeRing participants may strive to reduce and manage their substance use (Zemore et al., 2018). Additionally, 12-step participants attended more meetings than Women for Sobriety, LifeRing, or SMART Recovery participants, but there was higher satisfaction and group cohesion among participants in Women for Sobriety, LifeRing, and SMART Recovery than 12-step programs (Zemore et al., 2017).

Mental Health

Individuals with substance use disorders experience mood and anxiety disorders at higher rates than the general population (Grant, et al., 2004). Co-occurring substance use disorders and mental health issues, particularly major depression or anxiety, is often associated with longer and more severe substance use, increased risk of suicide, and worse treatment outcomes (Worley, Tate, & Brown, 2012). Mental health issues and substance use disorders are also well documented consequences associated with victimization (Janssen, Oberwittler, & Koeber, 2020; Zimmerman et al., 2006). For these reasons, there is a strong interest in the field to understand the relationship between peer support groups and mental health outcomes.

There is an association between attending 12-step meetings and improved mental health (Wilcox et al., 2015). Several research studies report the frequency of attending 12-step meetings predicted reductions in depression (Kelly, Stout, Magill, Tonigan, & Pagano, 2010; Wilcox et al., 2015; Worley et al., 2012), but the causal mechanisms driving this change are unclear. Kelly and colleagues (2010) theorized frequent attendance at 12-step meetings leads to a reduction in substance use, which then leads to a reduction in depression. Worley et al. (2012) concluded individuals who frequently attended 12-step meetings experienced less depression, which then led to a reduction in substance use. Wilcox and colleagues (2015) argued reductions in substance use predicts reductions in depression, but there are other mediating or moderating factors, such as spiritual practices, leading to improved mental health outcomes.

Most research on Seeking Safety is based on participation in non-peer-led group sessions (Najavits & Hien, 2013). These studies suggest Seeking Safety participation reduced symptoms of mental illness, including depression, PTSD, and suicidal thoughts (Cook et al., 2006; Desai et al., 2008; Lenz et al., 2016; Schäfer et al., 2019; Wolff et al., 2012). Two studies, one of which was an RCT, explored outcomes for individuals participating in peer-led Seeking Safety group sessions also found reduced symptoms of PTSD (Crisanti et al., 2019; Najavits et al., 2014) and increased mental health functioning (Crisanti et al., 2019). Very limited research exists on mental health outcomes among SMART Recovery, Women for Sobriety, and LifeRing participants, but preliminary findings indicate improved psychiatric symptoms (Beck et al., 2017; Zemore et al., 2017).

Coping

Coping is a process of detecting, handling, and learning from stress and conflict (Skinner & Zimmer-Gembeck, 2016) using a variety of adaptive and maladaptive coping strategies. Adaptive coping strategies include reinterpreting the stressor in a positive way (“finding the silver lining”), using social support systems or resources, finding comfort through humor or religion, accepting there is a stressor, making a plan to address the stressor, and taking action. Maladaptive coping strategies include denying there is a problem, physically avoiding the stressor, mentally giving up on or detaching from the stressor, “complaining excessively about the stressor,” and “using drugs or alcohol” (Lange-Altman et al., 2017). Research examining the relationship between peer support groups and coping skills generally finds a positive correlation with participation and improved coping

Peer-Led Support Groups: Overview of the Empirical Research and Implications for Individuals Who Have Experienced Trafficking and Substance Use Disorder

skills. These findings hold regardless of whether the peer support groups address trauma or victimization more generally (e.g., Leech & Littlefield, 2011) or focus on substance use specifically through 12-step programs (Blonigen, Timko, & Moos, 2013; Kelly et al., 2020; Majer, Droege, & Jason, 2012), SMART Recovery (Bogdonoff, 2003), or Seeking Safety (Boden et al., 2012; Crisanti et al., 2019; Lynch, Heath, Mathews, & Cepeda, 2012; Najavits et al., 2014). It is unknown² whether participation in Women for Sobriety or LifeRing is associated with improved coping skills.

Peer support groups, particularly for substance use, are shown to improve coping skills among participants, but the research findings on the lasting impact of coping skills remains equivocal. In one study, Seeking Safety participants increased their coping skills through their participation in peer support groups over a 6-month period (Najavits et al., 2014). Using a coping skills scale capturing use of 17 different coping skills, participants rated how frequently each skill was used, ranging from 0 (not used at all) to 5 (used often). At the start of the program, the authors found the average coping score was 3.43. By month 4, the score increased to 3.96, a 15 percent (statistically significant) increase in the overall score. Boden et al. (2012) examined improved coping scores among a sample of 117 veteran men with co-occurring SUDs and PTSD and found participants improved their coping skills after 3 months of participation in Seeking Safety. Similarly, a study examining changes in coping skills of participants in a combined clinician-led Seeking Safety with a 12-step peer support model, reported improvements in usage of adaptive coping strategies and reduction in maladaptive coping strategies (Lange-Altman et al., 2017). Although more research is needed before drawing definitive conclusions, peer support groups for individuals who have experienced crime may help them develop positive coping skills, thereby mitigating negative effects of the trauma (Graham, Powell, & Karam, 2014; Leech & Littlefield, 2011).

Other research suggests any net gain in coping skills are not sustained over the long term. Based on a recent study by Crisanti and colleagues (2019), peer-led Seeking Safety participants significantly increased their coping skills within the first 6 months of the program. However, their increased coping skills was contingent on completing the program and, even among those who completed the program, their coping skills waned over time. Individuals who completed the program had higher coping scores than those who did not complete the program at the 3-month follow-up, but there was no effect at the 6-month follow-up (Crisanti et al., 2019). This finding suggests without reinforcement, coping skills gained while participating in a peer support group are short-lived.

Quality of Life

The empirical research on peer support groups has explored a variety of outcomes that impact one's quality of life, including outcomes such as self-confidence/self-esteem, self-compassion (Najavits et al., 2014), hope and optimism, life satisfaction, validation, and decreased distress (Cook et al., 2006; Laudet, Morgen, & White, 2006; Money et al., 2011). Other researchers (e.g., White et al., 2016) include outcomes such as decreased cravings, reduced HIV/HCV risk, housing stability, and relationship stability as other measures of quality of life. Several research studies measured quality of life with the Quality of Life Inventory (Cook et al., 2006; Najavits & Hien, 2013)—an evidence-based psychology test capturing 16 aspects of quality of life, including health, home, love, creativity, learning, play, and neighborhood (Frisch et al., 2005).

Seeking Safety participants in Najavits et al.'s (2014) study experienced a significant increase in self-compassion, operationalized with a scale of self-kindness, common humanity, and mindfulness.

² The authors were unable to find empirical research on the relationship between these two peer group models and outcomes on coping skills.

Peer-Led Support Groups: Overview of the Empirical Research and Implications for Individuals Who Have Experienced Trafficking and Substance Use Disorder

More specifically, at the start of the program, the average self-compassion score was 3.2 on a scale of 1 to 4, with a higher score interpreted as higher levels of self-compassion. By month 4, the self-compassion score increased to 3.9, a 21 percent (statistically significant) increase in the overall score. These findings align with an earlier review of improvement in quality of life following participation in peer support groups. In particular, Money and colleagues (2011) found participation in peer support groups improved quality of life across a number of dimensions, including improved satisfaction with one's health, increased resilience, increased compliance with medication adherence, overall improvement in perceived wellness, and greater acceptance of one's situation or illness. Some researchers studied the relationship between quality of life and peer support groups using the Quality of Life Inventory. Cook et al. (2006) found participants in the Seeking Safety support group had improved ability to communicate, problem solve, and identify and manage their triggers. Additionally, participants' ratings in the Quality of Life Inventory improved after 25 sessions (see also Najavits & Hien, 2013).

These findings are supported by qualitative findings. McCormack and Katalinic (2016) studied outcomes of a peer support group in a residential setting for 25 adults of childhood victimization who had PTSD and SUDs, incorporating the perspectives of both clients and facilitators. The results included themes such as feelings of hope and empowerment. Participants, both clients and facilitators, also noted their participation provided opportunities for continued healing through addressing personal challenges such as facing old demons and, for facilitators specifically, burnout. These challenges provided opportunities for further personal reflection and altruistic growth through helping others with shared experiences.

Quality of life is also positively correlated with peer support group participation for individuals who have experienced crime. Guthrie (2013), in her examination of a domestic violence support group (led by a trained non-peer facilitator), found participation in the group to help with validation in their experiences and they are not alone. Sharing and hearing the experiences of other individuals who have experienced crime brought about a sense of hope and increased optimism. According to one participant, "Just listening to everybody...I don't know, my self-confidence is kind of coming back sort of. But I mean it's nice to hear that I am worth it" (p. 153). Participants also noted one of the most helpful benefits of their participation related to improved safety planning and learning about red flags in relationships. In the only study exploring peer support for participants who experience trafficking, nearly half (7 out of 15 participants) accessed support groups as one method for coping with what happened to them (Evans, 2019). Although a small portion reported negative experiences, others found it helpful particularly in learning coping and life skills as well as communication skills. These findings should be interpreted with caution, however, given the small sample size, the qualitative nature of the research design, and because the peer support group was an IPV group—not one focused on trafficking.

Support Networks

Studies consistently show peer support group programs result in better outcomes when participants are frequently involved with group meetings and activities (e.g., identifying a sponsor or close friend, volunteering, leading meetings, helping newcomers), satisfied with participation in the group, and feel the group is cohesive (i.e., feelings of belonging to and acceptance by the group) (Corrigan, Sokol, & Rüschi, 2013; Kelly et al., 2015; Kendra et al., 2015). These findings highlight the value social capital (i.e., the connections, networks, and relationships among people) can have in positively influencing individuals who have experienced crime or substance use disorders during their healing journey. Peer support groups represent one strategy for building social capital.

Peer-Led Support Groups: Overview of the Empirical Research and Implications for Individuals Who Have Experienced Trafficking and Substance Use Disorder

Research suggests networks are a key factor in facilitating positive outcomes through peer support groups (Donovan et al., 2013). 12-Step programs facilitate participation in groups that expand supportive networks and interaction with individuals who support sobriety, while reducing interaction with individuals who support substance use and activities related to substance use. In turn, 12-step participants avoid situations where they may be tempted to drink or use drugs and cope with stress and cravings in situations where they were unable to avoid others who are drinking or using drugs (Kaskutas, Bond, & Humphreys, 2002; Kelly et al., 2010; Kelly, Hoepfner, Stout, & Pagano, 2012). Members of peer support groups bond with each other over their shared experiences, model behaviors supporting abstinence, provide structure and opportunities for developing goals (Kelly, 2017; Kelly, Magill, & Stout, 2009; Kelly et al., 2017; Moos, 2008) and mitigate feelings of shame and loneliness by fostering a sense of belonging (Yalom, Irvin, & Leszcz, 2008). Interacting with others who have been successful with recovery fosters hope recovery is possible, positively influence motivation, improve coping skills, and promote self-efficacy (Kelly, 2017).

“Participation in a peer program also gives individuals the opportunity to take care of each other and empowers them to be a part of the solution by helping others.”

(Money et al., 2011)

There is also limited support for Seeking Safety and associated positive outcomes on improved social support for participants. Lynch and colleagues (2012) reported improved scores for relationship functioning among their sample of 114 incarcerated women with PTSD and/or a history of SUDs. Similarly, Najavitas, Schmitz, Gotthardt, and Weiss (2005) reported improved scores for family and social problems at the end of treatment for Seeking Safety male participants (N=5) with a current diagnosis of PTSD and substance use dependence. Neither of these studies measured these outcomes long term, so it is unclear if these findings are sustained after treatment. In addition, both of these studies had a small sample size, so the finding should be interpreted with caution.

Through the peer support and social connections, individuals who have experienced crime who participate in support groups can address personal feelings of shame and self-blame while helping others through the same process. This reciprocity helps build trusting relationships and “the satisfaction of giving back” (Fearday & Cape, 2004). This creates challenges for some peers who are trying to serve as role models but also an opportunity to work through difficult emotions and painful experiences with the rest of the group. Some participants felt uncomfortable and triggered when listening to others talk about their victimization; however, many participants believed this gave them the opportunity to grow and heal (Konya et al., 2020; McCormack & Katalinic, 2016). Trained peer support group facilitators reported it is important for peer support groups to set boundaries and show respect when group members challenge each other’s preconceived ideas about victimization and blame. Peer support groups provide a space to “practice safe, assertive relationships” while enhancing feelings of empowerment and self-control (McCormack & Katalinic, 2016).

Outcomes Summary

Overall, the research generally supports positive outcomes among participants in peer support groups, including reductions in substance use, improved mental health, learned coping skills, enhanced quality of life, and strengthening of support networks and peer connections. However, the research limitations preclude any definitive statements about their efficacy over the long term. There are also outstanding empirical questions about whether the positive outcomes reported in the literature are generalizable to individuals who have experienced crime, those who have experience trauma, or marginalized groups (e.g., cultural/ethnic minorities, LGBTQIA+). These findings are summarized below.

Peer-Led Support Groups: Overview of the Empirical Research and Implications for Individuals Who Have Experienced Trafficking and Substance Use Disorder

Peer Support Group Models: Summary of Outcomes

Model	Outcomes				
	Substance Use	Mental Health	Coping Skills	Quality of Life	Support Networks and Peer Connections
Alcoholics Anonymous	Participation increased likelihood of abstinence and reduced the intensity of drinking, cravings, and alcohol-related consequences. These findings hold in 12-month follow-up periods	Attendance improved mental health outcomes, including reductions in depression symptoms.	Increased duration of participation was associated with a decrease in impulsivity and increase in psychosocial outcomes. This finding held across the 16-year follow-up period.	Unknown	Participants expanded their supportive networks and interaction with individuals who supported sobriety and reduced interaction with individuals who supported substance use and activities related to substance use.
SMART Recovery	Participation reduced the number of drinks per day and alcohol-related problems and increased the likelihood of abstinence. These effects might not hold long term (e.g., 12 months after participation)	There is not enough research to draw conclusions, but preliminary findings suggest participation decreased number of psychiatric hospital stays.	Unknown	Unknown	Unknown
Women for Sobriety	Greater program participation reduced alcohol use and severity for participants.	Unknown	Unknown	Unknown	Unknown
LifeRing	Greater program participation reduced alcohol use and	Unknown	Unknown	Unknown	Unknown

Peer-Led Support Groups: Overview of the Empirical Research and Implications for Individuals Who Have Experienced Trafficking and Substance Use Disorder

Model	Outcomes				
	<i>Substance Use</i>	<i>Mental Health</i>	<i>Coping Skills</i>	<i>Quality of Life</i>	<i>Support Networks and Peer Connections</i>
	severity for participants, but participants were less likely to be abstinent or have no alcohol problems at 12-month follow-up.				
Seeking Safety	Participation increases likelihood of abstinence and decreases cravings for alcohol and addiction severity in the short term, but the outcomes might not be sustainable in the long term.	Participation reduced symptoms of mental illness, including depression, PTSD, and suicidal thoughts, and improved mental health functioning.	Participation correlated with improvements in usage of a variety of adaptive coping strategies and reduction in maladaptive coping strategies. Improvements might not last long term (e.g., 9- and 12-month follow-up).	Participants reported significant increases in self-compassion (e.g., self-kindness, common humanity, and mindfulness) and support for improved ability to communicate, problem solve, and identify and manage triggers.	Participants improved scores for relationship functioning and decreased scores for family and social problems.

SUMMARY AND RECOMMENDATIONS

Although peer support models have different philosophies and structures, they share several key components. These components include (1) the voluntary nature to promote relationship building, (2) uniting around a shared experience, and (3) giving and receiving help in a nonjudgmental and nonhierarchical social dynamic. The purpose of this literature review was to understand how different peer support group models can be used or adapted to support individuals who have experienced trafficking. To accomplish this goal, the extant research on outcomes associated with peer support group models with two populations was examined: peer support groups for individuals with substance use disorders and with individuals who have experienced crime. These two populations were selected because individuals who have experienced trafficking also experience similar consequences of their victimization as other victims of crime. Moreover, substance use and abuse is prevalent among individuals who are currently experiencing trafficking or who have experienced trafficking (Baldwin et al., 2015; Hopper & Gonzalez, 2018; Lederer & Wetzel, 2014). While research on support groups specifically for individuals who have experienced trafficking was included in the scope of this review, the research in this domain is practically nonexistent even though there is expressed interest in the field to explore this avenue of support.

Research on peer support groups for individuals who have experienced crime is extremely limited, but these groups appear to be offered through service provider organizations and facilitate unstructured discussions about shared experiences, coping strategies, and safety plans (Fearday & Cape, 2004; Sullivan, 2012; Tutty et al., 2017). Participants in peer support group programs for substance use (1) participate in activities intended to help achieve recovery and positive behavioral changes (e.g., 12 steps; recovery tools, worksheets, and exercises; sponsorship/mentoring); (2) set recovery goals (e.g., abstinence, reduced use); and (3) attend in-person or online meetings to talk with others who have similar lived experiences (Zemore et al., 2017). A large body of research shows Alcoholics Anonymous leads to positive behavior change through a simultaneous combination of (1) reduced substance use, (2) social networks supporting abstinence and recovery (3) increased coping skills and self-efficacy³ associated with recovery, and (4) sustained motivation to maintain recovery. The mechanism of change for Alcoholics Anonymous differs for each individual person. For example, some people may benefit more from the changes in their social networks while others may find the improved coping skills and motivation more helpful (Kelly, 2017). Research on other peer support group models like SMART Recovery and Seeking Safety indicate similar mechanisms of change and, although more research is needed, it does not appear one type of peer support group is better than another (Atkins & Hawdon, 2007; Kelly, 2017; Zemore et al., 2017, 2018). Thus, some researchers suggest participating in peer support groups leads to better outcomes—no matter what type of group the individual chooses (Atkins & Hawdon, 2007; Tsutsumi et al., 2020).

However, 12-step models do not appear to be trauma informed and may not address the needs of individuals who have experienced trafficking. For example, 12-step models emphasize powerlessness rather than empowerment; focus on spirituality; and require members to identify character defects that led to their substance use, acknowledge harm they have inflicted on themselves and others, and make amends to others who may have been harmed by their substance use. 12-step members are also encouraged to share traumatic experiences with the group, which can trigger individuals who have experienced crime (Najavits et al., 2015). For these reasons, many

³ “Confidence in one’s ability to remain abstinent when confronted with high risk social drinking situation or when experiencing depression/anxiety/anger” (Kelly, 2017)

Peer-Led Support Groups: Overview of the Empirical Research and Implications for Individuals Who Have Experienced Trafficking and Substance Use Disorder

Individuals are interested in participating in peer support groups with different philosophical frameworks and structures, including those rooted in evidence-based strategies like cognitive behavioral therapy. SMART Recovery, Women for Sobriety, and LifeRing were developed as alternatives to 12-step programs to address the challenges associated with 12-step models (Zemore et al., 2017) but, like 12-step programs, they were designed to focus on substance use rather than trauma. Seeking Safety was developed as a clinician-led, structured program that addresses both substance use and trauma simultaneously and recently adapted to a peer-led format (Treatment Innovations, 2020). More research is needed to understand whether 12-step models can be an effective resource for individuals who have experienced trafficking and other crimes, or if they would benefit more from peer support groups that address both substance use and trauma, emphasize empowerment, acknowledge the role of victimization in their substance use, address substance use and trauma simultaneously, and use structured skill-building tools and exercises to enact positive changes in behavior. The key appears to be choosing the right type of peer support group to meet individual needs. Individuals who are satisfied with their peer support group are more likely to attend meetings and engage with a sponsor or peer coach. Greater participation in peer support programs is associated with better outcomes (Zemore et al., 2018).

The research on peer support group outcomes for individuals who have experienced trafficking and other crimes are sorely lacking from the scholarly literature. The following recommendations are based on (1) current knowledge of peer support groups and (2) outstanding empirical research that needs to be addressed to leverage the benefits of peer support in assisting individuals who have experienced trafficking and substance use problems:

1. **Provide options.** SAMHSA (2015) recommends tailoring peer support to the needs of the individual. There is no one-size-fits all approach to peer support; different elements of peer support models appeal to each individual and people tend to be more successful in peer support programs they feel comfortable attending (Beck et al., 2017; Horvath & Yeterian, 2012). Individuals are also more likely to leave treatment if they are not matched to the right program (Atkins & Hawdon, 2007). Thus, it is important to give individuals who have experienced trafficking a wide range of peer support group options to meet their needs. The following options associated with primary need, peer support model philosophy and structure, group membership, and accessibility should be considered:
 - a. *Primary Need.* Individuals who have experienced trafficking often identify their primary peer support needs in different ways (Salami et al., 2018). For example, some individuals may believe the primary issue is their substance use, some may want support from peers who have experienced trafficking, and others may prefer to focus on victimization or trauma more broadly. It is important to provide access to a wide range of peers with different experiences who can be supportive in different ways. It may not be possible to participate in a peer support program addressing all of an individual's needs, so consider advising individuals who have experienced trafficking to identify their primary need and choose a peer support group that aligns with that need. Some researchers also recommend encouraging clients to participate in multiple types of treatment and peer support groups simultaneously (Zemore et al., 2017). Individuals who frequently participate in multiple types of peer support and treatment tend to have better outcomes (Donovan et al., 2013). For example, an individual who has experienced trafficking could attend one peer support group for addiction and another peer support group for victimization or trauma (or one group addressing both) while participating in therapy with a trained mental health provider.

Peer-Led Support Groups: Overview of the Empirical Research and Implications for Individuals Who Have Experienced Trafficking and Substance Use Disorder

- b. *Peer Support Model Philosophy and Structure.* There are a variety of peer support models with different philosophies and structures. It is important for individuals who have experienced trafficking to consider what type of peer support model best aligns with their preferences. For example, does the individual prefer a spiritual peer support group like 12-step or secular peer support groups like SMART Recovery, Women for Sobriety, and Seeking Safety? Do they prefer to attend unstructured peer support meetings (e.g., 12-step, abuse focused) or structured peer support meetings that use cognitive behavioral therapy and psychoeducation techniques, tools, and manuals (e.g., Seeking Safety, Women for Sobriety, SMART Recovery)? What type of recovery goal does the individual want to make (e.g., abstinence or reduced use) (Zemore et al., 2017)? Individuals receiving medication-assisted treatment (MAT) (e.g., Methadone, Buprenorphine) may also be interested in learning if local peer support groups are supportive of MAT or insist they strive for complete abstinence from all substances.
 - c. *Group Members and Norms.* Some individuals who have experienced trafficking may be more (or less) comfortable with certain demographics of group members (e.g., gender, gender identity, age, race, ethnicity, culture, sexual orientation) (Donovan et al., 2013; Najavits et al., 2015). Individuals who have experienced trafficking should be encouraged to try out different types of groups to see whether they are comfortable with the group membership and norms. If service providers are aware of the different peer support group options and the population they are serving, they can better direct clients to different types of groups. For example, who attends and leads the meetings? Are individuals pressured to speak, or are they allowed to share when ready? Is the group encouraged to provide feedback to each other (sometimes referred to as “cross-talk”), or do they refrain from sharing feedback? Do some individuals tend to dominate the discussion, or is there equal opportunity for everyone to speak? Are certain topics off limits? Do the meetings feel chaotic—or calm and supportive? Do individuals feel judged? (Penn et al., 2016).
 - d. *Accessibility.* Many individuals value flexibility. They want access to many meetings at different times (both in person and online) throughout the week so they do not have to worry about scheduling conflicts (Tsutsumi et al., 2020). 12-step meetings are widely available and accessible throughout the United States (Donovan et al., 2013), but SMART Recovery, Women for Sobriety, and LifeRing are less widely available and have fewer members (Zemore et al., 2017). It is unclear how many Seeking Safety groups are offered throughout the United States (Treatment Innovations, 2020). It is important to provide options for both in-person and online peer support, especially for those with limited access to services or who may be uncomfortable participating in person.
2. **Encourage peer support group attendance to address both substance use and trauma.** Many individuals experience symptoms of both substance use and trauma, yet substance use and mental health often are treated separately (Najavits & Hien, 2013). This is problematic because individuals who experience *both* SUD and PTSD tend to use substances at an earlier age and have more severe substance use, worse treatment outcomes, and other mental health problems (e.g., anxiety, depression) than individuals who have *either* PTSD or SUD (Schäfer et al., 2019). Individuals who have a history of trauma also tend to have higher dropout rates from substance use treatment programs than individuals without a history of trauma (Amaro et al., 2007). Peer support integrating cognitive

Peer-Led Support Groups: Overview of the Empirical Research and Implications for Individuals Who Have Experienced Trafficking and Substance Use Disorder

behavioral and cognitive processing approaches may benefit individuals who have experienced trafficking who are also experiencing co-occurring symptoms of substance use, trauma, mental illness, shame, and guilt (Salami et al., 2018). Individuals who have experienced trafficking could attend multiple peer support groups with different focuses to meet their needs (e.g., individuals who have experienced crime peer support group and 12-step, Women for Sobriety, or SMART Recovery for substance use). If attending multiple peer support groups is not viable, individuals who have experienced trafficking could attend a peer support group that addresses trauma and substance use simultaneously (e.g., Seeking Safety).

3. Raise awareness among service providers and other professionals about peer support group models and how they can support individuals who have experienced crime.

Many service providers are unaware of different types of peer support models and how group peer support can help their clients. Service providers may be less aware of group peer support programs other than 12-step programs and may not be aware that Seeking Safety can be provided in a peer-led format. Encourage service providers working across a variety of disciplines (e.g., behavioral health, social services, substance use treatment, hospitals, criminal justice system) to become familiar with the different types of available peer support in their vicinity and how peer support programs may benefit their clients (Donovan et al., 2013). Awareness raising should include information about the variety of peer support models, how peer support facilitates positive change, the strengths and challenges of using each model with individuals who have experienced trafficking, whether each model is trauma informed, and potential associated positive outcomes.

4. Share information about peer support groups with clients.

Research shows promising outcomes for individuals with substance use outcomes who participate in peer support groups, but many professionals are unfamiliar with the different types of peer support group models and availability of peer groups in their area (Donovan et al., 2013). Individuals who struggle with victimization, trauma, and addiction may be interested in participating in peer support groups but are unaware of their options. Discussing preferences for peer support, explaining the different options for peer support, making recommendations for different peer support groups available nearby, and providing warm handoffs may encourage individuals who have experienced trafficking to participate in peer support programs (Manning et al., 2012; Timko, DeBenedetti, & Billow, 2006; Walitzer, Dermen, & Barrick, 2009). Service providers could share information with clients privately or host events where clients can share their experiences with different types of peer support with each other (Donovan et al., 2013). During these events, individuals who are experienced with different peer support models could answer questions, offer to take others to (or meet them at) their first peer support meeting (Walitzer et al., 2009), and encourage clients to attend different meetings to decide which meeting(s) best fit their needs and comfort level. It is also important to discuss the potential of being triggered or re-traumatized while listening to their peers discuss past traumatic experiences (Najavits et al., 2014) and provide resources for additional support should this occur. Service providers should share the potential challenges for individuals interested in participating in peer support groups who have experienced trafficking and explore partnerships that provide more opportunities for peer support.

5. Build survivor leader capacity to provide peer support to individuals who have experienced trafficking.

Lived experience is the foundational component of peer support groups. Consider training survivor leaders to be peer specialists (i.e., individuals who are trained and certified) and facilitate structured peer support models (e.g., Seeking Safety,

Peer-Led Support Groups: Overview of the Empirical Research and Implications for Individuals Who Have Experienced Trafficking and Substance Use Disorder

Women for Sobriety, SMART Recovery). Once trained, survivor leaders can facilitate local peer support groups, help others who have experienced trafficking learn how to facilitate peer support groups, provide guidance to service providers interested in developing peer support groups for individuals who have experienced trafficking, and serve as peer mentors. Service providers could also consider hiring peer support specialists to share information and resources, provide referrals, and serve as a liaison to local peer support meetings.

Organizations that hire peer support specialists should be very clear about their role, scope of responsibilities, and policies for confidentiality (Money et al., 2011) and provide infrastructure for self-care. This may include (1) offering training on trauma-informed peer support; (2) administering self-care assessments and developing self-care plans; (3) administering compassion fatigue assessments to identify and prevent vicarious trauma; (4) providing supportive supervision (e.g., weekly meetings to discuss self-care and provide encouragement); (5) hosting wellness events for peer support staff to connect with each other peer support staff; and (6) referring staff to counseling services (Philadelphia Department of Behavioral Health and Disability Services, 2017).

6. **Conduct research and evaluation.** A large body of research suggests peer support groups lead to better outcomes for individuals who have experienced substance use. However, very little research explores the use of peer support programs among individuals who have experienced crime (especially trafficking). Future research and evaluation should explore:
 - a. Individuals with lived experienced perceptions of and interest in peer support groups tailored to individuals who have experienced trafficking and SUD
 - b. Whether and how service providers are currently adapting existing peer support models for individuals who have experienced trafficking
 - c. Prevalence of peer support group participation of individuals who have experienced trafficking
 - d. Outcomes for attending different types of peer support groups for individuals who have experienced trafficking and those from different ethnic and cultural backgrounds
 - e. Methods of promoting inclusivity in peer support groups for individuals who have experienced trafficking (e.g., culture, gender, gender identity, sexual orientation, age, race, ethnicity), including ways to increase feelings of comfort and safety
 - f. Methods of integrating peer support specialists into human trafficking service programs

Peer support groups may be able to provide a space for individuals who have experienced trafficking to share their experiences with others who understand what they have gone through, expand their support networks, build trust, and begin to heal. However, it is unclear which peer support group models can best meet the unique needs of individuals who have experienced trafficking. More research and evaluation is needed to understand how to offer peer-led, trauma-informed support for individuals who have experienced trafficking in a group setting.

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