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When Treatment Ends: Peer Support, Family Presence, and the Evidence Behind Recovery's Most Dangerous Threshold

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There is a particular kind of fear that arrives when the structured scaffolding of formal treatment ends and a person steps back into an ordinary life that has not yet caught up to the new version of themselves. For families watching this moment — the discharge from residential treatment, the final session of intensive outpatient care, the transition out of early intervention services — hope and terror often arrive together. Research has only recently begun to articulate just how dangerous this threshold is, and how much the presence of skilled peer support and engaged family members can determine what happens next.

THE ARCHITECTURE OF TRANSITION

A 2026 protocol paper published in *BJPsych Open* offers a window into some of the most rigorous thinking yet about how to support people through treatment transitions. The MyPREPED (My Personal Recovery Plan for Early Discharge) trial, led by Milton and colleagues, is designed to evaluate a peer-delivered, co-designed digital and paper-based self-management tool for young people exiting early intervention in psychosis services. The intervention uses peer coaches — people with lived experience of mental health challenges — who deliver up to ten structured sessions covering discharge planning, recovery, well-being, relapse prevention, goal-setting, and service navigation (Milton 2026). The trial's designers note that peer-supported self-management at the point of discharge has received "limited attention," and the study aims to fill that gap rigorously, using a hybrid effectiveness-implementation design at eight Australian sites.

What is striking about the MyPREPED model is not its novelty in isolation but what it implies: that the moment of discharge has historically been treated as an ending, when the evidence increasingly demands we treat it as a beginning requiring its own specialized support. This logic applies with equal force to addiction treatment. The post-discharge period after substance use disorder treatment is, by a consistent body of longitudinal research, the interval of highest relapse risk — a vulnerable seam in the care continuum where people are most likely to slip back into the patterns that brought them to treatment in the first place. What happens in the weeks immediately after leaving formal care can shape the entire trajectory of recovery.

THE EVIDENCE FOR PEER SUPPORT

A 2025 systematic review published in *Current Addiction Reports*, authored by Eddie and colleagues, synthesized findings from 28 quantitative, multi-group studies involving 12,601 participants, updating an earlier 2019 review with 17 new studies. What the results showed was striking, though not without nuance. Peer recovery support services (PRSS) demonstrated consistent benefits for treatment engagement and retention: in one inpatient study reviewed, 80% of participants who received recovery coaching were still engaged with recovery support services at follow-up, compared to only 24% of those in a control group. Another study found greater engagement in recovery support services at 30-day follow-up among peer-supported participants — 84%, against 34% for controls (Eddie 2025).

The evidence for direct substance use reduction was more mixed. While some studies reported improvements in abstinence rates and reduced drinking, many found no significant between-group differences in drug use measures. Eddie and colleagues are candid: "evidence to date is weaker for PRSS on substance use outcomes," suggesting peer support may work primarily by keeping people connected to care rather than by reducing use directly in the short term (Eddie 2025). This distinction

matters for how families understand the recovery process. Peer support is not a cure dispensed in sessions; it is the mechanism by which someone learns to stay tethered to the people and resources that make sustained recovery possible. Staying connected to care is the first prerequisite for everything that follows.

WHY LIVED EXPERIENCE BRIDGES WHAT CLINICIANS CANNOT

The question becomes: what does peer support accomplish, structurally, that makes it so effective at keeping people connected? Horn and colleagues, in a 2025 taxonomy paper published in *Frontiers in Public Health*, developed a six-domain framework for understanding how peer recovery support services function. Peer workers offer emotional, informational, instrumental, and affiliational support, delivered through a combination of lived experience, structured training, and contextually matched settings — clinical, community-based, and justice-involved. Critically, Horn and colleagues argue that peer support workers "bridge the gap between formal intervention and the personal experience of recovery" in a way that clinical staff, however skilled and however well-intentioned, cannot replicate (Horn 2025). This is not a deficit in clinical training — it is a structural reality. There are things only someone who has walked through the same door can say, and be believed.

The distal outcomes identified in Horn and colleagues' framework — long-term resolution of substance use, improved quality of life, economic stability, family reunification — are not abstract aspirations. They are the actual endpoints that peer support, over time, has been shown to contribute toward. Families reading this should understand that when a loved one connects with a peer recovery coach, they are engaging with a model whose design has been carefully and empirically developed.

THE IRREPLACEABLE ROLE OF FAMILIES

But peer workers cannot do this alone, and families are not passive witnesses to this process. A 2021 narrative review published in the

Journal of Substance Abuse Treatment, authored by Hogue and colleagues, synthesized decades of research on family involvement across the substance use disorder treatment and recovery continuum for transition-age youth — broadly defined as those between the ages of 15 and 26. The review found that families are "powerful resources for enhancing treatment and recovery success" across every stage of the continuum, from initial problem identification through active treatment and into ongoing recovery support, yet they "are not routinely included in clinical practice" (Hogue 2021).

The specific mechanisms are worth naming plainly. Families can serve as problem identifiers during screening, providing clinicians with context that a young person may not yet be able to articulate. They can use evidence-based engagement strategies — including the Community Reinforcement and Family Training (CRAFT) model — to encourage treatment entry among people who are still ambivalent. During active treatment, family involvement in behavioral therapies has shown consistent impact across client age, individual characteristics, and treatment models. And in the recovery phase, families can act as what Hogue and colleagues call "resource advocates" — connecting their loved one to peer support services, community resources, and continuing care — while providing the sustained relational presence that no clinical service can substitute for (Hogue 2021).

A meta-analysis cited within the Hogue review found that family-based treatment models prevailed in almost every comparison against other approaches. Another found that family-involved treatment produced approximately a 5.7% reduction in substance use frequency — roughly three fewer weeks of use per year — compared to individual treatment alone (Hogue 2021). These are not dramatic numbers taken in isolation, but compounded over months and years they translate into trajectories that diverge considerably.

SOCIAL SUPPORT AS MEASURABLE MEDICINE

The protective mechanism of social support against relapse is not merely intuitive — it is quantifiable. A 2023 study published in *Addiction & Health* by Arabshahi and colleagues examined the relationship between perceived social support, childhood trauma, and relapse outcomes in people with addiction, using multivariate regression analysis. The results were unambiguous: social support caused a significant reduction in the relapse rate of more than three times (Arabshahi 2023). Total social support showed a correlation coefficient of -0.350 with relapse frequency — a statistically and clinically meaningful inverse relationship.

Family support was specifically identified in this research as an external social support structure with direct predictive power. Household support emerged as a significant predictor of improvement in drug rehabilitation programs. Arabshahi and colleagues also found that childhood trauma increased the likelihood of multiple relapses by 13%, suggesting that for individuals carrying histories of early adversity — who are disproportionately represented in addiction populations — the protective weight of family and social support becomes not merely valuable but physiologically critical (Arabshahi 2023). Trauma disrupts the neurological systems that regulate stress and impulse; social support, over time, helps rebuild them.

This is not abstract. When a family member chooses to remain present and engaged — to offer non-judgmental support, to learn about recovery rather than retreat into shame and blame — they are doing something with measurable consequences. They are, in the data, tilting the statistical odds toward survival.

SYNTHESIS: WHAT ALL OF THIS MEANS FOR A FAMILY

What unites these threads is a coherent picture of what the transition out of formal treatment actually demands. The MyPREPED model (Milton 2026) shows us the architecture: peer coaches with lived experience, structured self-management modules, a span of sessions designed not

just to exit a person from services but to help them build a life within which recovery becomes sustainable. The Eddie et al. (2025) review confirms that peer support at this juncture dramatically improves the likelihood that people remain connected to care. The Horn et al. (2025) taxonomy explains why — because lived experience bridges a distance that clinical training alone cannot cross. And Hogue et al. (2021) and Arabshahi et al. (2023) together make clear that families who remain engaged, informed, and present are not merely loving — they are, by the weight of the evidence, among the most powerful protective factors available to a person in recovery.

CONCLUSION

What this research offers families is not a manual but a reorientation. The transition out of treatment is not a graduation. It is a threshold — perhaps the most dangerous one in the recovery journey. The instinct to exhale when formal care ends is understandable, even reasonable. But the evidence says this is precisely when family presence matters most, when peer support becomes most critical, when hope must be most deliberate and most structured.

For families standing at that threshold with their loved one, the research offers something more than reassurance. It offers clarification: your presence is not sentimental. It is, in the data, evidence-based. It is, by the numbers, the difference. And understanding this — approaching recovery with patience, sustained engagement, and the kind of non-judgmental steadiness that allows someone to come back after a setback rather than disappear in shame — is what the science consistently identifies as the path that holds.

Works Cited

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