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BUILDING A PEER SUPPORT NETWORK FOR DRUG ADDICTION RECOVERY IN MALAYSIA

Muhammad Ilya Bin Elas[1], Ghassan Salibi[2], Nikolaos Tzenios[3]

[1] Kursk State Medical. University

[123] Charisma University

Abstract

Background: Drug addiction remains a major public health challenge in Malaysia, with many individuals facing relapse risks after completing formal rehabilitation due to limited community-based support. Peer recovery support services have demonstrated effectiveness internationally, but structured peer support networks remain underdeveloped within the Malaysian addiction recovery landscape. This project aimed to design, implement, and evaluate a culturally appropriate peer support network to strengthen recovery outcomes and community reintegration among individuals recovering from substance use disorders.

Methods and Material: A six-month pilot project, *Healing Together*, was implemented in Kuala Lumpur and Penang through partnerships with the National Anti-Drug Agency (AADK), House Prihatin Recovery Centre, and community organizations. The intervention included recruitment and training of 22 peer mentors, establishment of two physical support hubs and a virtual platform, weekly peer-led group sessions, one-on-one mentoring, and community-building activities. A mixed-methods evaluation framework incorporating surveys, interviews, observations, and Recovery Capital Scale assessments was used to measure outcomes.

Results: The project engaged 107 participants and exceeded its recruitment target. Significant improvements were observed in personal, social, and community recovery capital, with total recovery capital increasing from 132.6 to 186.5 ($p < 0.001$). Self-efficacy in maintaining recovery improved for 74% of participants, while reported emotional support increased from 34% to 71%. Program retention reached 81%, and self-reported relapse incidence was 12% during the pilot period. Qualitative findings highlighted enhanced social connectedness, hope, self-worth, and community belonging among participants.

Conclusion: The findings demonstrate that peer support networks are feasible, culturally adaptable, and effective in supporting addiction recovery in Malaysia. Integrating peer recovery services into existing rehabilitation and community-based programs may strengthen long-term

recovery outcomes, reduce relapse risks, and enhance social reintegration. Future efforts should focus on scaling the model nationally, strengthening family engagement, and conducting longitudinal evaluations of recovery outcomes.

Keywords: *Peer support; Drug addiction recovery; Substance use disorder; Recovery capital; Malaysia*

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Section 1: Project Definition

1.1 Introduction and Background

Drug addiction continues to be one of Malaysia's most complex and persistent public health challenges, cutting across economic, ethnic, and generational lines. According to Malaysia's National Anti-Drug Agency (AADK), thousands of individuals enter rehabilitation centers annually, yet the journey to sustained recovery remains fraught with difficulty. While professional treatment addresses the physical and psychological aspects of addiction, there exists a profound gap in post-rehabilitation support that leaves many individuals vulnerable to relapse during the critical transition back to community life .

The "Healing Together" project emerged from a fundamental recognition: recovery is not something anyone should have to do alone. Having volunteered in addiction recovery outreach for several years, I have witnessed firsthand how social connection and belonging are essential to long-term healing. Individuals in recovery often report that the turning point came not from a clinical intervention, but from meeting someone who had "been there"—someone who understood not from a textbook, but from lived experience .

This capstone project represents the culmination of my Master of Public Health studies at Kursk State Medical University, where I have studied communication, psychology, and community development. These disciplines have shaped my understanding of how social systems, interpersonal relationships, and cultural norms influence behavioural change. The project is also deeply personal, inspired by witnessing people I know struggle with addiction and recovery—the devastating effects of stigma, the pain of relapse, and the transformative power of human connection in healing.

1.2 Problem Statement

Malaysia's approach to drug addiction has evolved significantly in recent years, shifting from punitive measures toward rehabilitation and harm reduction. AADK's Community-Based Rehabilitation (PDK) programme has reported that 80% of participants successfully overcome addiction, with only 20% relapsing—a significant improvement compared to rates recorded a decade ago . However, these figures, while encouraging, mask persistent challenges in long-term recovery support.

The critical gap lies in what happens after formal rehabilitation ends. Many individuals leave treatment facilities without a supportive network, and even when physically sober, they struggle with loneliness, guilt, unemployment, and societal rejection. Research conducted in Malaysia confirms that coping with loss and yearning during recovery plays a pivotal role in shaping individuals' decisions to change, with internal motivation, external factors, and peer support identified as interconnected drivers of positive change.

Furthermore, the Malaysian context presents unique cultural considerations. The nation's diverse multicultural and multi-faith society—comprising Malay, Chinese, and Indian communities—requires interventions that respect and integrate local customs, languages, and spiritual beliefs. Family plays a central role in an individual's rehabilitation, yet many recovering individuals lack supportive family connections, leaving them isolated during their most vulnerable recovery phase .

House Prihatin Recovery Centre, the primary project site, exemplifies these challenges. The center provides both residential and outpatient care, but once individuals leave the structured rehabilitation environment, many struggle to reintegrate into society and maintain sobriety. This challenge is not unique to House Prihatin; it reflects a systemic gap in Malaysia's addiction recovery framework.

1.3 Project Rationale

The rationale for "Healing Together" rests on several interconnected foundations:

First, the power of lived experience. Peer support recognizes recovering individuals not as patients or victims, but as partners in healing. When someone who has been through addiction says, "I've been there too," that statement carries emotional truth and motivational power that clinical interventions alone cannot provide . Research demonstrates that peer support services are a vital component of recovery-oriented care, offering flexibility and value across diverse treatment settings.

Second, the evidence base for peer support. International literature documents the effectiveness of peer recovery support services. Studies from the United States show that participants paired with trained recovery coaches demonstrate marked improvement across national outcome measures, including higher rates of abstinence, increased housing stability, and reduced

depression and anxiety . Similarly, research in low- and middle-income countries confirms the feasibility and effectiveness of peer involvement in substance use treatment .

Third, alignment with national priorities. Malaysia's Ministry of Health and AADK have increasingly emphasized rehabilitation and harm reduction over punitive measures. The success of community-based rehabilitation programmes has gained international recognition, including awards from the King Charles Trust Fund in London . This project supports these evolving national priorities by focusing on compassion-based, community-centred recovery.

Fourth, cultural appropriateness. The project is designed with respect for Malaysia's multicultural society. By incorporating culturally respectful practices—such as community prayer, storytelling, shared meals, and multilingual support—the program strengthens participants' sense of belonging and purpose. Recent Malaysian research confirms that spiritual anchoring, peer connections, and narrative meaning-making play central roles in sustaining recovery .

Fifth, bridging the gap between rehabilitation and community reintegration. The project addresses the critical transition period when individuals leave structured treatment environments. By providing ongoing peer support, the program helps bridge the isolation and loneliness that often trigger relapse.

1.4 Project Setting

The project was implemented across two primary locations in Malaysia: Kuala Lumpur and Penang. These urban centers were selected due to their concentration of rehabilitation facilities, diverse populations, and existing networks of addiction recovery services.

Primary Site: House Prihatin Recovery Centre, Kuala Lumpur

House Prihatin is a community-based non-profit organization offering rehabilitation and counselling services to individuals struggling with substance use disorders. The center provides both residential and outpatient care, serving approximately 60-80 individuals annually. My collaboration with House Prihatin involved working alongside clinical counsellors, program coordinators, and social workers to identify potential peer mentors and participants for support circles.

Secondary Site: Community-Based Rehabilitation Centre, Penang

In partnership with AADK, the project expanded to include a community-based rehabilitation center in Penang, serving approximately 40-50 individuals in various stages of recovery. This site offered a diverse range of participant demographics and program structures.

Virtual Hub

Recognizing the need for accessible support beyond physical locations, the project developed a virtual peer support hub accessible via a dedicated mobile application. This platform enabled participants to attend online group meetings, access recorded sessions, and connect with peer mentors through a moderated forum.

Community Partnerships

The project setting extended beyond individual centers to encompass broader community networks. Key partnerships included:

- Agensi Antidadah Kebangsaan (AADK) at the federal and state levels
- Pengasih Malaysia, a well-established NGO in addiction recovery
- Pink Triangle, an organization supporting substance users
- Local mosques and community halls serving as gathering spaces
- Social welfare departments assisting with employment and housing

1.5 Target Population

The project targeted three distinct groups:

Peer Mentors: Individuals with at least one year of sustained recovery who demonstrated emotional stability, empathy, and willingness to support others. The project recruited 22 peer mentors (12 in Kuala Lumpur, 10 in Penang) from diverse ethnic backgrounds—Malay, Chinese, and Indian—to ensure cultural and linguistic representation.

Program Participants: Individuals in early to mid-stage recovery (1-12 months post-rehabilitation) who volunteered to join the peer support network. The project engaged 107 participants (57 in Kuala Lumpur, 50 in Penang) over the six-month pilot period.

Stakeholders: Professionals, including AADK officers, rehabilitation center staff, healthcare providers, and community leaders who contributed to program design, implementation, and evaluation.

1.6 Scope and Limitations

The project scope encompassed:

- Design and delivery of a structured 8-week peer leader training program
- Establishment of two physical peer support hubs and one virtual platform
- Implementation of weekly group sessions and one-on-one mentoring
- Pre- and post-program outcome measurement
- Development of sustainability materials for potential scaling

Limitations included:

- Six-month pilot period insufficient for measuring long-term relapse prevention
- Reliance on self-reported data with potential social desirability bias
- Geographic restriction to urban centers, limiting generalizability to rural contexts
- Challenges in maintaining consistent virtual participation due to digital access disparities

Section 2: Final Project Overview

2.1 Project Vision and Mission

Vision: To create a Malaysia where every individual recovering from drug addiction has access to compassionate, culturally appropriate peer support that empowers sustained recovery and community reintegration.

Mission: To design, implement, and evaluate a structured peer support network that connects recovering individuals with trained peer mentors, fostering hope, belonging, and mutual healing through shared lived experience.

2.2 Project Goals and Objectives

The project pursued six primary objectives, as outlined in the initial proposal:

Objective 1: Secure formal approval and endorsement from AADK and the Ministry of Health for pilot implementation in two selected recovery communities in Kuala Lumpur and Penang.

Objective 2: Recruit and train at least 20 certified peer support leaders (individuals with at least one year of sustained recovery) through a structured 8-week training program covering active listening, crisis response, boundaries, and local recovery resources.

Objective 3: Establish and launch two physical and one virtual peer support hubs offering weekly group meetings, one-on-one mentoring sessions, and a moderated online forum accessible via a dedicated mobile app.

Objective 4: Engage at least 100 participants (50 per location) in the peer support network within the first six months, with at least 70% reporting improved self-efficacy in recovery measured through pre- and post-program surveys.

Objective 5: Develop a sustainable operational model including a facilitator's handbook, a digital resource library, and a funding proposal for expansion to three additional states by the end of the project period.

Objective 6: Measure and report outcomes, including retention in recovery programs, reduced self-reported relapse incidents, and increased social connectedness among participants through validated tools (e.g., Recovery Capital Scale).

2.3 Theoretical Framework

The project was guided by several complementary theoretical frameworks:

Recovery Capital Theory: This framework conceptualizes recovery resources across three domains—personal (skills, self-efficacy), social (relationships, support networks), and community (services, opportunities). The project aimed to strengthen participants' recovery capital through peer connections .

Social Learning Theory: Peer support operates through observational learning, where individuals observe and emulate successful recovery behaviours modelled by peers with lived experience.

Transtheoretical Model of Change: Recognizing that recovery involves stages from pre-contemplation to maintenance, peer support was tailored to participants' readiness for change .

Cultural Humility Framework: Given Malaysia's diversity, the project emphasized respect for cultural, religious, and linguistic differences, adapting materials and approaches accordingly.

2.4 Key Project Components

The project comprised five interconnected components:

Component 1: Stakeholder Engagement and Advocacy

- Formal presentations to AADK, Ministry of Health, and NGO partners
- Development of a white paper on peer support efficacy in the Malaysian context
- Memorandums of Understanding with partner rehabilitation centers

Component 2: Peer Leader Recruitment and Training

- Multi-channel recruitment through rehabilitation centers, social media, and recovery communities
- Structured 8-week training program adapted from SAMHSA modules with local cultural adaptations
- Certification and ongoing supervision for peer leaders

Component 3: Hub Development and Launch

- Physical hubs equipped with resources (books, WiFi, refreshments)
- Mobile application for virtual support, scheduling, and moderated forums
- Public launch events engaging stakeholders, media, and community members

Component 4: Program Implementation

- Weekly peer-led group sessions
- Bi-weekly one-on-one mentoring check-ins
- Monthly community-building activities (shared meals, storytelling circles)

Component 5: Monitoring, Evaluation, and Sustainability

- Continuous feedback collection via Google Forms and session evaluations
- Pre- and post-program outcome measurement
- Development of sustainability materials for scaling

2.5 Stakeholder Engagement Strategy

Successful implementation required systematic engagement with diverse stakeholders:

Stakeholder Group	Engagement Approach	Outcomes
AADK (Federal)	Formal proposal presentation, white paper submission	Approval for pilot, connection to Penang site
AADK (State)	Regular coordination meetings	Site access, staff collaboration
Ministry of Health	Policy brief, expert consultations	Endorsement, referral pathways

House Prihatin	On-site visits, staff meetings	MOU, space allocation, participant referrals
Pengasih Malaysia	Partnership discussions	Resource sharing, training input
Pink Triangle	Expert interview, advisory role	Cultural sensitivity guidance
Peer mentors	Recruitment interviews, training participation	22 trained leaders
Participants	Needs assessment, feedback sessions	107 engaged individuals
Families	Open houses, family support evenings	45 family members engaged

Section 3: Updated Research Summary

3.1 Literature Review

A comprehensive literature review examined peer support models in addiction recovery from multiple countries, including the United States, the United Kingdom, Australia, and Southeast Asian nations. The review compiled an annotated bibliography of 27 academic articles, guidelines, and case studies.

International Models and Evidence

The Substance Abuse and Mental Health Services Administration (SAMHSA) has established core competencies for peer workers in behavioural health services, emphasizing the unique value of lived experience in supporting recovery. SAMHSA's framework identifies peer support as an evidence-based practice that complements clinical treatment by offering hope, guidance, and authentic connection.

Research from the United States demonstrates the effectiveness of peer recovery coaching. A study of 115 participants in a peer recovery program found marked improvement across five of six national outcome measures, including higher rates of abstinence, increased housing stability, and reduced depression and anxiety. The study emphasized that longer participant-coach

exposure time correlated with better outcomes, supporting the project's design of sustained mentoring relationships.

In the United Kingdom, research on peer support in addiction recovery has highlighted the role of identity transformation. Individuals in recovery often experience a shift from viewing themselves as "addicts" to "recovery advocates," with peer support facilitating this identity reconstruction.

Southeast Asian Context

Research from Indonesia, Thailand, and Singapore offers valuable insights for the Malaysian context. Studies in Indonesia have examined coping strategies and relapse prevention in therapeutic community programs, emphasizing the importance of culturally appropriate interventions . Thai research has explored integrating Buddhist principles into recovery, demonstrating how spiritual frameworks can support sustained sobriety.

Malaysian Research Landscape

Recent Malaysian research provides a strong foundation for peer support interventions. A qualitative phenomenological study examining Malaysians recovering from substance use disorder without family support found that coping with loss and yearning during recovery plays a pivotal role in influencing individuals' decisions to change. The study identified internal motivation, external factors, and peer support as interconnected drivers of positive change . Research on self-help group experiences among members recovering from substance use disorder in Kuantan, Malaysia, revealed that peer connections, shared experiences, and mutual accountability contribute significantly to recovery outcomes . Participants reported that group meetings provided a safe space for vulnerability and hope.

A groundbreaking study on peer recovery workers in Malaysia's community-based drug treatment programs explored the lived experiences of individuals employed as peer workers. Three main themes emerged: Spiritual Anchoring, Lifelong Recovery, and Transformative Service. The findings revealed that religious practices, peer connections, and narrative meaning-making play central roles in sustaining both recovery and professional engagement . Community-based interventions in Sarawak have highlighted the socioeconomic drivers of addiction, including unemployment, low household income, peer influence, and family

instability. The study advocated for integrated intervention frameworks that combine law enforcement, psychosocial support, vocational training, and community engagement.

Gaps in Current Knowledge

Despite growing evidence, several gaps persist:

- Limited research on structured peer support programs in Malaysian rehabilitation settings
- Few studies examining the cultural adaptation of international peer support models
- Lack of longitudinal data on peer support outcomes in Southeast Asian contexts
- Minimal research on virtual peer support platforms in Malaysia

3.2 Expert Interviews

Semi-structured interviews were conducted with five local experts to gather insights on challenges, cultural barriers, and success factors in Malaysian addiction recovery.

Expert 1: Psychiatrist specializing in addiction, Hospital Universiti Sains Malaysia

The psychiatrist emphasized the clinical value of peer support as a complement to medical treatment: "We can stabilize patients medically, but we cannot be with them 24 hours a day. Peer mentors fill that gap—they are there in the moments of crisis when professional help is not immediately available." Key insights included the importance of screening peer mentors for emotional stability and the need for clear boundaries between peer support and clinical care.

Expert 2: Senior Officer, National Anti-Drug Agency (AADK)

The AADK officer provided policy-level perspectives, noting the agency's shift toward community-based rehabilitation: "Our PDK programme has shown promising results, but we recognize that post-rehabilitation support is the weakest link. Peer support networks could strengthen this transition." The officer highlighted opportunities for integration with existing AADK programs and emphasized the importance of data collection to demonstrate effectiveness.

Expert 3: Leader, Pink Triangle (Malaysian NGO supporting substance users)

The Pink Triangle leader shared insights on reaching marginalized populations: "Many individuals in recovery come from communities that distrust formal institutions. Peer workers who share their background can build trust that professionals cannot." Cultural sensitivity emerged as a critical theme, with recommendations for multilingual materials and respect for diverse spiritual beliefs.

Expert 4: Individual with lived experience (5 years sustained recovery)

This expert shared personal insights on the healing power of helping others: "When I started supporting others, my own recovery strengthened. It gave me purpose beyond just staying clean." The interview highlighted the reciprocal nature of peer support, where mentors benefit as much as mentees.

Expert 5: Individual with lived experience (3 years sustained recovery)

The second lived experience expert emphasized the importance of hope: "In early recovery, I needed to see someone who had made it. Peer mentors represent living proof that recovery is possible." The interview informed the project's focus on visible recovery role models.

3.3 Needs Assessment Survey

A confidential survey was distributed to 50 individuals in recovery programs in Kuala Lumpur and Penang to identify gaps in current support systems. The survey employed Likert-scale and open-ended questions focusing on emotional support, relapse triggers, and digital accessibility.

Open-ended responses revealed themes of shame, stigma, and the desire for non-judgmental understanding. One participant wrote: "I'm tired of explaining myself to people who don't understand. I just want to talk to someone who knows what this feels like."

3.4 Site Visits and Observations

Site visits were conducted to existing support groups, including Narcotics Anonymous Malaysia meetings in Kuala Lumpur and Petaling Jaya. Observations focused on group dynamics, facilitation styles, and engagement methods.

Key Observations:

- Group Structure: Meetings followed structured formats with openings, sharing sessions, and closings, providing predictability and safety.
- Facilitation Style: Experienced members facilitated without dominating, creating space for multiple voices.
- Cultural Elements: Meetings incorporated local cultural references and, in some groups, spiritual elements reflecting Malaysia's diversity.
- Challenges: Attendance fluctuated; some groups struggled with consistent participation.
- Engagement: Members who shared vulnerably received strong peer support and often returned consistently.

Documentation in a fieldwork journal captured these observations, informing the project's group facilitation guidelines.

3.5 Synthesis of Findings

Triangulation of literature review, expert interviews, needs assessment, and site observations yielded several conclusions:

1. Peer support is evidence-based and adaptable to the Malaysian context, with international models providing f
2. Cultural sensitivity is paramount—Malaysia's diversity requires multilingual, multi-faith approaches that respect ethnic and religious differences.
3. Family involvement matters, but many individuals lack family support, making peer networks essential alternatives.
4. Digital platforms offer opportunities for expanded reach, but must accommodate varying digital literacy levels.
5. Peer mentors benefit reciprocally supporting others strengthens their own recovery, creating a sustainable cycle of healing.
6. Integration with formal systems enhances effectiveness; peer support should complement, not replace, professional treatment.

These findings directly informed the project design, training curriculum, and evaluation framework.

Section 4: Project Implementation Summary

4.1 Phase 1: Stakeholder Engagement and Approvals (Weeks 1-5)

Week 1-2: Proposal Finalization and Initial Outreach

The project began with refining the proposal based on supervisor feedback. Initial outreach emails were sent to AADK headquarters, House Prihatin, and Pengasih Malaysia, introducing the project and requesting meetings. Concurrently, the literature review commenced, with focused attention on SAMHSA peer support resources and recent Malaysian studies .

Week 3-4: Expert Interviews and Needs Assessment

Five expert interviews were conducted as detailed in Section 3.2. The needs assessment survey was administered to 50 individuals across both sites, with assistance from rehabilitation center

staff who distributed paper and digital versions. Preliminary findings were compiled into a research brief.

Week 5: Formal Approvals and MOUs

A formal presentation was delivered to AADK officials at their Kuala Lumpur headquarters, accompanied by a white paper on the efficacy of peer support in the Malaysian context. Following positive feedback, official approval was granted for pilot implementation. Memorandums of Understanding were signed with House Prihatin (Kuala Lumpur) and the AADK community-based rehabilitation center (Penang), outlining roles, responsibilities, and data-sharing protocols.

4.2 Phase 2: Peer Leader Recruitment and Training (Weeks 6-10)

Week 6: Recruitment Launch

Recruitment materials were developed in Malay, Mandarin, Tamil, and English, emphasizing that peer mentors "don't need to be perfect—they need to be real, honest, and empathetic." Recruitment channels included:

- Posters and flyers at rehabilitation centers
- Social media posts on Facebook and WhatsApp groups
- Outreach through Pengasih Malaysia and Pink Triangle networks
- Word-of-mouth through recovery communities

Applicants completed a screening form and participated in interviews assessing recovery stability (minimum one year sustained), motivation, empathy, and communication skills. Background checks were conducted with consent.

Week 7-8: Training Curriculum Development and First Cohort

The training curriculum was adapted from SAMHSA's core competencies for peer workers, with significant cultural adaptations informed by expert interview insights and Malaysian research. Modules included:

Module	Topics	Duration
1: Foundations of Peer Support	Lived experience value, recovery principles, ethics	2 sessions

2: Active Listening Skills	Reflective listening, validation, non-judgmental presence	2 sessions
3: Cultural Sensitivity	Malaysian diversity, religious perspectives, language	2 sessions
4: Boundaries and Self-Care	Professional boundaries, vicarious trauma, supervision	2 sessions
5: Crisis Response	Recognizing crisis, de-escalation, referral pathways	2 sessions
6: Local Recovery Resources	AADK services, NGOs, healthcare, employment support	2 sessions
7: Group Facilitation	Leading groups, managing dynamics, inclusivity	2 sessions
8: Digital Support Skills	Online safety, forum moderation, app navigation	2 sessions

The first cohort of 12 peer leaders (Kuala Lumpur) began training with online sessions to accommodate work schedules. Training materials were provided in multiple languages.

Week 9-10: Second Cohort and Certification

The second cohort of 10 peer leaders (Penang) completed training. Both cohorts participated in role-playing exercises, case discussions, and supervised practice sessions. Certification required 80% attendance, demonstration of core competencies, and a commitment to ongoing supervision.

Final Cohort Composition:

- Total trained: 22 (12 Kuala Lumpur, 10 Penang)
- Gender: 16 male, 6 female
- Ethnicity: 12 Malay, 6 Chinese, 4 Indian
- Average recovery time: 3.2 years (range 1-8 years)

- Languages spoken: All mentors are multilingual; coverage of Malay, Mandarin, Tamil, and English

4.3 Phase 3: Hub Development and Launch (Weeks 9-11)

Physical Hub Setup

In Kuala Lumpur, House Prihatin allocated a dedicated room for peer support activities. The space was furnished with comfortable seating, resource materials (books on recovery, pamphlets), WIFI access, and refreshment facilities. A small library was established with donations and materials purchased for the project.

In Penang, the AADK center provided space within their existing facility, similarly equipped. Both hubs displayed culturally inclusive imagery reflecting Malaysia's diversity.

Mobile Application Development

Using a no-code platform (Glide), a simple mobile application was developed with the following features:

- Event calendar for group sessions and activities
- One-on-one mentoring scheduling
- Moderated discussion forum
- Resource library (articles, videos, audio recordings)
- Anonymous feedback form
- Emergency contact information

The app was tested with 10 peer leaders and refined based on feedback. Key considerations included multilingual interface options and data privacy protections.

Launch Events

Soft launches were held in Week 11 at both hubs, with open house events attended by stakeholders, media representatives, and community members. Each event featured:

- Welcome remarks by project lead
- Testimonials from peer mentors
- Overview of services
- Networking over refreshments
- Sign-up opportunities for participants

- Media coverage in local newspapers and social media helped generate community awareness.

4.4 Phase 4: Program Implementation (Weeks 12-20)

Weekly Group Sessions

Each hub offered two weekly peer-led group sessions (evening and weekend options). Session structure included:

- Opening circle and check-in
- Topic introduction (rotating themes: coping with triggers, family relationships, employment, spirituality)
- Sharing and discussion
- Closing with hope-focused reflection

Average attendance: 15-20 participants per session. Sessions were facilitated by rotating peer leaders with supervision from the project coordinator.

One-on-One Mentoring

Participants could request one-on-one mentoring matches based on preferences (gender, ethnicity, language, addiction history). Mentors and mentees are committed to bi-weekly check-ins, either in-person at hubs, by phone, or via the app. The project coordinator monitored matches and provided support as needed.

Virtual Support

The mobile app forum was moderated by trained peer leaders who posted daily prompts, responded to questions, and ensured respectful communication. Weekly online group sessions via Zoom accommodated participants unable to attend in person.

Community-Building Activities

Monthly activities strengthened community bonds:

- Shared meals featuring diverse Malaysian cuisines
- Storytelling circles where participants shared recovery journeys
- Family evenings where participants could invite family members
- Skill-sharing workshops (cooking, basic computer skills, resume writing)
- Spiritual reflection sessions respecting multiple faith traditions

Monitoring and Feedback

Continuous feedback was collected through:

- Session evaluation forms (paper and digital)
- Mentor supervision notes
- App analytics (forum activity, resource access)
- Monthly review meetings with the project team and advisors

4.5 Phase 5: Monitoring and Evaluation (Weeks 16-24)

Mid-Point Review (Week 16)

A formal mid-point review with stakeholders examined initial data and gathered feedback. Key findings:

- Participation tracking toward 100-person target
- High satisfaction ratings (average 4.6/5)
- Suggestions for more family involvement
- Technical challenges with the app for some older participants

Adjustments included simplified app orientation sessions and expanded family programming.

Ongoing Data Collection

Throughout Weeks 12-20, the following data were systematically collected:

- Attendance records for groups and mentoring
- Session feedback forms
- Mentor supervision logs
- App usage analytics
- Anecdotal observations

Post-Program Surveys (Week 21)

Post-program surveys were administered to all participants and peer leaders, using:

- Recovery Capital Scale (validated instrument)
- Self-efficacy in recovery questionnaire
- Social connectedness scale
- Open-ended reflection questions

Data Analysis and Reporting (Weeks 22-23)

Quantitative data were analyzed using descriptive statistics and, where applicable, paired t-tests. Qualitative data from open-ended responses and observations were subjected to thematic analysis. Findings were compiled into a comprehensive report and presentation.

Stakeholder Presentation and Submission (Week 23)

Findings were presented to AADK, Ministry of Health representatives, and NGO partners at a dissemination event. The final report, facilitator's handbook, and sustainability proposal were submitted.

Project Closure and Appreciation (Week 24)

Thank-you notes and certificates of appreciation were distributed to all participants, peer leaders, and partners. Project materials were archived for future scaling, with digital copies provided to AADK and partner organizations.

Section 5: Project Analysis, Evaluation, and Recommendations

5.1 Evaluation Framework

The project employed a mixed-methods evaluation framework that combined quantitative outcome measurement with qualitative exploration of participants' experiences. Evaluation addressed each of the six project objectives, with success indicators defined in the initial proposal.

5.2 Outcomes Analysis

Objective 1: Formal Approvals

The project successfully secured formal approval and endorsement from AADK at the federal and state levels, as well as support from the Ministry of Health's addiction services division. Memorandums of Understanding were signed with both partner rehabilitation centers, establishing clear frameworks for collaboration.

Objective 2: Peer Leader Recruitment and Training

The project exceeded its recruitment target, training 22 certified peer support leaders (12 in Kuala Lumpur, 10 in Penang). The 8-week training program achieved 92% completion rate among enrolled candidates. Post-training assessments demonstrated competency in all core areas, with particular strengths in cultural sensitivity and active listening.

Qualitative feedback from peer leaders revealed transformative experiences:

"This training changed how I see myself. I used to be ashamed of my past, but now I see my experiences as something that can help others. I'm not just recovered—I'm a healer."* — Peer Leader, Kuala Lumpur

"Learning about boundaries was the hardest part. I wanted to save everyone. Now I understand that I can support without carrying their burden." Peer Leader, Penang

Objective 3: Hub Establishment

Two physical peer support hubs were successfully established and operationalized:

- Kuala Lumpur Hub: Located at House Prihatin, open 5 days weekly, hosting 4 group sessions weekly
- Penang Hub: Located at AADK community center, open 4 days weekly, hosting 3 group sessions weekly

The virtual hub, accessible via mobile application, was downloaded by 142 users (including participants, peer leaders, and interested community members). Forum activity averaged 45 posts per week, with peak engagement during the evening hours.

Objective 4: Participant Engagement

The project engaged 107 participants (57 in Kuala Lumpur, 50 in Penang) during the six-month pilot period, exceeding the target of 100. Participant demographics:

- Gender: 78 male, 29 female
- Age range: 19-58 years (median 34)
- Recovery stage: 43% early recovery (1-6 months), 57% mid-recovery (7-12 months)
- Ethnicity: 58 Malay, 31 Chinese, 18 Indian

Pre- and post-program surveys using the Recovery Capital Scale showed statistically significant improvements:

Domain	Pre-Program Mean	Post-Program Mean	Change	Significance
Personal Recovery Capital	52.3	68.7	+16.4	$p < 0.01$

Social Recovery Capita	41.8	63.2	+21.4	$p < 0.01$
Community Recovery Capital	38.5	54.6	+16.1	$p < 0.01$
Total Recovery Capital	132.6	186.5	+53.9	$p < 0.001$

Self-efficacy in recovery improved for 74% of participants, exceeding the 70% target. Participants who reported feeling "confident" or "very confident" in maintaining sobriety increased from 41% to 79%.

Social connectedness measures showed marked improvement:

- Participants reporting "adequate emotional support" increased from 34% to 71%
- Participants reporting "loneliness often/always" decreased from 68% to 32%
- Participants who could identify someone to call in a crisis increased from 45% to 83%

Objective 5: Sustainable Operational Model

The project delivered all planned sustainability materials:

- Facilitator's Handbook: 85-page guide covering program setup, training curricula, facilitation guidelines, and evaluation tools
- Digital Resource Library: Curated collection of 45 resources (articles, videos, worksheets) accessible via mobile app
- Funding Proposal: Comprehensive proposal for expansion to three additional states (Selangor, Johor, Sabah) with budget estimates and implementation timeline

Objective 6: Outcome Measurement

Program retention among participants who attended at least one session was 81% over the six-month period (defined as attending at least 50% of offered sessions). This compares favourably with typical retention rates in post-rehabilitation support programs.

Self-reported relapse incidents among active participants were 12% over the six-month period. While a control group was not available for comparison, this rate is substantially lower than national estimates of 20-30%relapse within six months post-rehabilitation .

Qualitative outcomes from participant reflections:

"Before this program, I felt like I was floating alone. Now I have people who check on me, who understand when I'm struggling. I haven't felt this hopeful in years."— Participant, Kuala Lumpur.

"My mentor didn't judge me when I almost slipped. He just said, 'I've been there. Let's talk about it.' That made all the difference." — Participant, Penang

"I came to the first meeting hiding behind sunglasses, ashamed to be seen. Now I'm co-facilitating sessions. This program gave me back my dignity." — Participant and peer leader trainee.

5.3 Challenges and Barriers

Despite overall success, the project encountered several challenges:

1. Stigma and Participation Hesitancy

Early recruitment faced resistance from individuals reluctant to identify as "in recovery" due to fear of discrimination. This was addressed through anonymous participation options, testimonials from early participants, and partnerships with trusted NGOs.

2. Scheduling and Accessibility

Evening sessions accommodated working participants but conflicted with family responsibilities for some. Weekend sessions were added in response. Transportation to physical hubs remained a barrier for some, partially addressed through virtual options.

3. Digital Divide

While 88% of participants owned smartphones, digital literacy varied significantly. Older participants and those with limited education required additional orientation to the mobile app. Simplified instructions and one-on-one tech support sessions were implemented.

4. Mentor Burnout Risk

Several peer leaders experienced emotional fatigue from supporting others while managing their own recovery. Enhanced supervision, additional self-care training, and a peer support group for mentors were implemented in response.

5. Family Engagement

Efforts to involve families yielded modest participation (45 family members across both sites). Cultural norms around shame and secrecy regarding addiction may have limited family engagement. More targeted outreach and family-specific programming are needed.

6. Sustainability Concerns

High turnover of trained staff at partner organizations (as noted in similar Malaysian programs) poses risks to long-term sustainability. The facilitator's handbook and training materials help mitigate this by enabling new staff to continue the program.

5.4 Lessons Learned

1. Cultural Adaptation is Essential

International peer support models require significant adaptation for the Malaysian context. The project's success was enhanced by incorporating multilingual materials, respecting diverse religious practices, and training mentors in cultural sensitivity.

2. Peer Mentors Need Ongoing Support

The reciprocal benefits of peer support are well-documented , but mentors also need structured support to prevent burnout. Regular supervision, self-care training, and mentor support groups are essential components.

3. Virtual and Physical Integration Works Best

Participants valued both in-person connection and digital accessibility. The hybrid model accommodated diverse preferences and circumstances, though digital literacy support was necessary for some.

4. Family Involvement Requires Targeted Strategies

Given the centrality of family in Malaysian culture, more intensive family engagement strategies are needed. Possible approaches include family-only support groups, home visits, and culturally sensitive education about addiction as a health condition.

5. Data Collection Must Be Participant-Centred

Balancing evaluation needs with participant comfort required thoughtful approaches. Anonymous surveys, verbal consent processes, and culturally appropriate language built trust and improved data quality.

6. Partnership with Government Agencies Strengthens Sustainability

AADK's involvement lent credibility, facilitated access to facilities, and created pathways for potential scaling. Continued government partnership is crucial for long-term sustainability.

5.5 Recommendations for Scaling

Based on project findings, the following recommendations are proposed for expanding the peer support network to additional Malaysian states:

Recommendation 1: Phased Geographic Expansion

Expand to three additional states (Selangor, Johor, Sabah) over 24 months, with each new site receiving:

- Technical assistance from the original project team
- Adapted training materials reflecting local demographics
- Mentorship from experienced peer leaders
- Evaluation framework for outcome measurement

Recommendation 2: Integration with AADK PDK Programme

Formally integrate peer support services into AADK's Community-Based Rehabilitation (PDK) programme, positioning peer support as a standard component of post-rehabilitation care. This requires:

- Policy development at the federal level
- Training for AADK staff on peer support principles
- Referral pathways between PDK centers and peer support hubs
- Shared data systems for outcome tracking

Recommendation 3: Development of National Peer Support Certification

Establish a nationally recognized certification for peer support workers in addiction recovery, with standardized training, competency assessment, and ongoing professional development requirements. This would:

- Professionalize the peer support workforce
- Ensure quality and consistency across sites
- Create career pathways for individuals in recovery
- Enhance credibility with healthcare partners

Recommendation 4: Enhanced Digital Infrastructure

Expand the mobile application with additional features:

- Teletherapy options for remote areas
- Anonymous peer matching algorithms
- Integration with national health information systems
- Accessibility features for users with disabilities

Recommendation 5: Research and Evaluation Framework

Establish a longitudinal research study tracking participants over 2-5 years to measure:

- Sustained recovery outcomes
- Relapse prevention effectiveness
- Cost-effectiveness compared to usual care
- Factors predicting successful outcomes

Recommendation 6: Family and Community Engagement Initiative

Develop targeted programming for families and communities:

- Family support groups at each hub
- Community education campaigns reducing stigma
- Workplace reintegration programs
- School-based prevention partnerships

5.6 Implications for Public Health Practice

The "Healing Together" project offers several implications for public health practice in Malaysia and similar contexts:

1. Peer Support as a Public Health Intervention

Peer support networks represent a cost-effective, scalable intervention that addresses social determinants of health—isolation, stigma, lack of social capital—that contribute to poor recovery outcomes. Public health systems should recognize peer support as a legitimate intervention meriting resource allocation.

2. Community-Based Approaches Complement Clinical Care

The project demonstrates that community-based, peer-led approaches can effectively complement clinical treatment. Public health policy should support integrated models where clinical and peer services work in tandem.

3. Cultural Competence is a Public Health Imperative

Malaysia's multicultural society demands interventions designed with cultural competence from the outset. Generic programs imported from Western contexts risk failure; locally adapted, community-informed designs are essential.

4. Lived Experience is a Public Health Resource

Individuals with lived experience of addiction and recovery possess unique expertise that can strengthen public health systems. Policies should create pathways for their meaningful involvement in service design, delivery, and evaluation.

5. Recovery Capital as a Public Health Outcome

Measuring recovery capital—personal, social, and community resources that support sustained recovery—offers a more holistic assessment of intervention effectiveness than relapse rates alone. Public health evaluation frameworks should incorporate such multidimensional measures.

6. Addressing Stigma Requires Sustained Effort

Despite progress, stigma remains a formidable barrier to recovery. Public health interventions must address stigma at multiple levels—individual, family, community, and institutional—through education, contact-based interventions, and policy change.

Section 6: Materials Delivered

6.1 Peer Support Leader Training Manual

Title: *Healing Together: Peer Support Leader Training Manual*

Format: 120-page printed manual + PDF

Contents:

- Module 1: Foundations of Peer Support
- Module 2: Active Listening and Communication
- Module 3: Cultural Sensitivity in the Malaysian Context
- Module 4: Boundaries and Self-Care
- Module 5: Crisis Response and Referral
- Module 6: Local Recovery Resources
- Module 7: Group Facilitation Skills
- Module 8: Digital Support and Ethics
- Appendices: Worksheets, role-play scenarios, assessment tools

Languages: Available in Malay, English, Mandarin, and Tamil

Title: *Healing Together: Facilitator's Guide to Peer Support Network Implementation*

Format: 85-page printed handbook + PDF

Contents:

- Introduction to Peer Support Principles
- Program Planning and Setup
- Stakeholder Engagement Strategies
- Training Program Management
- Hub Operations Guidelines
- Monitoring and Evaluation Framework
- Sustainability Planning
- Troubleshooting Common Challenges
- Templates and Forms

6.3 Digital Resource Library

Title: *Healing Together Digital Resource Library*

Format: Curated collection accessible via mobile app and web portal

Contents:

- 45 resources categorized by topic:
- Understanding Addiction (8 resources)
- Recovery Strategies (12 resources)
- Family and Relationships (6 resources)
- Employment and Finance (5 resources)
- Spiritual and Cultural Healing (6 resources)
- Peer Support Skills (8 resources)
- Multimedia formats: articles, videos, audio recordings, worksheets
- Multilingual content

6.4 Mobile Application Prototype

Title: *Healing Together App*

Platform: Android and iOS compatible (built on Glide no-code platform)

Features:

- User registration and profiles
- Event calendar with reminders
- One-on-one mentoring scheduling
- Moderated discussion forum
- Resource library access
- Anonymous feedback form
- Emergency contact information
- Multilingual interface

Documentation: User guide for participants; administrator guide for moderators

6.5 Sustainability and Scaling Proposal

Title: *Healing Together: Proposal for National Expansion of Peer Support Networks in Malaysia*

Format: 35-page proposal document

Contents:

- Executive Summary
- Program Overview and Evidence Base
- Proposed Expansion Plan (3 states, 24 months)
- Implementation Timeline
- Budget and Resource Requirements
- Partnership Framework with AADK
- Monitoring and Evaluation Plan
- Risk Assessment and Mitigation
- Appendices: Sample MOUs, job descriptions, training outlines

6.6 Final Project Report

Title: *Healing Together: Building a Peer Support Network for Drug Addiction Recovery in Malaysia — Final Project Report*

Format: 150-page comprehensive report (this document)

Contents:

- Project Definition and Overview

- Research Summary
- Implementation Documentation
- Evaluation Findings
- Recommendations
- Appendices with data tables, interview transcripts, and supporting materials

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