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Peer Recovery Support Services & Residential Communities

David Eddie, PhD, ABPP

Associate Director of Clinical Translational Recovery Science, Recovery Research Institute, Center for Addiction Medicine, Massachusetts General Hospital

Clinical Psychologist, Department of Psychiatry, Massachusetts General Hospital

Assistant Professor, Harvard Medical School

Disclosures

I sit on the scientific advisory boards of mental-healthcare companies ViviHealth and Innerworld and am a partner in Peer Recovery Consultants.

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Learning Objectives

Participants will be able to:

1. Recognize two important characteristics of an effective recovery coach/peer support.
2. Describe at least one important consideration for the inclusion of recovery coaches/peer support specialists to the collaborative care substance use diosrder team.
3. Name at least three types of residences that support longitudinal recovery.

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Peer Recovery Support Services / Recovery Coaching

The Nuts and Bolts of Including People with Lived/Living Experience

Defining the Role

"A peer-helping-peer service alliance in which a peer leader in stable recovery provides social support services to a peer who is seeking help in establishing or maintaining their recovery."

Image courtesy NAMI N. Carolina

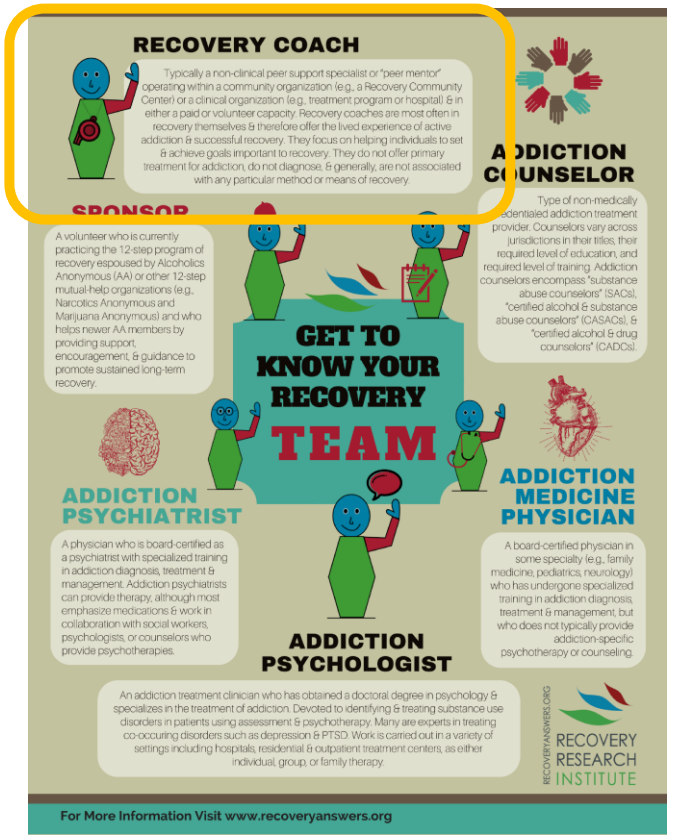
SAMHSA
Substance Abuse and Mental Health Services Administration

(SAMHSA, 2015)

Defining the Role

- Not sponsors
- Not aligned with any one therapeutic approach
- Don't diagnose
- Don't provide psychotherapy or treatment
- Do provide social support, education, and medical system navigation
- Core competencies for peer workers:

  Recovery-oriented, person-centered, relationship-focused, and trauma-informed

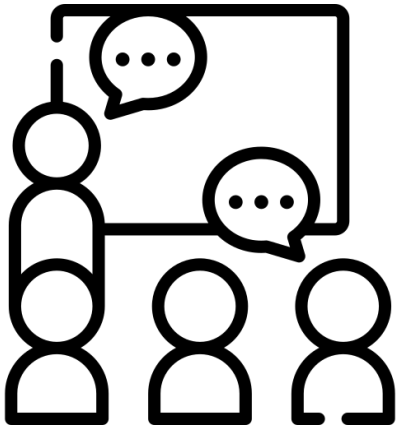


https://www.recoveryanswers.org/media/meet-your-recovery-team-infographic/

(Eddie et al., 2025; SAMHSA, 2015)

Hiring and Training

- Anticipate hiring challenges. e.g., institutional restrictions, CORI checks
- Training should be specific to the role and include information about all types of treatment pathways
- Stigma may exist in peer services and must be addressed in training
- Consider additional training needs that may not be apparent (e.g., technology literacy)



(Eddie et al., 2025; SAMHSA, 2015; Pasman, Brown, et al., 2023; Pasman, O'Shay, et al., 2023; Suzuki et al., 2022)

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Supporting Recovery Coaches

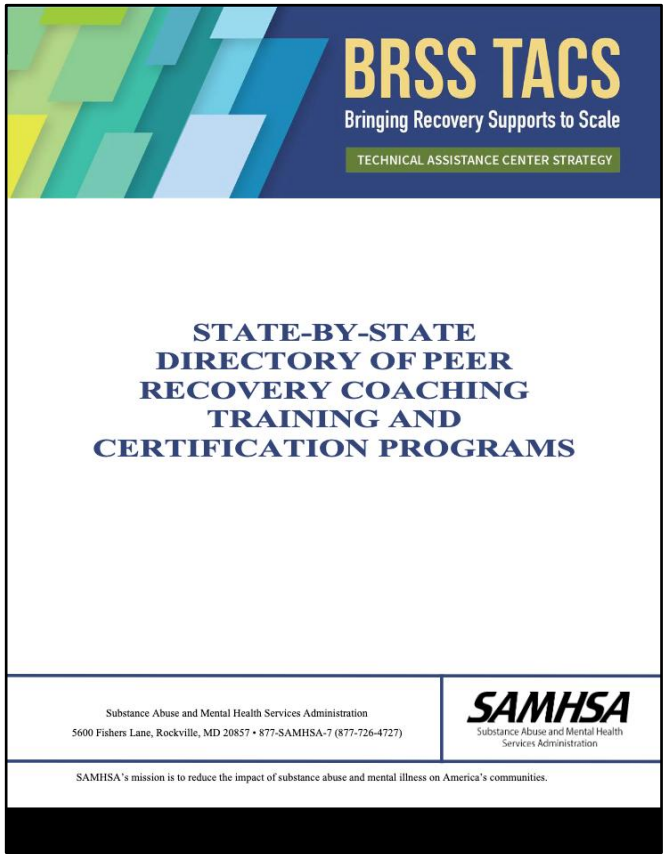
Including & supporting recovery coaches is key

- Including coaches in clinical team meetings/conversations/decision making
- Formal supervision; preferably by someone who is not the supervisor
- Peer-peer consultation meetings
- Guidelines for supporting coaches in event of relapse (doesn't happen often but important to have plan)

(Eddie et al., 2025; Guenzel & Dai, 2021)

Certification Landscape

- Formal systems for licensing and management of recovery coaches are emerging in many states.
- Get the SAMHSA report here



Certification Landscape

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	NAADAC NCPRSS	MBSACC CARC
Education	High school diploma or GED	High school diploma or GED
Lived Experience	At least 2 years of recovery from lived experience in substance use and/or co-occurring disorder	Not applicable
Training	60 contact and training hours (CEs) of peer recovery-focused education and training. • At least 48 hours of peer recovery-focused education/training • At least six hours of ethics education and training and six hours of HIV/other pathogens education and training within the last six years. *1 hour of education/training = 1 CE; 1 quarter college credit = 10 CEs; and 1 semester college credit = 15 CEs.	60 hours in the four CARC domains and additional trainings: 1. Advocacy (10 hours) 2. Mentoring/Education (10 hours) 3. Recovery/Wellness Support (10 hours) 4. Ethical Responsibility (16 hours) Additional trainings: Cultural Competency (3 hours), Addictions 101 (5 hours), Mental Health (3 hours), Motivational Interviewing (3 hours)
Direct Practice	200 hours (volunteer or paid) of experience in peer recovery support environment (supervisor-attested)	500 hours of work experience in the four CARC domains, completed in the last 10 years
Supervision	Not applicable	35 hours of work experience (minimum of 5 hours per CARC domain), supervised by a trained Recovery Coach supervisor
Exam?	Yes	Yes
Recertification	20 hours of continuing education every two years, including six hours of ethics training. • Provide work history for the two years prior to renewal. • Self-attestation of ongoing recovery	30 contact hours of approved continuing education, approved by MBSACC, every two years

Courtesy Mass.gov

National Association for Alcoholism and Drug Abuse Counselors (NAADAC), National Certified Peer Recovery Support Specialist (NCPRSS)

NAADAC
NAADAC.ORG
THE ASSOCIATION FOR ADDICTION PROFESSIONALS

The Massachusetts Board of Substance Abuse Counselor Certification (MBSACC), Certified Addictions Recovery Coach (CARC)

MBSACC

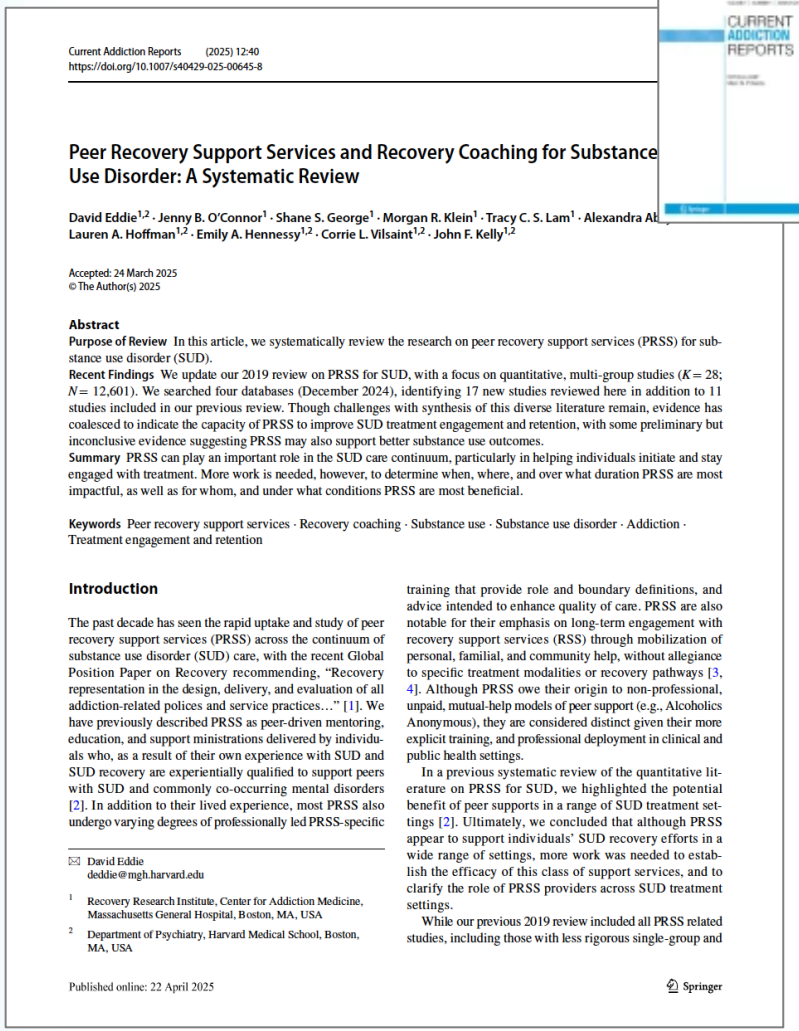
Connecticut Community for Addiction Recovery (CCAR)

CCAR

Recovery coaches improve outcomes

Growing evidence supports improved outcomes with recovery coaches

- Strong evidence for peer support services on treatment linkage and engagement
- Effects on substance use also very promising
- Preliminary support for accrual of recovery resources (i.e., recovery capital)



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Peer Recovery Support Services and Recovery Coaching for Substance Use Disorder: A Systematic Review

David Eddie[1,2] · Jenny B. O'Connor[1] · Shane S. George[1] · Morgan R. Klein[1] · Tracy C. S. Lam[1] · Alexandra Ak
Lauren A. Hoffman[1,2] · Emily A. Hennessy[1,2] · Corrie L. Vilsaint[1,2] · John F. Kelly[1,2]

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Abstract
Purpose of Review In this article, we systematically review the research on peer recovery support services (PRSS) for substance use disorder (SUD).
Recent Findings We update our 2019 review on PRSS for SUD, with a focus on quantitative, multi-group studies ($K = 28$; $N = 12{,}601$). We searched four databases (December 2024), identifying 17 new studies reviewed here in addition to 11 studies included in our previous review. Though challenges with synthesis of this diverse literature remain, evidence has coalesced to indicate the capacity of PRSS to improve SUD treatment engagement and retention, with some preliminary but inconclusive evidence suggesting PRSS may also support better substance use outcomes.
Summary PRSS can play an important role in the SUD care continuum, particularly in helping individuals initiate and stay engaged with treatment. More work is needed, however, to determine when, where, and over what duration PRSS are most impactful, as well as for whom, and under what conditions PRSS are most beneficial.

Keywords Peer recovery support services · Recovery coaching · Substance use · Substance use disorder · Addiction · Treatment engagement and retention

Introduction

The past decade has seen the rapid uptake and study of peer recovery support services (PRSS) across the continuum of substance use disorder (SUD) care, with the recent Global Position Paper on Recovery recommending, "Recovery representation in the design, delivery, and evaluation of all addiction-related polices and service practices…" [1]. We have previously described PRSS as peer-driven mentoring, education, and support ministrations delivered by individuals who, as a result of their own experience with SUD and SUD recovery are experientially qualified to support peers with SUD and commonly co-occurring mental disorders [2]. In addition to their lived experience, most PRSS also undergo varying degrees of professionally led PRSS-specific training that provide role and boundary definitions, and advice intended to enhance quality of care. PRSS are also notable for their emphasis on long-term engagement with recovery support services (RSS) through mobilization of personal, familial, and community help, without allegiance to specific treatment modalities or recovery pathways [3, 4]. Although PRSS owe their origin to non-professional, unpaid, mutual-help models of peer support (e.g., Alcoholics Anonymous), they are considered distinct given their more explicit training, and professional deployment in clinical and public health settings.

In a previous systematic review of the quantitative literature on PRSS for SUD, we highlighted the potential benefit of peer supports in a range of SUD treatment settings [2]. Ultimately, we concluded that although PRSS appear to support individuals' SUD recovery efforts in a wide range of settings, more work was needed to establish the efficacy of this class of support services, and to clarify the role of PRSS providers across SUD treatment settings.

While our previous 2019 review included all PRSS related studies, including those with less rigorous single-group and

✉ David Eddie
deddie@mgh.harvard.edu

1 Recovery Research Institute, Center for Addiction Medicine, Massachusetts General Hospital, Boston, MA, USA

2 Department of Psychiatry, Harvard Medical School, Boston, MA, USA

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(Eddie et al., 2025; Satinsky et al., 2020) (Crowthers et al., 2022; Cupp et al., 2022; Hansen et al., 2022; Lukacs et al., 2023; Suzuki et al., 2023)

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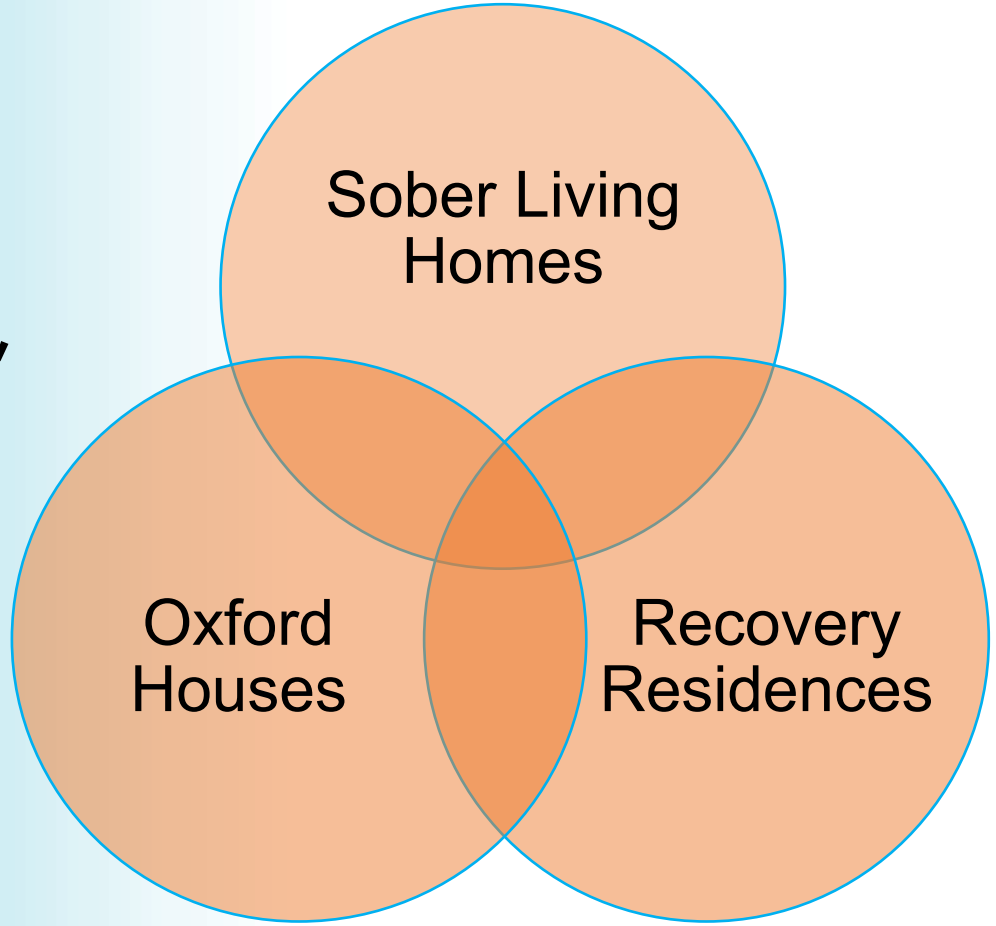
Recovery Housing

From Housing First to Sober Homes

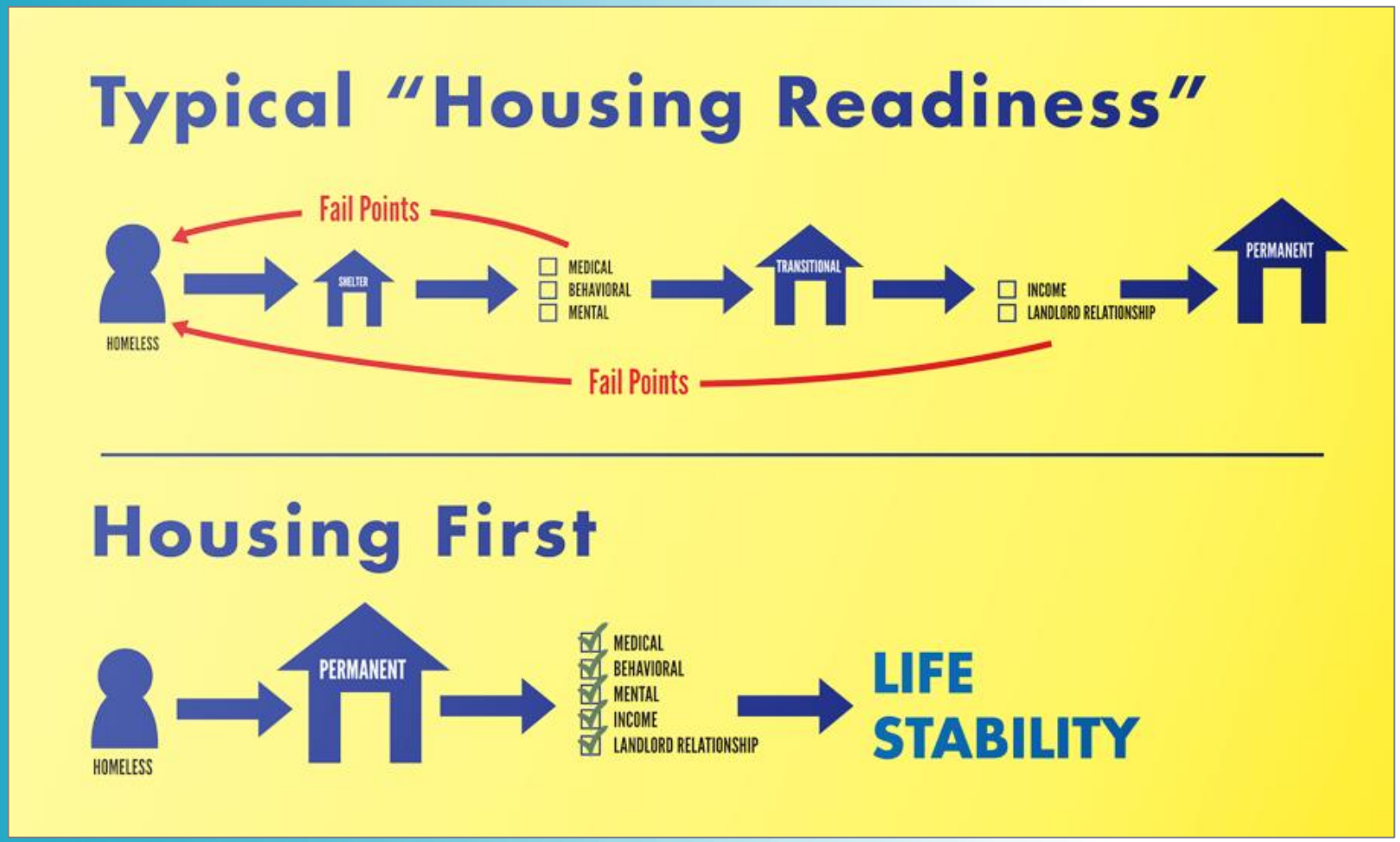
Recovery Housing

- Goal to provide a safe, abstinent-based, supportive housing, with peers in recovery, and support long-term recovery from substance use disorder



(Vilsaint et al., 2025)

Housing First



(Kerman et al., 2021)

Levels of Recovery Housing

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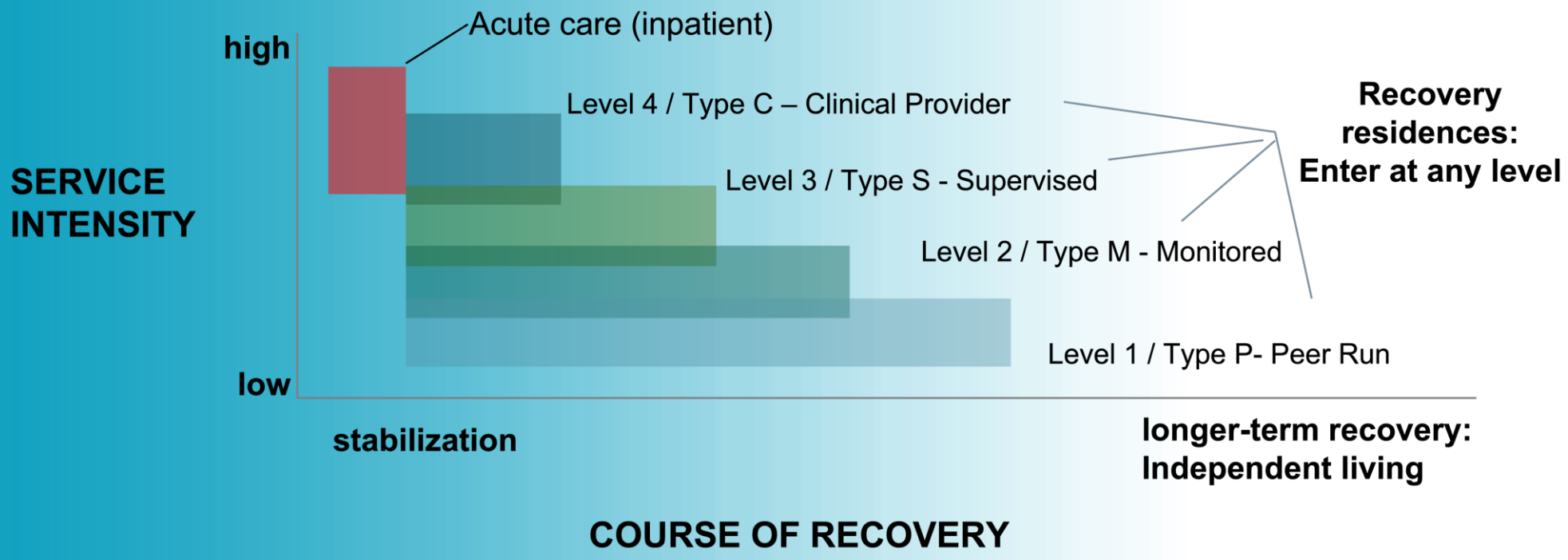

MASH
Massachusetts Alliance for Sober Housing

HALF WAY HOUSE DIRECTORY

(Edwards et al., 2021; Mahoney et al., 2021; Mericle et al., 2019, 2020, 2023; Polcin et al., 2021)

MOUD and Recovery Residences

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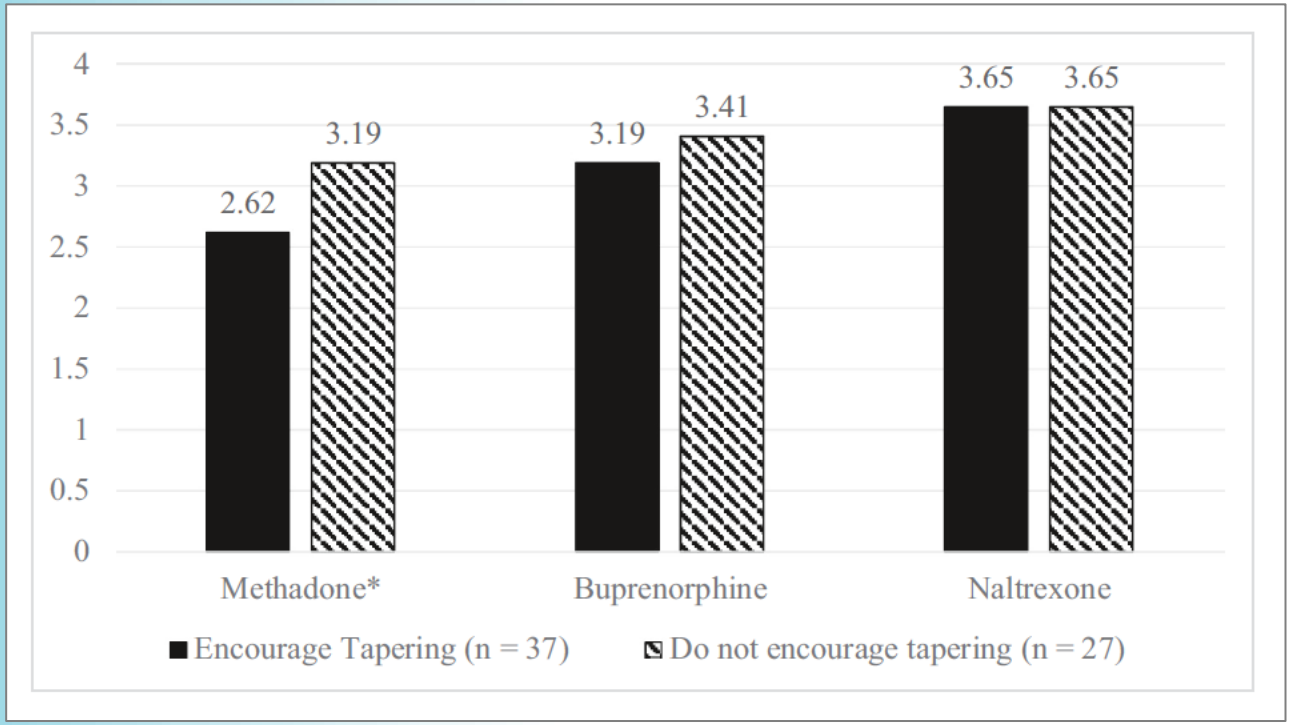
- Varying levels of acceptance of Medications for opioid use disorder (MOUD) in many recovery housing
- Housing supervisors and staff may press for tapering



Missouri Recovery residences preference for taper / no taper

(Wood et al., 2022; Patel et al., 2020)

Evidence for Recovery Housing

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Compared to Usual Care

- Greater alcohol/drug abstinence
- Improved income & employment
- Reduced criminal charges & rearrest
- Mixed findings for incarceration
- Higher net benefit per person
- More cost effective

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EDITED BY
Julia Dickson-Gomez,
Medical College of Wisconsin, United States

REVIEWED BY
Mehmet Şeremet,
Yüzüncü Yıl University, Türkiye
Elizabeth O. Obekpa,
University of Texas Health Science Center at Houston, United States

*CORRESPONDENCE
Corrie L. Vilsaint
cvilsaint@mgh.harvard.edu

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Recovery housing for substance use disorder: a systematic review

Corrie L. Vilsaint[1,2]*, Alex G. Tansey[1], Emily A. Hennessy[1,2], David Eddie[1,2], Lauren A. Hoffman[1,2] and John F. Kelly[1,2]

[1]Recovery Research Institute, Center for Addiction Medicine, Massachusetts General Hospital, Boston, MA, United States, [2]Department of Psychiatry, Harvard Medical School, Boston, MA, United States

Recovery housing, an abstinence-based living environment, is the most widely available form of substance use disorder (SUD) recovery support infrastructure. This systematic review characterized the randomized control trials (RCT) and quasi-experimental designs (QED) research on recovery housing. We conducted a search across PubMed, EMBASE, CINAHL, PsycINFO and CENTRAL published prior to February 2024. For inclusion, studies had to compare recovery housing alone to a non-recovery housing condition. Our search identified 5 eligible studies including 3 RCTs and 2 QEDs, across 11 reports. Participants Ns ranged from 150 to 470 and follow-up durations were 6–24 months. Recovery housing interventions performed better than continuing care as usual/no intervention on abstinence, income, employment, criminal charges and to a lesser extent incarceration. Recovery housing also performed better than comparative interventions delivered in other types of residential settings (e.g., therapeutic communities) on increasing alcohol abstinence and reducing days of substance use, while also increasing income and employment rates. An exception was in study samples that had high percentages of formerly incarcerated women (90% or more) where reduced substance use was the only benefit of recovery housing when compared to other types of residential interventions and was inconsistent when compared to continuing care as usual/no intervention. Moreover, recovery housing demonstrated higher cost effectiveness than continuing care as usual/no intervention and comparative interventions. Based on quantity, quality, and support for the service, the existing level of evidence for recovery housing is considered moderate. Expanding access to recovery housing may enhance outcomes for individuals with SUD, in general, while producing cost saving benefits, but given the small number of high quality studies additional comparative trials are needed. Also, future research should identify specific sub-groups who may or may not benefit from recovery housing interventions and why, so as to develop and test suitably augmented housing models or identify helpful alternatives.

(Vilsaint et al., 2025; Ashworth et al., 2022; Mahoney et al., 2021; Mericle et al., 2019, 2020, 2022; Miles et al., 2022; Patel et al., 2020; Polcin et al., 2021b, 2021a, 2023; Tsatsi & Plastow, 2021; Wong et al., 2019)

Evidence for Recovery Housing

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Compared to Residential Therapeutic Communities

- Greater alcohol abstinence
- Less days of substance use
- Improved income & employment outcomes
- Higher net benefit per person

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EDITED BY
Julia Dickson-Gomez,
Medical College of Wisconsin, United States

REVIEWED BY
Mehmet Şeremet,
Yüzüncü Yıl University, Türkiye
Elizabeth O. Obekpa,
University of Texas Health Science Center at Houston, United States

*CORRESPONDENCE
Corrie L. Vilsaint
cvilsaint@mgh.harvard.edu

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[1]Recovery Research Institute, Center for Addiction Medicine, Massachusetts General Hospital, Boston, MA, United States, [2]Department of Psychiatry, Harvard Medical School, Boston, MA, United States

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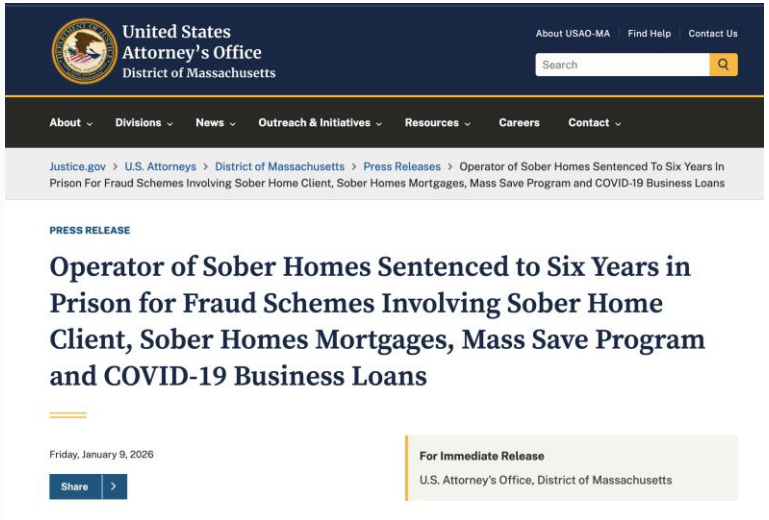
Risks of Victimization

- Hierarchical structure / vulnerable population puts residents at elevated risk for victimization
- Risk of stolen/diverted medications
- Risk for sexual coercion and violence



(Edwards et al., 2021) (Mahoney et al., 2021; Mericle et al., 2019, 2020; Polcin et al., 2021)

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