



RECOVERY RESIDENCES AND MEDICATIONS FOR OPIOID USE DISORDER

Abbreviations: ‘**OUD**’: Opioid Use Disorder; ‘**MOUD**’: Medications for Opioid Use Disorder.
(We are using the term ‘**MOUD**’ to refer primarily to methadone and buprenorphine)

MAR: Medication-Assisted Recovery

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SHOULD ACCESS TO MOUD BE A QUALITY STANDARD FOR RECOVERY RESIDENCES?

Recovery residences provide a therapeutic milieu with evidenced-based improvement in abstinence rates, substance use, employment, income, and criminal involvement. (Vilsaint, 2025) It is estimated that there are over 17,000 recovery homes in the U.S. that serve about 250,000 people over the course of a year. (Jason, 2021)

As of 2020, 36 states used NARR standards (National Alliance for Recovery residences) for ensuring quality in recovery residences. (Martin, 2020) Access to medication-assisted recovery is not a NARR standard. The only reference to medication in the NARR Standards (Version 3.0; <https://narronline.org/standards>) is that facilities include “Policy and procedures that address residents’ prescription and non-prescription medication usage and storage consistent with the residence’s level and with relevant state law.” However, “No universal set of measures has been developed for widespread adoption [for recovery housing].” (Thompson, 2024)

Many owners and operators are open to expanded MOUD access but are concerned that residents using MOUD may experience negative outcomes due to reduced social support. Such negative outcomes can occur in recovery residences (Dewey, 2026) and in 12-step groups (Andraka-Christou, 2022) which are closely associated with recovery houses. Negative attitudes toward MOUD are common in recovery houses.

However, multiple reports have shown that residents who use MOUD in Oxford Houses, living with those who do not, still derive positive social support and other benefits. (Majer, 2019; Majer, 2020; Soto-Nevarez, 2023) Although this appears more likely when there is more than one resident using MOUD, (Majer, 2020b) increased social support over time has also been demonstrated for those who are the only resident using MOUD. (Sikora, 2025)

William L. Wright M.A, a respected authority on recovery services, and distinguished co-authors, wrote that: “Despite the risk of encountering negative attitudes [toward MOUD],

participation in recovery mutual aid groups and other recovery support institutions is

associated with better MOUD clinical outcomes and a planned treatment completion." (White 2025)

Incentives and mandates for MOUD access do not necessarily overcome negative attitudes. In 64 Recovery Homes required to demonstrate a "medication friendly" culture of MOUD acceptance as a condition of their SAMHSA grant funding, most managers reported that tapering off MOUD was encouraged, and only one if these houses offered all three medications for OUD. (Wood, 2022)

Adequate funding, education & technical assistance could expand access to MOUD by helping to change negative attitudes in recovery residences. However, MOUD stigma researcher Erin Manning Ph.D. noted that improving MOUD access "requires a multi-pronged approach . . . You can do all the training that you want and you're only going to get so far" [without policy change as well]. (Manning 2022) An increasing number of states are enacting laws or regulations requiring access to MOUD in recovery residences as a quality standard.

ATTITUDINAL AND CAPACITY (LOGISTICAL) BARRIERS TO MOUD ACCESS

Recovery residences need to maintain a milieu of abstinence from illicit substances for the benefit of all residents, and typically check random drug screens and observe residents' behavior. More robust monitoring and control over MOUD may be needed for houses to become MAR-capable (MAR: "Medication-Assisted Recovery"). This may be associated with increased costs and staffing requirements which have been described as capacity barriers that could prevent Level I and II houses from becoming MAR-capable. Other perceived or actual capacity barriers may include lack of staff knowledge about MOUD, lack of capacity for care coordination or to facilitate telemedicine or other provider visits. (Winograd, 2026).

However, access to MOUD in recovery residences is slowly increasing, including in Oxford Houses (which have no staff). In 2018, Oxford House Inc. strongly endorsed MOUD as a legitimate harm reduction strategy during its 2018 World Convention, (Sikora, 2025) described as a "major cultural shift." (Sikora, I-STARR webinar, 2026)

There are reasons to believe that attitudinal barriers related to MOUD stigma, not capacity barriers, may be the primary factors limiting MOUD access in this setting. MOUD stigma is related to the belief that the use of medications for OUD, which are opioids, is just "trading one addiction for another." (Olsen, 2014; Manning, 2021). The word "abstinence" is often used, confusingly, to mean abstinence from illicit drugs, or abstinence from all opioids including MOUD. Equating medication with drugs may cause some Recovery Residence operators to think of MOUD diversion/misuse as nearly equivalent to diversion/misuse of illicit, addicting drugs. (Unlike other opioids, MOUD causes physical dependence, but not addiction).

A survey of Arizona recovery residences found that "more favorable attitudes toward MOUD were significantly associated with higher odds of reporting organizational resources to meet licensing requirements regarding MOUD." (Hernandez, 2025)

In a national sample of 547 outpatient substance use treatment units, older director age and director's endorsement of abstinence as the most important treatment goal were associated with a lower likelihood of adopting buprenorphine for opioid maintenance. (Friedmann, 2010). From a study of publicly funded treatment organizations, "In our survey and consistent with prior national studies, we find that the leadership of most agencies endorse financial barriers to implementing MOUD. . ." However, "Our results indicate that high MOUD adopting organizations have found ways to address these barriers . . . what differentiates high and low MOUD-adopting agencies are their leadership's beliefs about the efficacy and effects of medications, anticipation of MOUD misuse, and perceptions of negative attitudes towards MOUD within their organization." (Stewart, 2022) [The published literature] "illustrates that . . . recovery residences are capable of supporting residents on MOUD when they intentionally set out to do so." (Winograd, 2026)

DIVERSION & MISUSE OF METHADONE AND BUPRENORPHINE

MOUD diversion/misuse should be minimized, in recovery residences. Although it does not have the same implications as relapse or use of illicit addicting drugs, it could be a marker that an individual may be using, or is at risk of using illicit drugs. Rules and expectations against diversion / misuse of MOUD should be clear, (Howell, I-STARR webinar, 2024) and this should be effectively controlled in recovery residences to the extent practical, balancing the need for safety and a therapeutic milieu with avoidance of unnecessary barriers or stigmatization affecting people who use MOUD.

Steps to minimize MOUD diversion/misuse could include monitoring these medications in the drug screens that are already collected, pill counts, observing self-administration, maintaining a log of each dose taken, and/or controlling access with lock boxes or a locked / restricted medication room. Not all of these measures are needed for all residents using MOUD.

Flexible individualized approaches to MOUD monitoring in recovery residences developed by trial and error, balancing autonomy with oversight, have been described. (Gallardo, 2026) "While diversion did happen, it was rare. . . Stakeholders noted little differences between operating MOUD-accepting and non-MOUD-accepting homes and their residents."

Some individuals use non-prescribed MOUD "to get high," and published studies consistently show this is a much less common motivation than using it for therapeutic reasons: to self-treat or prevent withdrawal symptoms, to prevent using illicit opioids, when a prescribed dose is too low, to overcome barriers to prescribed medication, and related to this, to guard against unexpected interruptions or to be in control of one's own medication. (Carroll, 2018; Cicero, 2014; Doernberg, 2019; Daniulaityte, 2019; Silverstein, 2020; Yokell, 2011) Diversion is often done to help others as "therapeutic diversion." (Kenney, 2017) MOUD is also diverted to generate income.

Misuse of MOUD is much less common among those in early recovery than in those in active drug use or when seeking OUD treatment. Misuse of methadone, and especially buprenorphine, is much less dangerous than illicit opioids, and multiple studies have shown it is associated with reduced overdose rates (among those in active drug use). (Carlson, 2017) Buprenorphine confers lower health and mis-use risks than other opioids.

(Chilcoat, 2019; Yokell, 2011)

Pharmacologically, methadone and buprenorphine are less rewarding than other opioids and are rarely drugs of choice; they are typically used, for any of the above reasons, when other opioids are less available. (Cicero, 2014)

Some individuals do mis-use methadone or buprenorphine “to get high” and can experience euphoria. Even when mis-used for this purpose, non-prescribed MOUD might not cause euphoria in individuals already using MOUD. Such individuals have opioid tolerance which tends to block the effects of fentanyl and any other opioids. (Daniulaityte, 2012)

MOUD IS OFTEN INACCESSIBLE IN RECOVERY RESIDENCES; MOUD STIGMA IS “RAMPANT”

“MOUD-related stigma (prejudice and discrimination towards MOUD) is rampant across the continuum of treatment and recovery services.” (Gallardo, 2024) “Only 12.5% of all sixteen recovery houses that accept discharged patients from Vanderbilt University Medical Center in Nashville accept residents who use MOUD without requiring them to taper off. 0% allow maintenance methadone. (Patel, 2020)

Of 100 recovery residences (levels I-IV) certified by the Florida Association of Recovery Residences (FARR), 16% accepted residents on buprenorphine without conditions, 53% prohibited buprenorphine and 31% accepted buprenorphine with conditions. These conditions were a mandatory taper (38.7%), maximum 8 mg. daily dose (12.9%), maximum 12 mg. (6.5%), maximum 16 mg. (6.5%), a provider letter (9.7%), or not reported (9.7%). (Guido, 2025)

Recovery support facilities appear to be particularly unlikely to allow MOUD access. Among all 360 facilities offering services for opioid related needs in a midwestern metropolitan area, the 77 facilities offering recovery support services were essentially the least likely to allow MOUD. Only 6% of these were in the “High acceptance” category, 32% in the “Moderate acceptance” category, 20% in the “Low acceptance” category, and 42% were in the “Zero acceptance” category. Of fifteen facility characteristics separately analyzed, offering recovery support services was the characteristic associated with the second lowest rate of allowing MOUD. (Kepple, 2019)

The recovery community says it offers refuge from opioid addiction. But it is still hostile to lifesaving addiction medications.” (Facher, 2024)

CONSENSUS AMONG HEALTH AND GOVERNMENT ORGANIZATIONS

According to **the American Society of Addiction Medicine (ASAM) 2025 Public Policy Statement**

on **'Housing's Role in Addressing Substance Use and Facilitating Recovery,'** "Best Practice Standards . . . include explicit support for residents' use of prescribed medications for mental or physical health conditions, including medications for addiction treatment such as buprenorphine and methadone." ASAM recommends that "Governments require . . . quality measures, . . . credentialing of recovery residences through accreditation, licensure, or certification . . . based on (1) nationally recognized quality standards and **SAMHSA's 2023 Best Practices for Recovery Housing** which include explicit support for residents' use of . . . medications for addiction treatment such as buprenorphine and methadone" . . . and (2) that The U.S. Department of Justice prioritizes enforcing the Americans with Disabilities Act [and other federal laws] related to recovery residences. . . on policies on FDA-approved SUD medications . . ." (ASAM, 2025; SAMHSA, 2023)

(Note that the existence of federal laws such as the Americans with Disabilities Act have been cited as a reason that additional regulations are not needed, though it is well known that these laws are not enforced in recovery residences. No federal law has been used to protect MOUD access in recovery residences). According to **the Legal Action Center**, people who take methadone or buprenorphine often experience illegal barriers to recovery residences. (Legal Action Center, 2022)

Also according to **SAMHSA's 2023 Best Practices for Recovery Housing**, "It is a best practice in recovery housing not to "have any barriers or restrictions for residents to use prescribed medications for behavioral or physical health conditions . . . This includes the use of the FDA approved medications for alcohol use and/or opioid use disorders - including buprenorphine, methadone, and naltrexone." (SAMHSA, 2023).

According to **SAMHSA's 2021 Substance Abuse and Mental Health Services Administration Treatment Improvement Protocol 63 Medications for Opioid Use Disorder**, "Medication for OUD should be successfully integrated with outpatient and residential treatment . . ." Patients treated in these settings should have access to OUD medications . . . Patients who discontinue OUD medication generally return to illicit opioid use . . . even when discontinuation occurs slowly and carefully. . . The best results occur when a patient receives medication for as long as it provides a benefit ('maintenance treatment') (SAMHSA, 2021)

According to the **National Academies of Sciences, Engineering, and Medicine's 2019 report: Medication for Opioid Use Disorder Saves Lives**, "There is no scientific evidence that justifies withholding medications from OUD patients in any setting or denying social services (e.g., housing, income supports) to individuals on medication for OUD. Therefore, to withhold treatment or deny services under these circumstances is unethical." (NASEM, 2019).

According to **the World Health Organization's 2009 Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence**, "Pharmacological treatment of opioid dependence should be widely accessible . . . Essential pharmacological treatment options should consist of opioid agonist maintenance . . . (in all settings as a minimum standard)." (WHO, 2009).

According to **the O'Neill Institute**, "MOUD restrictions [in recovery housing] are often rooted in stigma, and concerns that individuals who are not on MOUD may misuse the prescribed MOUD. MOUD Restrictions are often connected to homelessness and housing insecurity, and may exacerbate SUD symptoms." (O'Neill Institute, 2023)

ANNOTATED REFERENCES:

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[groups/](#)

People experiencing widespread stigmatization of MOUD in 12-step programs (being prohibited from speaking, being refused a sponsor or being unable to claim recovery time, etc.) may respond by feeling shame, anger, leaving the group, etc. The authors concluded that healthcare systems should help address MOUD stigma experienced by patients in 12-step groups, such as by offering non-12-step alternative groups. . .

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Interviews in level III Recovery Houses found that “inconsistent staff attitudes toward MOUD revealed underlying stigma, which some residents found intrusive or isolating. . . recovery homes rarely address MOUD-related stigma formally, creating tension between medical and social models of recovery and contributing to judgment or marginalization of MOUD recipients. . .” “The influence of 12-step groups, which emphasize abstinence as the foundation of recovery, has led some to the perception that individuals prescribed MOUDs are not in recovery.”
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“A strongly held view in the organizational literature is that organizations are profoundly influenced by top managers . . . including promoting and sustaining innovation.”
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The authors conducted 138 interviews with residents and staff of Level II and Level III MOUD-accepting recovery homes including residents using and not using MOUD. All but one of the houses utilized lockboxes in various ways. A goal was “to ensure that residents taking MOUD felt supported and not stigmatized. . . Stakeholders developed MOUD policies related to screening, intake, medication oversight, storage and resident access. Some allowed a choice of recovery program without mandating a 12-step model.
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“As with any other disease, medications should not be withheld from people with OUD without sufficient medical justification. Withholding them on ideological or other non-evidence-based grounds is denying people needed medical care. . . care settings that could provide or enable access to medication-based treatment for OUD include residential facilities . . . many of which . . . impose a zero-tolerance policy for opioid use of any kind - with no exception for evidence-based medications like methadone and buprenorphine.”
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"Any increases in control or monitoring should be considered in parallel with efforts to increase access to affordable and sustainable opioid agonist therapy for dependent individuals. . . attempt to limit the diversion and illicit use of buprenorphine [may] result in a concomitant decrease in the accessibility of this potentially lifesaving medicine."

See www.StopStigmaNow.org – 'Recovery Residences.'

Stop Stigma Now is an independent 501c3 nonprofit organization. Please donate today.