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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)

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)

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." Notwithstanding the NARR Standards, "No universal set of measures has been developed for widespread adoption [for recovery housing]." (Thompson, 2024).

NARR strives to expand MOUD access and advocates for more financial support for residences to facilitate this. Some NARR members have cited concerns that, in houses with a culture of negative attitudes toward MOUD, residents using MOUD may experience negative effects due to reduced social support. Such stigma-related negative effects have been reported. (Best, 2021; (Andraka-Christou, 2022) William L. Wright M.A, a respected authority on recovery services, with a group of leaders in addiction treatment and recovery, 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)

MOUD education / technical assistance could potentially expand access with adequate funding, though this would take time. MOUD stigma expert 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)

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"), which may increase costs. These costs have been described as a capacity (logistical) barrier to allowing the use of MAR/MOUD. Other possible capacity barriers may include lack of staff knowledge about MOUD, lack of capacity for care coordination or to facilitate telemedicine provider visits. (Winograd, 2026)

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 (and others) to think of MOUD diversion/misuse as nearly equivalent to diversion/misuse of illicit, addicting drugs. (Unlike illicit 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 current 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). "In our survey and consistent with prior national studies, we find that the leadership of most agencies endorse financial barriers to implementing MOUD. . . 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)

DIVERSION & MISUSE OF METHADONE AND BUPRENORPHINE

MOUD diversion/misuse should be minimized, particularly in Recovery Residences, though it does not have the same implications as relapse or use of illicit addicting drugs. Diversion or misuse could be a marker that may identify an individual who has relapsed or used illicit drugs.

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. In addition to the costs of monitoring, Recovery Residences seeking a balance between control over MOUD and autonomy should consider that vigorous monitoring and control can be inconvenient and stigmatizing for residents and may stigmatize the use of MOUD itself. Flexible individualized approaches to MOUD monitoring in Recovery Residences developed by trial and error, balancing flexibility with oversight, have been described: "While diversion did happen, it was rare. . . Stakeholders noted little differences

between operating MOUD-accepting and non-MOUD-accepting homes and their residents." (Gallardo, 2026)

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 in these ways 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 numerous studies have shown it is associated with reduced overdose rates (among those in active drug use). (Carlson, 2017) Buprenorphine confers lower health and abuse 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 often does 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)

Diversion/misuse of MOUD can be a marker to identify relapse and use of illicit opioids, and should be prohibited and effectively controlled in Recovery Residences to the extent practical, balancing flexibility with oversight, and avoiding unnecessary costs.

MOUD IS OFTEN INACCESSIBLE IN RECOVERY RESIDENCES; MOUD STIGMA IS "RAMPANT"

"MOUD-related stigma, or 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 or require 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. Of 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. 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 rates of allowing MOUD. (Kepple, 2019)

CONSENSUS AMONG HEALTH AND GOVERNMENT ORGANIZATIONS

The American Society of Addiction Medicine (ASAM) 2025 Public Policy Statement on 'Housing's Role in Addressing Substance Use and Facilitating Recovery' 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 Best Practice Standards, 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' . . . 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, although it is well known that these federal laws are not enforced in Recovery Residences. No federal law has been used to protect MOUD access in recovery residences. People who take methadone or buprenorphine often experience illegal barriers to recovery residences. (Legal Action Center, 2022)

"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." (National Academy of Sciences, 2019). "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, 2025).

"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).

"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).

"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)." (World Health Organization, 2009).

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

"The overdose crisis is an epidemic of poor access to care. One of the tragic ironies is that with well-established medical treatment, opioid use disorder can have an excellent prognosis." (Wakeman, 2018). "Many still believe that recovery depends solely on willpower to abstain from all opioids, including methadone and buprenorphine. . ." (Olsen, 2014)

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  Interviews in four 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. . . "
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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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