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REPORT TO THE LEGISLATURE

TO: Joint Standing Committee on Health and Human Services
FROM: Maine Department of Health and Human Services
DATE: June 5, 2026
RE: Committee request regarding LD 1973, *Resolve, to Establish the Commission to Study Oversight and Funding Structures for Recovery Residences and Resident Protections*

LD 1973, *Resolve, to Establish the Commission to Study Oversight and Funding Structures for Recovery Residences and Resident Protections,* would have established a legislative study to review the oversight and funding of recovery residences in the state. The members of the Joint Standing Committee on Health and Human Services Committee unanimously voted the bill as "ought not to pass," with a request to the Department of Health and Human Services (Department) for additional information and responses to six areas of interest regarding recovery residences that deserve closer inspection.

Please note, the recommendations presented in this report are generated by the interested parties involved in this analysis. They do not necessarily reflect the position of the Department, nor do they necessarily reflect future proposals of the Department or convey support for specific legislation. The Department will continue to engage with partners and the Legislature on individual initiatives as appropriate.

Engagement Process

In response to the Committee's request, the Department engaged with interested parties and performed other analyses and investigation into each of the questions raised in the June 16, 2025 letter. As the letter did not request specific participants, the Department engaged the Maine Association of Recovery Residences, recovery and peer service organizations, municipalities, and individuals with lived or professional experience in the field of recovery through Summer and Fall 2025.

The principal and consistent theme was support for the growth of recovery residences throughout Maine and how best to manage the expansion and long-term sustainability.

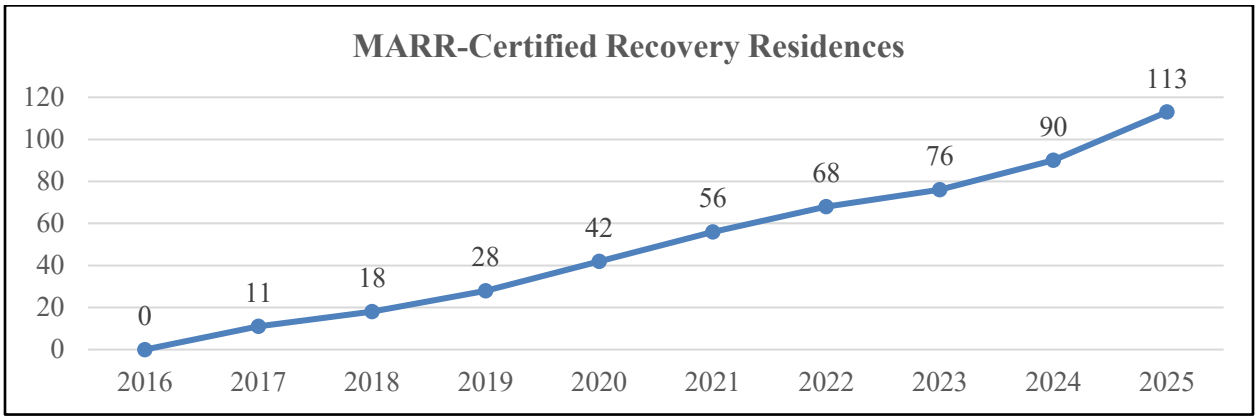
Background

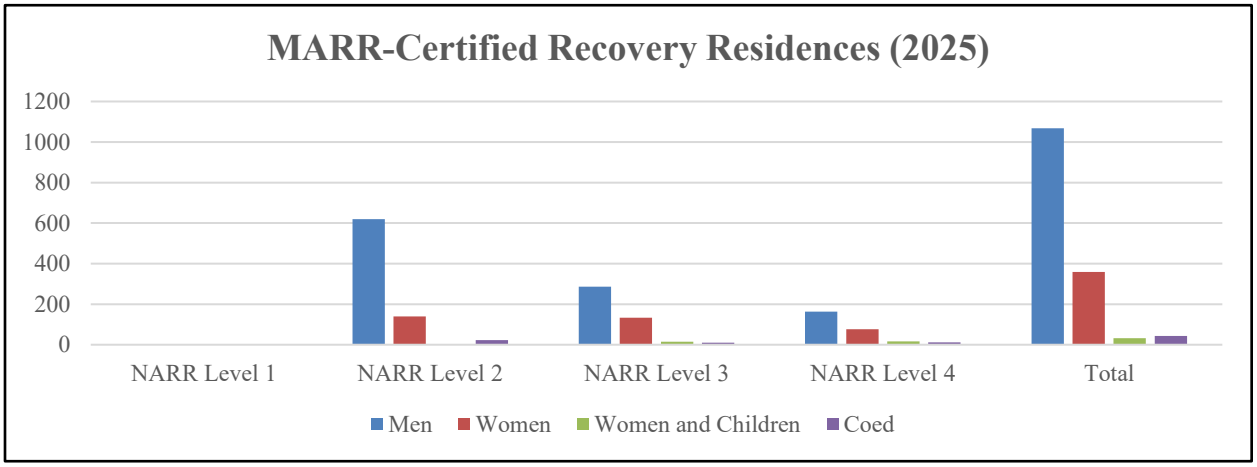
Recovery residences provide substance-free living environments that support individuals in recovery from addiction. They vary in structure but are all centered on peer support and a connection to services that promote long-term recovery.
The Office of Behavioral Health (OBH) contracts with the Maine Association of Recovery Residences (MARR) to provide several services related to recovery residences including, but not limited to: technical assistance to individuals or organizations seeking to open a recovery

residence in Maine, and to existing owners or operators; completing certification inspections and responsibilities pursuant to Maine law and standards imposed by the National Association of Recovery Residences (NARR); maintaining a publicly accessible directory of all certified recovery residences in Maine; and acting as an informational resource to local and state government for matters involving recovery residences and associated services.

MARR also administers the state's Housing Subsidy Support Program (HSSP) for recovery residences, which supported 1,492 individuals in 2025. The HSSP subsidizes bed-nights for up to 60 days at a rate of $24 per night for Level 2 MARR-certified houses, and $26 per night for Level 3 MARR-certified houses[1]. HSSP eligibility requires MARR certification, financial audits, and policies that permit residents to have prescription medications, including those for opioid use disorder (e.g., methadone and buprenorphine).

Maine's recovery residence landscape has grown substantially in recent years, and most significantly between 2020 and 2025. This growth has provided many benefits but has also raised challenges, as identified in discourse throughout LD 1973's public hearings and work sessions.





[1] Recovery residences span four levels, with Level 1 houses having the least oversight and Level 4 houses often integrating clinical services with the highest level of support and supervision.

Funding Structure for Recovery Residences
The funding structure for recovery residences is a combination of resident contribution, public funding, and private support, varying by program type (nonprofit v. for-profit), geographic location, and certification or accreditation status.

Resident Contribution and Private Pay
Resident contributions are the primary operating revenue for most recovery residences, in addition to shared household expenses for utilities and food contributions. These payments help cover the basic costs for maintaining operational solvency. In many homes, residents pay out of pocket or with financial assistance from family, which is consistently reported as the most dependable source of revenue for many operators.

Insurance coverage is significantly limited for recovery residences as most do not provide clinical services and therefore cannot bill private insurance or MaineCare. However, some recovery residences in Maine who have chosen to provide clinical services for substance use disorder are certified by MARR as Level 4 Recovery Residences and can receive insurance reimbursement. As these Level 4 houses are governed by MaineCare policy and state licensing regulations, they are not eligible for participation in the HSSP subsidy program. With the ability for recovery residences to offer clinical services at a Level 4 certification, there has been confusion about the differences between recovery residences and residential treatment programs which are entirely based on clinical programming and not intended to be viewed as housing.

Public Funding
Availability and amounts of public funding vary in support provided for both start-up and ongoing operational costs for recovery residences.

State Funding
Since 2020, Maine's Office of Behavioral Health has allocated $990,000 annually through a combination of federal grants, special revenue funds, and State Substance Use General Fund dollars to support recovery residences statewide through the HSSP subsidy program. Additionally, in November 2025, OBH was awarded State Opioid Response supplemental funds, allocating approximately $400,000 to support a special population of individuals aged 18 -24 years old seeking recovery housing through September 30, 2026.

Municipal (Local) Funding
General Assistance (GA) funds also support resident contribution requirements in recovery residences similar to rent for individuals in private dwellings. In 2023, GA undertook rulemaking to establish allowable maximums for recovery residences at 75% of the local fair market rent for a one-bedroom heated unit, with a requirement that individuals seeking housing assistance be living in a MARR-certified recovery residence for housing support beyond 30 days.
Maine's Recovery Council has also allocated funds to support recovery residences on a limited basis subject to availability of funding. Most notably, MARR received $542,000 to support the development of up to eight recovery residences in rural and underserved communities[2] through the Rural Recovery Residence Expansion Program. The Program provides first-year funding and

[2] Eligible counties include Aroostook, Franklin, Hancock, Lincoln, Oxford, Piscataquis, Sagadahoc, Somerset, Waldo, and Washington.

hands-on operational support, including house management and naloxone training, NARR certification preparation, peer navigation services, and tailored guidance for rural communities.

Nonprofit, Philanthropic, and Other Funding

There are several scholarship funds dedicated to supporting individuals entering recovery residences, however the State does not finance the entities that raise and distribute these funds and cannot speak to the amount, limitations, or eligibility criteria for each. These sources may include, but are not limited to MARR, the United Recovery Fund, and Family Restored.

Other funding streams may further include MARR's rural recovery residence expansion, Michael's Active Recovery, and Safe Harbor which all encompass operational costs for at least one year.

General Assistance and the Financial Viability of Recovery Residences

General Assistance has become a primary source of support for recovery residents, however the reliance on GA fluctuates considerably from one recovery residence to another. Among operators engaged, there were three key positions regarding resident applications and ability to pay:

1. Operators who include the ability to pay as part of their screening process, which often results in fewer admissions for residents without demonstrable ability to pay the requisite fees;
2. Operators who rely more on prior work experience and prospective employability as a future indicator of greater independence or success; and
3. Operators who believe readiness to enter sober living, commitment to recovery activities, and alignment with house expectations are of utmost importance.

The houses falling into the third group that focused most on resident readiness reported higher confidence in reliable public financial support, including the HSSP and GA to cover resident fees.

Recent data from MARR provides further insight as to where residents were residing immediately prior to admission, which is a factor utilized when evaluating an individual's ability to pay.

Residence Prior to Admission	Number of Individuals
Currently homeless	218
Living at a program, facility, or institution	326
Living alone	60
Living alone in their own property	2
Living in a hotel/motel	18
Living in a shelter	14
Living in temporary/transitional housing (including recovery housing)	270
Living in a vehicle	23
Living with family	94
Living with roommate(s)	32
Renting a room or apartment	15

Currently, neither MARR nor the Office of Behavioral Health have authority or mechanisms available to accurately capture information specific to how or the extent that GA is financially used to support operating costs. MARR had previously attempted to collect this information in a research project supported by the Fletcher Group who produced a report on Maine's recovery residence landscape attached as Appendix A. However, it is necessary to note that the findings are incomplete due to low response rates and the significant recent growth in recovery residences statewide.

Universal Certification or Licensing of Recovery Residences

There is a clear distinction between certification and licensing. *Certification* - the current model in Maine - is a form of third-party quality assurance, focusing on ethical, safety, and recovery standards. *Licensing* requires direct state regulatory oversight of all recovery residences – similar to health facilities, group homes, or residential care facilities (e.g., private non-medical institutions and residential substance use treatment programs).

<u>Certification</u>

While Maine currently does not have mandatory certification of recovery residences, it has created meaningful financial incentives for voluntary certification. Participation in the HSSP and GA eligibility beyond a single 30-day emergency both require certification by MARR. Additionally, an analysis shows houses or residences with MARR certification status typically receive more referrals and maintain higher occupancy rates. This may ostensibly be related to the belief that certification indicates and presumably assures potential residents and community partners of several elements noted below.

Arguments for Certification:

- **Safety, quality, and standards**: certification is built on the National Association of Recovery Residences (NARR) Standards[3] which include a national, evidence-based code for physical safety, ethical operations, resident rights, and recovery-focused practices. Certified houses also undergo mandatory annual inspections and are held to certain compliance standards which reduce the risk of unsafe conditions or exploitative practices that can occur in unregulated recovery housing with less formal oversight.
- **Transparency and consumer protection**: certification provides a public signal to residents, families, and referral networks (e.g., treatment programs, courts) that a house meets established quality criteria, making it easier to identify trusted environments.
- **Facilitation of funding and referral pathways**: Maine's recovery residence subsidies and municipal housing assistance are tied to certification.

Arguments Against Certification:

- **Medical cannabis**: some operators want to permit the use of medical cannabis which is prohibited by NARR.
- **Medication for opioid use disorder (MOUD)**: some operators prohibit MOUD in their residence(s) and are concerned with potential imposition of certification or licensing requirements pertaining to MOUD.
- **Regulatory authority**: Some operators are still unclear which is the best oversight or regulatory authority, and whether this is a state agency, quasi-agency, or State contractor.

Licensing

Only Level 4 Recovery Residences are currently subject to licensing requirements and regulations. Participants in these conversations were engaged on the prospect of moving away from the existing certification process to licensing, similar to other residential-based behavioral health services, and there were arguments both in favor and against such a shift with an overall preference toward retaining certification over licensure.

Arguments for Licensure:

- **oversight and accountability**: state licensing may include enforceable rules, **Stronger** inspections, and penalties which grants government authority to intervene if a residence fails to meet standards, protecting residents from harm.
- **Consistency across settings**: without licensing standards, recovery residences may vary widely in structure, safety, and services – sometimes creating confusion for referral partners and residents evaluating potential options.

Arguments Against Licensure:

- **Risk of over-regulation and reduced access**: licensing mechanisms utilized in some states have been subject to legal challenges, primarily in response to the imposition of costly requirements that effectively close smaller homes or peer-run programs (e.g., clinical staffing and facility upgrades). Maine has a broad network of peer-run

[3] Nationally, 36 states providing recovery residence services incorporate NARR Standards into their certification or other regulatory policies. The other 14 have little to no formal certification or regulatory standards.

organizations and programs and has historically aligned with the true intent of recovery residences, which is a smaller, home-like environment. Federal fair housing protections also impact or limit how states regulate housing for people with disabilities, including those in recovery.

- **Complex social models of recovery housing**: recovery residences are intended to be more informal, supportive peer environments. Licensing these houses as treatment providers could distort their mission and create unintended regulatory burdens that do not align with the evidence of what makes these homes most effective.
- **Legal and administrative costs**: state licensing would require new administrative infrastructure, rules, and ongoing enforcement costs without clear evidence that all homes must be under direct regulatory license as opposed to certification and focused oversight.

Majority Recommendation

At this time, State licensing is not recommended given the legal complexity, potential to reduce access, and incongruence with the social model of recovery housing. Furthermore, there was consensus on concerns regarding other barriers to entry, increased burden on operators, and increased financial challenges in response to licensing requirements.

Certification remains preferred as it would clarify eligibility and likely strengthen integration with other behavioral health systems. Certification is also viewed as a more beneficial approach for houses seeking public assistance or integration with other care systems as it promotes quality, safety, and consumer confidence without overburdening residence operators.

Formal Oversight of Recovery Residences

Current Oversight Structure

The current oversight structure is limited and almost entirely voluntary. Recovery residences in Maine are not legally required to be certified unless the residence receives housing subsidies from state agencies. MARR, the nonprofit state affiliate of NARR, inspects homes and awards certification based on national standards for quality and ethics, ensuring consistency and alignment with most other states.

Challenges and Gaps in Oversight

National reporting and local media have noted that unregulated sober homes can vary substantially in their quality, management, safety, and ethical behavior – sometimes resulting in poor living conditions or exploitation in other states. In Maine specifically, past reporting from MARR regarding non-certified houses indicated many recovery homes operated without formal oversight, lacked an official list of residences, and quality discrepancies from house to house.

Arguments for More Formal Oversight

- **Protecting vulnerable residents**: people entering recovery residences are often in early or otherwise fragile stages of recovery and depend on safe, supportive, and stable environments. Without formal oversight, there is an increased risk of inconsistent practices that could harm residents or compromise recovery outcomes.

- **Public trust, transparency, and accountability**: mandatory certification would make it easier for residents, families, and referral agencies to identify reputable providers as well as tracking of complaints, compliance histories, and other quality metrics.
- **Consistency across providers**: voluntary certification allows for a wide-ranging variation in standards which would be addressed through a mandatory certification with oversight to ensure all homes meet baseline requirements regardless of funding source or referral pathway.

Arguments Against More Formal Oversight

- **Risk of reduced access**: stronger regulatory requirements, particularly complex licensing standards, can increase costs and administrative burdens for smaller or peer-led homes, potentially reducing the overall supply of recovery housing.
- **Mission compatibility**: recovery residences are intended to be social and supportive environments, not clinical treatment facilities. Overly clinical or rigid regulations that aren't tailored to social model recovery housing could undermine the peer support ethos that makes recovery homes most effective.
- **Voice and choice**: considering the variability of viewpoints as they relate to recovery residences – housing or treatment – recovery services and residences should remain flexible and voluntary in alignment with the recovery model of care. Increased oversight and mandatory certification would diminish the principle that there are many pathways to recovery and that one size does not fit all.

Balanced Approach to Oversight

A pragmatic way forward that addresses the need for more oversight without jeopardizing access could include mandatory standards tied to safety and rights. The group consensus was the application of required baseline standards for all recovery residences (e.g., fire safety, overdose reversal, resident rights, and complaint mechanisms). While MARR mandates recovery residences develop their own policies with respect to these areas of operation pursuant to national standards, they do not offer a level of detail seen in licensing requirements. MARR could be tasked by the Legislature with developing these guidelines to promote uniformity in these services statewide with oversight by the Department and Office of Behavioral Health.

Recovery residences in Maine would benefit from more formal oversight, particularly around public safety, transparency, and accountability. Strengthening oversight through expanded certification, baseline safety standards, and targeted, peer-based regulation would improve outcomes without imposing undue barriers to access. This could be achieved through bolstering the certification process generally, and by including specific areas of improvement such as advocacy for residents, hearing and redressing complaints, and best practice compliance enforcement.

Prescription Medication and Medical Cannabis Restrictions

Uncertified recovery residences are not bound by uniform standards and have full autonomy with prescription or other medication policies, including medical cannabis. Consequently, practices in uncertified houses may differ extensively in comparison to houses certified by MARR pursuant to NARR standards. Regardless of certification status, most houses in Maine have common practices beyond legal requirements that often require personal medication to be stored securely

and administered privately to ensure the safety and respect of other residents. Maine law also requires all recovery residences to have naloxone hydrochloride or another opioid-overdose reversing medication available, regardless of certification status.

Prescription Medication

Current state law does not expressly regulate prescription medication use in recovery residences. Permitted prescription medications include medication-assisted treatment (MAT), such as buprenorphine or methadone, unless other contractual rules or house policies restrict them. These permissions are an eligibility requirement for houses enrolled in the HSSP subsidy program, however.

NARR standards also permit MAT as one of many viable recovery tools. Research shows that MAT improves engagement and outcomes when used alongside other recovery support services. NARR further prohibits recovery residence owners and operators from denying admission solely based on an applicant's current use of a physician-prescribed medication. Nevertheless, recovery residences may decline referrals of individuals who use certain medications when the recovery residence does not provide appropriate staff or services. In these cases, referrals should be made to alternative facilities with more suitable staffing or services.

Notably, advocates and providers have expressed increased challenges in finding a recovery residence that accepts referrals for individuals using MOUD to support their recovery. Of those involved in this engagement, several operators and advocates expressed concern with this alleged barrier, while others conversely remain opposed to MOUD to ensure a "truly substance-free, abstinence only" housing environment. As of January 2025, approximately 20% of MARR-certified recovery residences restrict the use of MOUD in their houses.

Nationally, most recovery residences following best practices will have written medication disclosure, storage, and management policies requiring residents to disclose and securely store both prescription and over-the-counter medications. These are house policies aimed at safety and diversion prevention rather than statutory mandates.

Medical Cannabis

Under Maine's medical marijuana law, licensed providers can certify patients to use medical cannabis for qualifying conditions. State law also allows possession and use with a valid medical card. Currently, there are no specific state laws governing medical cannabis use in recovery residences.

MARR Certification and Medical Cannabis

MARR's position on medical cannabis in certified recovery residences has evolved alongside the prevalence and use of medical cannabis and its accompanying legal landscape. In 2021, MARR allowed certified residences to adopt policies permitting medical cannabis use under specific restrictions (e.g., valid medical card, no smoking or vaping, secure storage, and no interference with recovery), and a few homes did implement these policies. In early 2024, MARR rescinded this policy due to practical and safety concerns, including non-compliance and interference with recovery, and certified homes that had allowed medical cannabis previously were granted a phased approach to meet new compliance.

Under NARR, medical cannabis is generally treated like alcohol or illicit substances and is not permitted in recovery residences unless there is a specific written policy that meets specific criteria. Furthermore, because cannabis remains a Schedule I substance under federal law, even medically authorized use can create legal complexities, such as possible protection implications under the Americans with Disabilities Act or Fair Housing Act, though this has not yet been fully adjudicated. Allowing the use of medical cannabis also limits the inclusion of federal funds in recovery residence allocations, including subsidy funding.

Recommendations

As noted at the beginning of this report, the recommendations presented in this report are generated by the interested parties involved in this work. They do not necessarily reflect the position of the Department, nor do they necessarily reflect future proposals of the Department or convey support for specific legislation. The Department will continue to engage with partners and the Legislature on individual initiatives as appropriate.

1. Establishment of a Statutory Framework for Recovery Residences
   Enact legislation that formally recognizes recovery residences in statute and establishes a clear framework that:

   - Defines recovery residences as non-clinical, peer-supportive housing;
   - Distinguishes recovery residences from licensed treatment or residential care facilities; and
   - Establish MARR, or a similar entity, as a public instrumentality to establish and organize regulatory standards that balance the social model of recovery and peer principles in partnership with OBH and the Division of Licensing and Certification

   Maine currently relies on indirect regulation through funding-based certification processes opposed to a distinct statutory framework. A clear and consistent statutory foundation would reduce ambiguity for municipalities, funders, and operators exclusively of clinical licensing requirements that do not, or should not, apply to recovery residences. Other states have adopted "registration and certification" models that preserve the inherent social model of recovery housing while instilling standards. The statutory definition should align with NARR's level system of recovery residences and include an explicit statement that recovery residences are not treatment providers unless clinical services are offered (e.g., through Level 4 Residences) and draw an unequivocal distinction between where the social model of housing and delivery of clinical services begin and end. Lastly, language could be codified more broadly to grant the Department authority to designate or recognize a certifying body to oversee recovery residences in Maine opposed to specifically incorporating MARR into statute.

2. Require Certification for Defined Public Purposes Only
   The Department is required to adopt rules under 5 M.R.S. §20005(22) that establish criteria for the certification of recovery residences, though this is only for voluntary certification. Title 5, Section 20005 could be amended to enforce mandatory certification requirements and

establish enforcement authority with a phase-in period allowing time for revised rulemaking and compliance deadlines.

3. Create a Dedicated, Sustainable Funding Stream for Recovery Residences
   Establish a subsidy program with data collection and quality assurance compliance requirements. However, implementing this recommendation would require appropriations due to current funding constraints.

   Current financial models rely heavily on resident rent and GA, creating instability and inconsistent operational success. Creating more stable funding improves and homogenizes quality, staffing, and geographic equality across all recovery residences statewide while reducing municipal pressure from GA expenditures.

4. Reform General Assistance Use for Recovery Housing
   General Assistance was not designed as a long-term financing tool for recovery housing and municipal administration results in regional inconsistencies and municipal fiscal strains, particularly in certain towns or cities. While state reimbursement reforms have mitigated some of this, the structural challenges remain.

   Replacing GA as the default housing payment mechanism for recovery residences with a state-administered recovery housing subsidy would build from the existing reforms already in place. Subsidies would be tapered and time-limited, paid directly to certified residences on behalf of qualifying residents, and be coordinated with employment and benefits navigation.

5. Provide Capital and Property-Related Supports
   Housing supply and capital costs are two significant barriers, especially in rural Maine. Stabilization of these would improve longer-term sustainability and promote greater parity between the rural and more populated areas of the state.

   To achieve this, the Department or Maine State Housing Authority could be authorized to provide capital grants or low-interest loans for property acquisition and renovation, as well as assistance with code compliance, fire safety upgrades, and accessibility improvements.

6. Clarify Medication and Medical Cannabis Policy in Statute
   Current laws and regulations have created a nebulous legal environment for operators and residences alike. Enacting clear statutory protections that prohibit discrimination against residents using legally prescribed medications, including MOUD, and allowing recovery residence operators to make administrative decisions to prohibit cannabis would address many of these concerns and challenges. Further, resident rights would be protected with maintaining respect for the recovery housing model and align Maine's policies with ADA and Fair Housing Act requirements.

Conclusion

There is no one-size-fits-all solution for improving the performance and financial solvency of recovery residences, however ensuring access to and retaining individual choice of recovery residence and recovery services is of utmost importance. Maine has seen significant growth in recovery residences over the last five years which has resulted in additional financial strain on municipalities' GA programs and created greater disparity among residences, their offerings, and their policies. Adding to this complexity is the ongoing variability of how recovery residences are viewed. For some, they are strictly housing for those who opt to reside in a substance-free environment as a means of supporting recovery. For others, they are viewed as treatment programs which suggest additional revenue streams based on providing billable, clinical treatment services in addition to rental contributions. While considering financial sustainability and the best approach to any universal recommendations, this juxtaposition cannot be underscored enough. The Department intends to review recovery residences for potential separation between the clinical Level 4 residences (licensed) and housing-based Level 1 through 3 (certified) residences which will aim to provide more clarity and address these challenges.

While imposing a solitary, standardized approach to recovery residences is well-intended, this would diminish the principle that there are many pathways to recovery and forego the reality that one size does not fit all in this domain. Considering the variability of viewpoints as they relate to recovery residences – housing, treatment, or a combination of both – recovery residences should remain flexible and voluntary in alignment with the recovery model of care at the core of these services. An expansion of the existing subsidy and/or the creation of alternative funding assistance would benefit a large number of recovery residences throughout Maine and ideally reduce the strain on municipal GA administrators who may ultimately still provide greater support to those residences ineligible for subsidies. Voice and choice of individuals in recovery should be held to the same esteem as operator preferences and regulatory oversight often receive. Building from existing standards – such as voluntary certification – reduces that disparity by ensuring regulated residences through certification in addition to alternative options that may be preferred by residents and operators alike

Appendix A

MAINE RECOVERY HOUSING FINANCIAL LANDSCAPE

PREPARED BY FLETCHER GROUP RESEARCH TEAM IN COLLABORATION WITH THE MAINE ASSOCIATION OF RECOVERY RESIDENCES

PUBLISHED MARCH 2025

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INTRODUCTION

Substance use disorder (SUD) is a pressing issue in the state of Maine, with the rate of drug overdose deaths increasing from 28.7 per 100,000 residents in 2016 to over 47.1 deaths per 100,000 residents in 2021, a 64% increase in 5 years.[1] An estimated 18% of Maine residents ages 12 and older met the criteria for a drug or alcohol use disorder in 2021, many of whom did not receive treatment for their SUD.[2] A recent analysis of the economic impact of opioid use disorder in Maine found that opioid use disorder and associated fatal opioid overdoses cost the state of Maine $6.8 billion in 2017.[3] Access to recovery support services in rural communities is of special importance in Maine as an estimated 62% of Maine's population lives in rural areas and face unique barriers to care related to access to recovery support services.[4]

An important recovery support service for individuals with SUD is recovery housing, a housing model that provides safe, healthy, family-like substance free living environments for those seeking recovery from SUD.[5,6] Recovery housing has been found to be associated with improved recovery related outcomes including reduced substance use, criminal justice involvement, anxiety, depression, and homelessness, and increased employment and income.[7–9] Although the exact number of recovery residences in the United States (U.S.) is unknown, latest estimates suggest there are approximately 10,000 recovery residences in the U.S.[10] As of November 2024, there were approximately 39 recovery housing organizations operating 91 recovery residences certified by the Maine Association of Recovery Residences (MARR).[11]

Although many federal agencies have identified recovery housing as an essential resource and best-practice, the recovery housing industry is still evolving, with many unknowns related to its effectiveness, prevalence, and financial landscape.[5] To help inform financial planning and expansion efforts in Maine, the RCORP-Rural Center of Excellence on SUD Recovery at the Fletcher Group, in collaboration with MARR, disseminated a survey to recovery housing organizations in Maine to assess the financial landscape of recovery housing. Specifically, the survey aimed to assess the financial size of recovery residences, revenue sources, operating expenditures, financial resiliency, and barriers related to operation including those related to the grant application process.

METHODS

A cross-sectional survey was employed with development led by Fletcher Group and MARR with feedback solicited from subject matter experts including researchers at the University of Kentucky Injury Prevention and Research Center and recovery residence owners and operators. The survey included questions about the types of individuals served by the recovery housing

organization, the programs and services offered, operating costs, revenue sources, operating expenditures, financial resilience, and barriers related to continued operation. The median time to complete the survey was approximately 39 minutes.

The survey was disseminated with recovery residence operators in Maine by emailed invitations from the MARR executive director. Survey recruitment focused on recovery residences that were certified or in the process of being certified by MARR. The total sampling pool included 91 recovery houses that were certified or in the process of being certified by MARR.[11] The study was approved by the University of Kentucky Institutional Review Board under protocol #53931. All data were collected via Qualtrics between October 21, 2024, and December 2, 2024.

Participants who began the survey but completed less than 50% of the questions (N = 7) were excluded. Our final sample consists of 13 operators representing 45 recovery residences. Given the total sampling pool in the state, this survey yielded a 49% response rate.

RESULTS

The majority (54%) of recovery housing organizations operated more than one recovery residence, with those who operated more than one residence operating a median of 4 residences. On average, recovery housing organizations had been in operation for 8 years, and MARR certified for 4 years; this certification option has been available since 2016. The median number of residents served per organization was 14. The 13 recovery housing organizations surveyed represent a total of 45 residences serving 364 residents.

Over a quarter (31%) of organizations were for-profit organizations and most (85%) organizations indicated they allowed medication assisted treatment (MAT) within their residences (Table 1). Almost half (46%) indicated they had a resident waitlist, with a median of 5 residents on their waitlist. The median number of paid staff across housing organizations was two. 33% of organizations indicated they did not have any paid staff working at their organization. Approximately 92% of the organizations surveyed indicated they were serving less residents than their maximum capacity, while 8% were serving their maximum capacity.

Table 1. Characteristics of recovery housing organizations surveyed, Maine, 2024, (N = 13)

Characteristic	Count (%)
Operate Many Residences	7 (54)
Offer Clinical Services in House	5 (38)
Require Residents to Work	10 (77)
Support Medication Assisted Treatment	11 (85)
Has a Waitlist	6 (46)
For-Profit Organization	4 (31)
Use a Resident Management/Data Collection Software	9 (69)

Most (92%) of the recovery housing organizations indicated they were MARR certified. Of the residences operated by surveyed organizations, 2% were certified as level 1, 64% were level 2, 18% were level 3, and 11% were level 4 (Table 2).[12] The majority of the residences were owned (64%) and 36% were rented by the organization.

Of organizations surveyed, 16% of residences were in a rural area, 76% of residences were in an urban area and 9% of residences were in a suburban area. On average, recovery housing organizations indicated that approximately 63% of the residents they serve are from rural areas. Organizations that do not operate any recovery residences in rural areas indicated that most (54%) of their residents were from rural areas.

Table 2. Characteristics of recovery residences surveyed, Maine, 2024, (N = 45)

Characteristic	Count (%)
NARR Certification Level	
Level 1	1 (2)
Level 2	29 (64)
Level 3	8 (18)
Level 4	5 (11)
Not MARR Certified	1 (2)
Missing	1 (2)
Geographic Location	
Rural	7 (16)
Urban	34 (76)
Suburban	4 (9)
Residence Ownership	
Rent	16 (36)
Own	29 (64)

Of the organizations surveyed, over a third served only males (5 organizations representing 6 residences) and males and females (5 organizations representing 29 residences). A quarter of the organizations (3 organizations representing 8 residences) served only females. One

organization representing 4 residences served females with children and no organizations served males with children.

Few recovery housing organizations (8%) reported serving veterans and individuals with disabilities. Only two organizations reported serving parenting individuals. Many organizations served individuals with a history of homelessness (77%), criminal justice involvement (77%), and mental health diagnoses (62%). No organizations reported serving pregnant individuals, youth, or non-English speaking individuals.

Table 3. Resident populations served by recovery housing organizations in Maine, 2024 (N = 13)

Characteristic	Count (%)
Populations Served	
Male	5 (38)
Female	3 (23)
Both Females and Males	5 (38)
Females with Children	1 (8)
Males with Children	0 (0)
Other	2 (15)
Special Populations Served	
Pregnant	0 (0)
Parenting	2 (15)
Youth	0 (0)
Non-English Speakers	0 (0)
Individuals with Disabilities	1 (8)
Veterans	1 (8)
Individuals with a History of Homelessness	10 (77)
Individuals with Criminal Justice Involvement	10 (77)
Individuals Diagnosed with a Mental Health Condition	8 (62)

The economic conditions of RH residents indicate that almost all organizations serve individuals receiving Medicaid (92%) and most serve those receiving SNAP benefits (62%) Over a quarter (38%) of recovery housing organizations that served unemployed individuals indicated their residents were not receiving unemployment benefits.

Table 4. Economic conditions of residents served in recovery housing organizations surveyed, Maine, 2024, (N = 13)

Characteristics	Count (%)
Receiving TANF	3 (23)
Receiving SSI	4 (31)
Receiving Medicaid	12 (92)
Receiving SNAP	8 (62)
Unemployed and Receiving Benefits	0 (0)
Unemployed and Not Receiving Benefits	5 (38)
Not able to Work	3 (23)
Retired and Not Receiving Social Security Benefits	1 (8)
Retired and Receiving Social Security Benefits	0 (0)
Disabled and Receiving Social Security Benefits	2 (15)
Disabled and Not Receiving Social Security Benefits	2 (15)
Veteran and Receiving Benefits	0 (0)
Veteran and Not Receiving Benefits	0 (0)

TANF = Temporary assistance for Needy Families; SSI = social security income; SNAP = supplemental Nutrition assistance program.

Of the organizations surveyed, a majority provided cleaning supplies (77%), toiletries (62%), and transportation (54%). Less than half of the organizations provide meals (38%), education opportunities (38%), life skills training (31%), recovery coaching (38%), clothing (46%), and employment opportunities (46%). Few organizations (15%) offer residents employment skills training.

OPERATING COSTS AND REVENUE

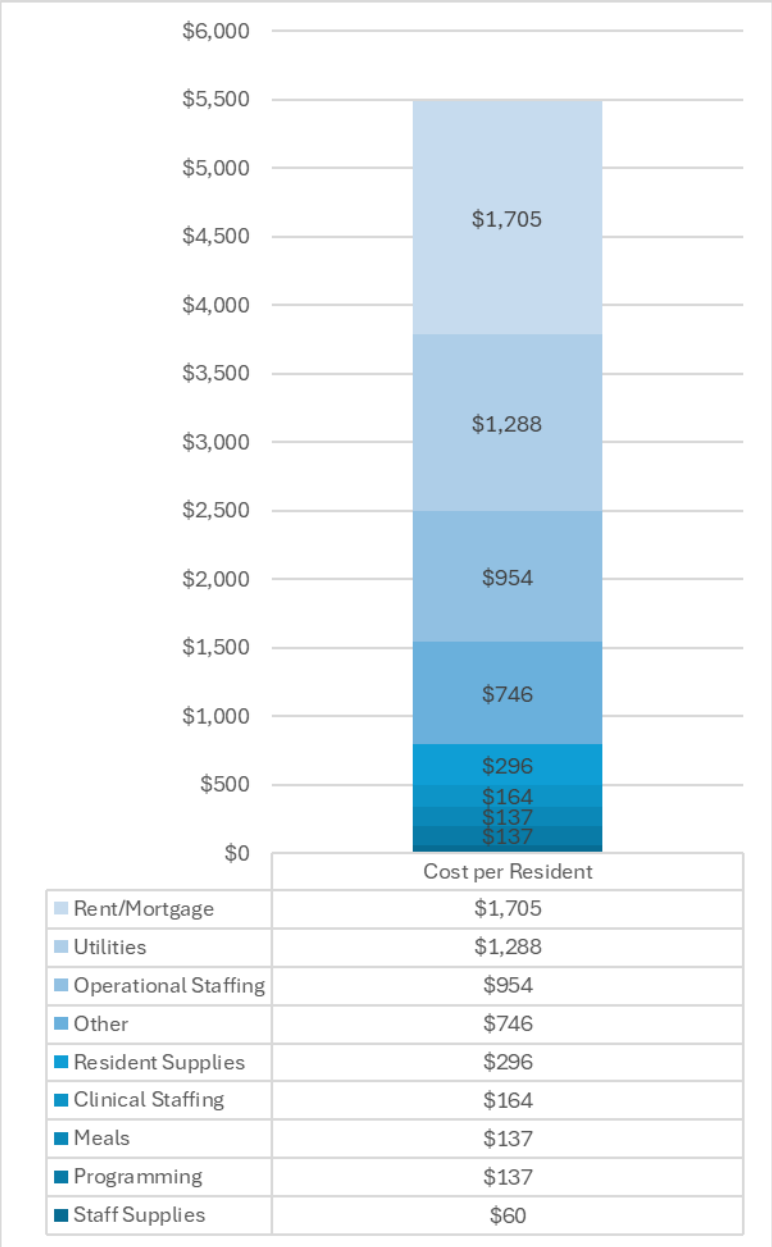
Reflecting the diversity of recovery housing models and service offerings, operating costs, which incorporate both services and room and board, varied widely among organizations surveyed. A total of 5 organizations (38%) surveyed provided an estimate of their annual operating costs between January 1, 2022, and December 31, 2022. The average annual operating cost was $298,100, with operating costs ranging from $120,000 to $970,000 per year.

Larger operating costs were generally associated with organizations that operate multiple homes, with organizations that operate multiple homes having an average annual operating cost of $404,900, compared to an average annual operating cost of $137,827 for organizations operating a single home. For organizations operating multiple residences, the average operating cost per home was almost $48,400.

As operating costs at the organization and residence level do not account for differences in the number of residents served by each organization and residence, we also calculate the cost per

resident served annually. The average amount spent by organizations was approximately $5,500 per resident served annually. The amount spent per resident differs by whether the recovery housing organization operates multiple residences. Organizations that operate multiple residences spent an average of $3,700 per resident annually while organizations operating only one residence spent an average of about $8,200 per resident annually.

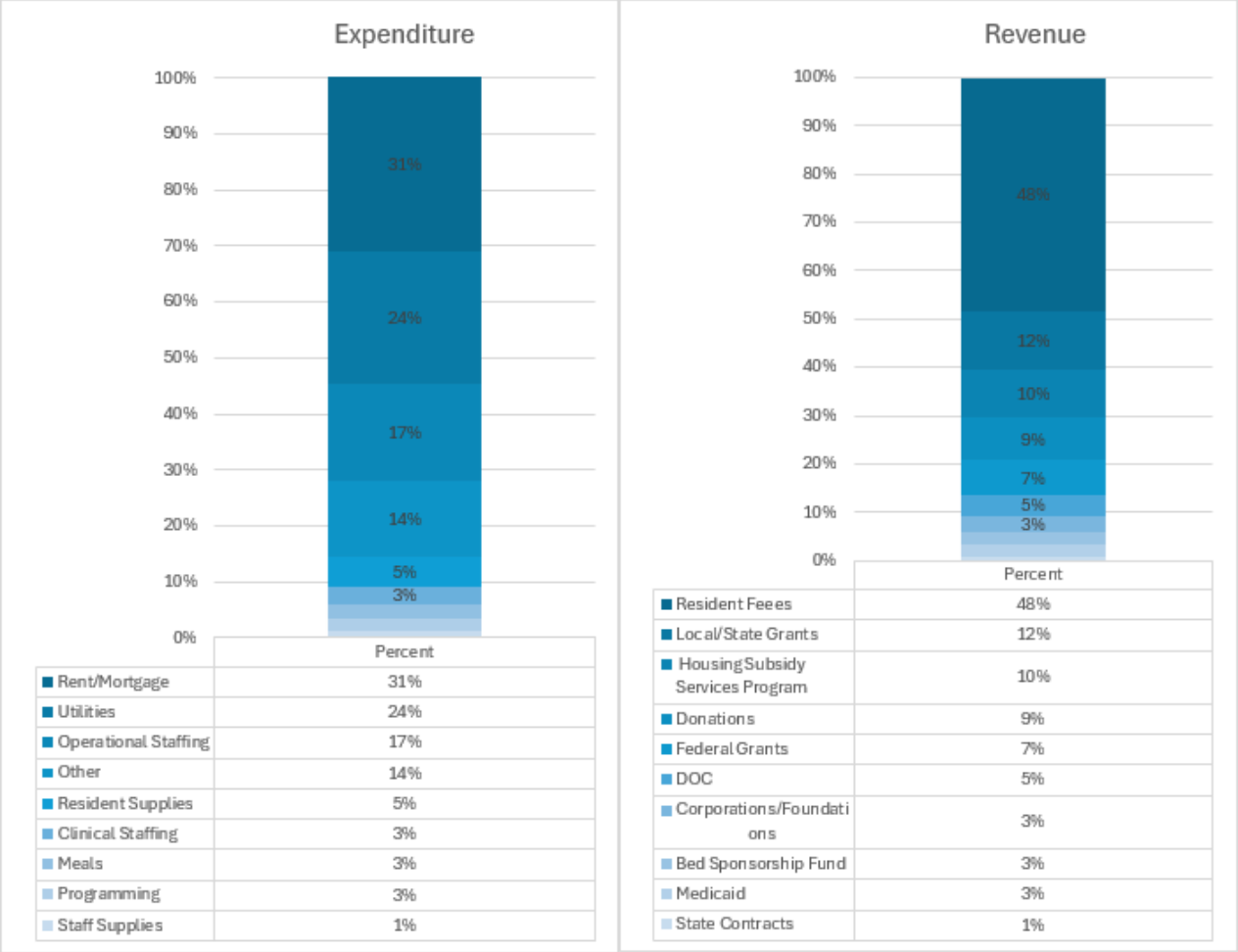
Figure 1. Annual median cost per resident under different cost categories reported by Maine recovery housing organizations, 2024, (N = 10).



	Cost per Resident
Rent/Mortgage	$1,705
Utilities	$1,288
Operational Staffing	$954
Other	$746
Resident Supplies	$296
Clinical Staffing	$164
Meals	$137
Programming	$137
Staff Supplies	$60

Operating costs associated with room and board such as staffing, mortgages/rent, and utilities accounted for 75% of total operating costs (approximately $4,112 per resident served). Mortgage/rent accounted for the largest share of operating costs (31%), followed by utilities (24%), operational staffing (17%) and clinical staffing (3%). Service costs including costs incurred from programming, resident and staff supplies, and meals accounted for 12% of operating costs (approximately $630 per resident served). Resident supplies accounted for approximately 5% of operating costs, and a relatively small amount of operating costs were spent on programming (3%), meals for residents (3%), and staff supplies (1%).

Figure 2. Percent of annual revenue from different sources and percent of annual expenditures associated with different categories reported by Maine recovery housing organizations, 2024, (N = 10).



In terms of revenue sources, the largest share of revenue comes from resident fees (48%). Of those who disclosed the amount they charge in resident fees (N = 12), the average amount charged was $700 per month, with some organizations charging as little as $540 per month and some as much as $900 per month. Organizations indicated they only received about 80% of the

resident fees they charge. Additionally, only 33% of organizations indicated they dismissed residents who were unable to pay for resident fees.

Local and state grants accounted for the second largest source of revenue with organizations indicating that an average of 12% of revenue came from local and state grants. Of those who indicated they had received local or state grants (N = 6), 50% indicated they had received State Targeted Response Funds, 0% indicated they received State Opioid Response funds, 17% indicated they had received Substance Abuse Prevention and Treatment Block Grants.

The Housing Subsidy Services Program accounted for 10% of revenue and donations accounted for 9% of revenue. Federal grants accounted for 7% of revenue. A small portion of revenue came from corporations and foundations (3%), the Department of Corrections (5%), the Bed Sponsorship Fund (3%), and Medicaid (3%).

CHALLENGES TO CONTINUTED OPERATION

Recovery housing is a service model that is privately developed, owned, and operated. Prior research indicates that sustainability of recovery housing organizations often face challenges pertaining to unstable funding sources (i.e., resident fees and rent and government funding), as well as stigma, "NIMBY beliefs".[13,14] In this study, among a list of 8 challenges to continued operations, the challenge that was ranked highest that impacted continued operation was a lack of financial resources. Of the 11 organizations that responded to this question, 82% indicated it was the most significant barrier their program faced. The next largest challenge identified was staffing shortages, followed by community stigma. Resident retention was identified as the 4th greatest challenge to continued operation, followed by state policies. Federal policies, COVID-19, and referrals were identified as some of the least significant challenges faced by owners and operators.

Figure 3. Ranking of challenges to continued operation with 1 representing the most significant barrier and 8 representing the least significant challenge (N = 11).

While lack of financial resources is a multi-faceted issue, difficulties finding and applying for grants may compound this barrier. Organizations that had received grants of any kind (N = 5) reported an average of 17 hours per month spent finding and applying for grants. Further, 73% of organizations indicated that it was somewhat or extremely difficult to find grants and 40% indicated it was somewhat or extremely difficult to apply for grants. Approximately 20% of organizations indicated it was somewhat or extremely difficult to comply with the terms of the grants they receive.

When asked why recovery housing owners and operators found applying for and finding grants difficult, organizations indicated that it was a difficult and time-consuming process. One operators wrote, "*I am very time-limited, I have no income source other than fees so I have to prioritize my time to pay my bills, many of the programs introduced in the past are gone now."* Another operator noted, *"We even hire a grant writer, and it's not easy to find grantors. We work hard and get some and are denied. Wish we had more places to apply."*

The compatibility of funding opportunities with the scope of recovery housing programs also presents challenges with one operator writing, *"A lot of places will not fund MAT houses."*

Finally, operators mentioned that funding sources supporting operational costs are needed with one operator writing, *"Have not seen many grants that may pay for the*

residence." Another operator wrote *"Need Direct Client assistance to cover rent. Fairly easy to cover staffing through grant."*

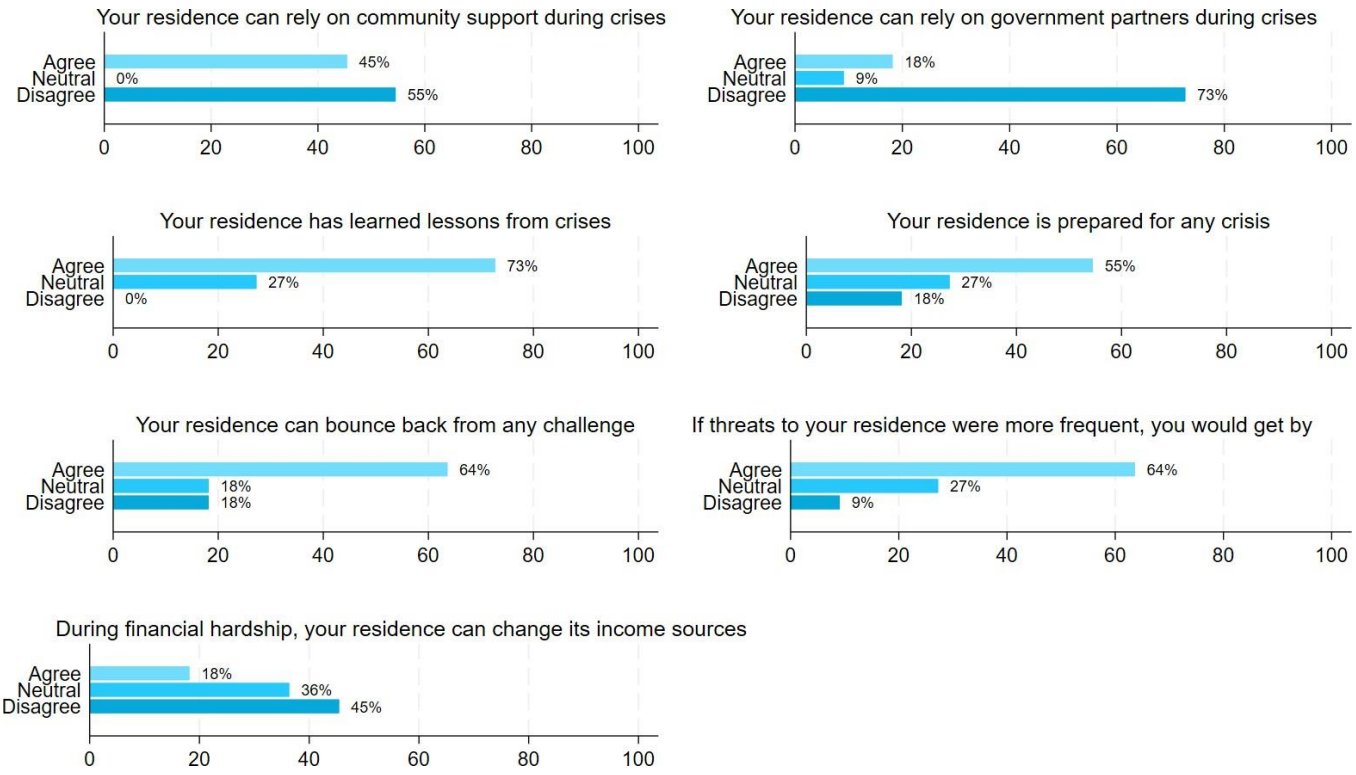
FINANCIAL RESILIENCE

Financial resilience, the ability of an organization to cope with financial shocks and difficulties, is essential to recovery housing organizations. To assess the financial resilience of recovery housing organizations in Maine, owners and operators were asked to rank on a scale of 1 to 10 how financially resilient they felt their recovery housing program was, with higher scores indicating higher resiliency. On average, organizations ranked their resilience at 5.6, indicating a moderate level of financial resiliency.

Most of the organizations surveyed (91%) indicated they were capable of overcoming funding disruptions and 9% indicated they were not at all capable of overcoming funding disruptions. Revenue diversification is also key to financial resilience. Over a quarter (33%) of recovery housing organizations surveyed indicated they received 75% or more of their revenue from one source.

Additionally, a series of questions were asked to ascertain operators' perceived ability to overcome financial crises, how community and government partnerships could help them overcome such crises, and if they had learned lessons from prior financial crises. Reflecting the barrier of community stigma discussed in the previous section, only 45% of organizations agreed that they could rely on their community for support during financial crises while 55% disagreed (Figure 4). Recovery housing organizations also indicated a lack of perceived government support during financial crises, with only 18% agreeing that they could rely on government partners during crises and 73% disagreeing. A total of 73% indicated that their recovery housing program has learned lessons from crises and 64% agreed that their residence can bounce back from any challenge. Similarly, 64% agreed that they would be able to get by if threats to their program were more frequent. Only 55% agreed that their organization is prepared for any crisis and only 18% agreed that their organization can change its income sources during financial hardships.

Figure 4. Share of Maine recovery housing organizations that agreed, disagreed, or were neutral for various financial resiliency statements, 2024, (N = 11).



FUNDING NEEDS AND BARRIERS IN MAINE

Recovery housing owners and operators were also asked to describe any other funding needs their organizations had. A few themes emerged from the qualitative analysis of the write in responses (N = 8).

First, operators noted the need for more funding in general, especially given their organization's reliance on program fees. One operator wrote, "*Funding sources for our residents is the single largest barrier to stable, safe and affordable housing."* Another operator noted, *"I wish there were more grants available for my guys as most have absolutely nothing when walking in the door. We need more financial help!"* Finally, one operator noted, *"I am the owner and am spending much of my own money for the funding."*

One funding pathway mentioned was through Medicaid. One operator highlighted some challenges,

"I first and foremost do not and cannot understand why it is made to be so difficult for sober houses/PNMI's to become state licensed and get help from Mainecare. I realize that rules, policies and procedures need to be in place, but to put us through the long, agonizing process is brutal and gets us owner/operators of such to the point of bankruptcy, despair, mental anguish, etc... There MUST be an easier way! We (most of us) are trying to get people off the streets, out of jails, hospitals, helping with no funds, no paychecks, it's not human what we are going through, yet we are doing it anyway. Please someone help, make this more accessible to funds so we can keep open without ruining our financial selves in the process of trying to do good and keep going!"

Another operator noted miscellaneous needs, *"Resources to help residents with managing money. Funding to help with staffing and educational needs for staff. Help with residents needing funding for more permanent housing."*

Other operators noted successes in Maine's funding opportunities. Another operator noted, *"So thankful for the (MARR Housing Subsidy Service Program) HSSP program, it is the only thing that has kept me afloat."*

DISCUSSION

Assessing the financial landscape of recovery housing is crucial to understanding the ability of recovery residences in Maine to continue providing quality services to those who need it. Further, understanding the implications of how the financial landscapes of recovery housing organizations differ across rural and non-rural communities will support evidence-based allocation of resources for expansion and capacity building to occur. As there are many unknowns about the operating costs, revenue sources, and financial resilience of recovery housing in Maine, the Fletcher Group partnered with MARR to conduct a statewide cross-sectional survey of recovery residence owners and operators.

The results show that, on average, 63% of residents served by recovery housing organizations in Maine are from rural areas, yet only 16% of residences are located in a rural area. This suggests there is a shortage of recovery housing resources in rural areas of Maine as nearly 62% of the Maine population lives in a rural area.

This survey also found that the average annual operating cost of recovery housing organizations was $298,100, but that there was significant variation in the financial size of individual organizations, with annual operating costs ranging from $120,000 to $970,000. On average, organizations spent approximately $5,500 per resident served annually. This suggests that

recovery housing organizations, the services offered within, and the resources needed to support them vary significantly among organizations in the state of Maine.

Results also show that most of the revenue for recovery housing organizations comes from resident fees, local and state grants, the Housing Subsidy Services Program, and donations. In qualitative analysis of write-in responses of program operators, a major theme that arose was the need for increases in the number of funding opportunities available for organizations. Specifically, operators noted the need for funding opportunities to support residents, staff, and staff training.

The survey also found that recovery residences in Maine consider themselves to be moderately financially resilient, and that there are vulnerabilities related to financial diversification and external partnerships. Approximately 45% of organizations disagreed when asked if they would be able to change their organization's income sources during financial hardship, suggesting the need for increased financial diversification in revenue sources. Finally, many organizations disagreed that community and government partnerships would be helpful in dealing with future financial crises.

This study has a few limitations to note. First, this study relies on convenience sampling methods. As such, the data presented in this report may not be representative of all recovery housing organizations certified by MARR. Additionally, this survey targeted recovery housing organizations that were currently certified or in the process of being certified by MARR. The results presented may not be representative of all recovery housing organizations in the state of Maine. Finally, this study relied on self-report data which may be biased due to recall error or social desirability bias.

POLICY CONSIDERATIONS

In response to the findings described above, there are a number of policy considerations that may aid the expansion and support of recovery housing in the state of Maine.

1. Increase certified recovery residence capacity in rural areas and develop strategies to address barriers presented by the lack of available transportation to, and within, these communities.
2. Increase the capacity of certified recovery residences that can provide culturally appropriate services to special populations, including pregnant and parenting people, families, veterans, individuals who speak English as a second language, and people with disabilities.
3. Increase the funding available to recovery housing organizations including funding for capital expenditures, initial start-up expenses, and programmatic operating expenditures.
4. Develop long-term (more than one year), sustainable funding opportunities for certified recovery residences.
5. Provide education and training to facilitate easier access to state grants and understanding of the grant application process; potentially a designated grant specialists at the state supporting recovery providers.
6. Cultivate new relationships and reinforce current relationships among recovery housing organizations and other recovery support providers along the SUD continuum of care with a specific focus on breaking down barriers to sustainable and meaningful partnerships.
7. Provide training and resources to recovery housing organizations to encourage community partnerships, to reduce stigma, and increase community support.
8. Conduct another assessment of the recovery housing financial landscape study in the future that includes additional financial incentives to program operators to increase study engagement.

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