Sober Home Scan – Final report

Landscape analysis of sober homes in Minnesota

04/29/2026

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Introduction

Sober homes have long been grounded in the principles of recovery, community support, and accountability. These residences provide a safe and supportive environment for individuals in recovery, helping them maintain sobriety and rebuild their lives. In Minnesota, sober homes are a critical resource for people in recovery.

The Minnesota Legislature defined sober homes as a living arrangement that provides temporary housing for individuals with substance use disorders, requires abstinence from alcohol and illicit drugs, charges a fee, does not offer counseling or treatment services, promotes sustained recovery, and follows federal guidelines. However, there is still great variation in the type of facilities that consider themselves "sober homes," with variation in structures, rules, and services provided. In addition, it is also not well-known where sober homes are in Minnesota, who they serve, and how residents access them.

As such, the 2023 state Legislature mandated a survey to identify sober home settings and gather information on their services, funding, and population specializations ("Sober Home Scan"). The purpose of this report is to meet the requirements laid out in S.F. No. 2934 61/4/26:

> "The commissioner of human services shall conduct a survey to identify sober home settings across the state and to collect information about the services they provide, their funding sources, whether they specialize in serving specific populations, and other information needed to inform policies to strengthen sober housing in the state.
>
> The commissioner must collaborate with the Minnesota Association of Sober Homes, sober home operators, the recovery community, behavioral health providers that work directly with sober housing, and recovery community organizations to provide input and data for this survey."

The Sober Home Scan gathered information needed to support and inform the State as it seeks to strengthen policies, systems, and processes related to sober homes in Minnesota.

Project team

The Minnesota Department of Human Services – Behavioral Health Administration (DHS) contracted with The Improve Group, an independent research and evaluation firm based in St. Paul, to oversee the design and implementation of the Sober Home Scan.

In coordination with DHS, The Improve Group convened a project Advisory Committee. This group included 12 people with a variety of views and types of expertise related to sober homes in Minnesota, including both professional and personal experiences. The Advisory Committee included members from the Minnesota Association of Sober Homes (MASH), sober home operators, behavioral health professionals who work directly with sober homes, representatives from recovery community organizations, and individuals from the recovery community. The group included people from diverse geographic locations (e.g., Twin Cities core metro, outer suburbs, and Greater Minnesota) and racial/ethnic backgrounds. Throughout the project, the Advisory Committee played a critical role in informing project design, outreach planning, and interpreting results.

Research questions

In July 2025, The Improve Group facilitated a workshop with the Advisory Committee and key representatives from DHS to review the legislation guiding this project and determine a set of overarching research questions for the scan. The workshop resulted in the following key questions:

1. What sober homes exist in Minnesota?
2. What operational structures, models, and processes do sober homes use?
    a. What operational barriers or challenges do sober homes experience?
3. Who are sober homes able to serve and in what ways?
    a. Who are sober homes not able to serve and why?
4. What could the State or others do to strengthen sober housing in Minnesota?

Methodology

The project team used a collaborative process to design the survey, identify potential respondents, and conduct outreach. In total, the survey received 97 responses. The Improve Group summarized all data reported in the survey.

Survey design

After The Improve Group, DHS, and the Advisory Committee finalized the research questions, the project team began drafting the survey. To further refine the survey instrument, The Improve Group hosted two survey design workshops. Workshops were open to service providers, sober home operators, MASH members, and individuals with lived experiences with recovery and sober homes. Workshops were 90 minutes, and all participants received a $50 stipend.

In total, 51 people participated across the two workshops. During these workshops, participants reviewed draft survey questions. They considered alignment in survey questions with the research questions and suggested additional questions to include. Participants also reviewed question language to make sure it would be clear and understandable to the survey respondents. They reviewed answer options in closed-ended questions for completeness. Lastly, workshop participants provided input into outreach strategies and supported the development of the survey contact list (described below).

After the workshops, The Improve Group finalized the survey instrument. The final survey included questions about

- the sober home(s) that respondents operate or recently operated in Minnesota, such as the number of homes they operate(d),
- their locations (county or Tribal reservation/community), and
- the number of residents that can live in each home, and
- populations served, services provided, funding sources, financial stability, and sober home(s) operations, like housing, staffing, and management models.

The survey included sections by content area; most questions were closed-ended, though each section had the option for respondents to provide additional context or information. The survey protocol can be found in Appendix A. After the survey was finalized, The Improve Group programmed the survey into the online QuestionPro survey platform in English, Spanish, Somali, and Hmong.

Sober home search and contact building

The intended audience for the survey was all people or organizations that provided sober housing in Minnesota in the previous 12 months. However, because there is no official or complete list of sober homes that exist in Minnesota, the project team conducted extensive research to identify homes and gather their contact information. Research to identify homes and contact information included

- pulling information from existing lists of sober homes (e.g., MASH-certified sober homes, lists created by treatment providers),
- pulling information from state registration/licensing of facilities that may be sober homes (e.g., providers registered with DHS as Free Standing Room and Board or Board and Lodging Special Services facilities), and
- searching online through Google, provider websites, and online forums and message boards.

Based on these methods, The Improve Group compiled a list of 215 operators of known or presumed sober homes. The Advisory Committee then reviewed the list using their knowledge of the field, adding homes that were missing and indicating which ones on the list had closed. Advisers also provided additional contact information, including operator email addresses and phone numbers, when possible. Finally, during the survey design workshops described above, participants reviewed and updated the list.

Survey outreach

The survey was open for 11 weeks, from Nov. 3, 2025, to Jan. 16, 2026. The project team promoted the survey through a series of broad and targeted methods. Data collection began with a physical letter mailed to all addresses on the project’s sober home list. This letter explained the project's purpose and invited operators to participate via an online link. The Improve Group also sent a series of email invitations to the 192 email addresses on the operator list, as well as to those who had expressed interest in the advisory committee and/or survey design workshops. Near the end of the data collection period, The Improve Group also made phone calls to operators on the list in geographic areas where responses were more limited.

DHS also conducted outreach through existing communication channels that may reach those whose work relates to sober housing. For example, DHS shared abbreviated messaging about the survey in DHS-operated newsletters, listservs, and websites. DHS also sent outreach to organizations whose work intersects with sober homes, such as MASH, the Minnesota Alliance of Recovery Community Organizations (MARCO), the Minnesota Alliance of Rural Addiction Treatment Programs (MARATP), the Minnesota Association of Resources for Recovery and Chemical Health (MARRCH), and the Pink Cloud Foundation.

Advisory Committee members also conducted individual outreach to sober home operators in their networks. This included one-on-one or small group communications to encourage responses and answer questions about the survey or project. Advisers also promoted the survey at community events, in relevant public spaces, and other local channels.

All outreach messages promoting the survey encouraged recipients to share information about the survey with others in their networks. The survey instructions also included language encouraging word-of-mouth promotion of the project.

Survey responses

To encourage candidness in responses, the survey was anonymous. While survey instructions noted that operators should take the survey only once, it is not possible to guarantee all responses are from unique operators.

In total, the survey received 97 responses. This included:

- Thirty-one respondents who operate one sober home,
- Fifty-two who operate multiple homes, and
- Fourteen operators who had recently closed all of their homes.

Of the survey responses, 46 reported operating homes only in the seven-county metro region (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington Counties), 33 reported operating homes only in greater Minnesota (i.e., all other counties besides those in the seven-county metro), and four reported operating homes in both regions.

Because there is no defined list of sober home operators eligible to take the survey, it is not possible to calculate a response rate. However, for relative comparison, the final contact list developed in preparation for the survey and updated during data collection included 215 operators.

Analysis

After the survey closed, The Improve Group performed initial cleaning of the dataset, including categorizing write-in responses, reviewing for duplicates, and transforming data as needed for analysis. Each section of the survey had an open-ended question for respondents to add to their responses, as needed. The Improve Group reviewed these and summarized or recategorized responses as appropriate. All other open-ended questions were themed and summarized.

The Improve Group analyzed closed-ended responses using the statistical analysis platform IBM SPSS Statistics and Microsoft Excel by conducting frequencies or descriptive statistics for all questions. The Improve Group also conducted subgroup analyses based on whether respondents operated one home or multiple, and by geographic region of the homes they operated (seven-county Twin Cities metro, greater Minnesota, or both

regions). While this report includes the frequencies of all survey questions, only subgroup analyses that resulted in noteworthy or practically significant[1] differences by respondent group are included.

After completing initial analyses, The Improve Group conducted an emerging findings meeting with DHS and the Advisory Committee to share preliminary results. In addition to DHS partners on this project, interest-holders from other DHS units, like housing support, facility licensing, and addiction and recovery policy, were invited. During this meeting, participants reviewed initial survey results and gave their input on interpretation and areas for further analysis or future research.

Results

This section describes survey results, organized by overarching research question. Throughout this report, the terms “sober home operators” and survey “respondents” are used interchangeably. The results cannot be generalized to all sober home operators in Minnesota.

Q1. What sober homes exist in Minnesota?

To understand the landscape of sober homes in Minnesota, the survey included questions about the locations and capacities of respondents’ open and recently closed sober homes. It also included questions about how full sober homes were and expectations for future operability of their homes.

More than two-thirds of sober homes operated by respondents were concentrated in the seven-county metro region.

Ninety-seven operators responded to the survey. Overall, they reported operating a total of 269 open sober homes in 25 counties across the state. About two-thirds (67 percent, or 179) of homes were in the seven-county metro region, as shown in Figure 1. Survey respondents operated homes in 29 percent of Minnesota counties and reported no homes in any of the 11 Tribal Nations sharing geography with Minnesota.

[1] Because it was not the focus of this study, The Improve Group did not conduct any analyses to detect statistically significant differences between groups.

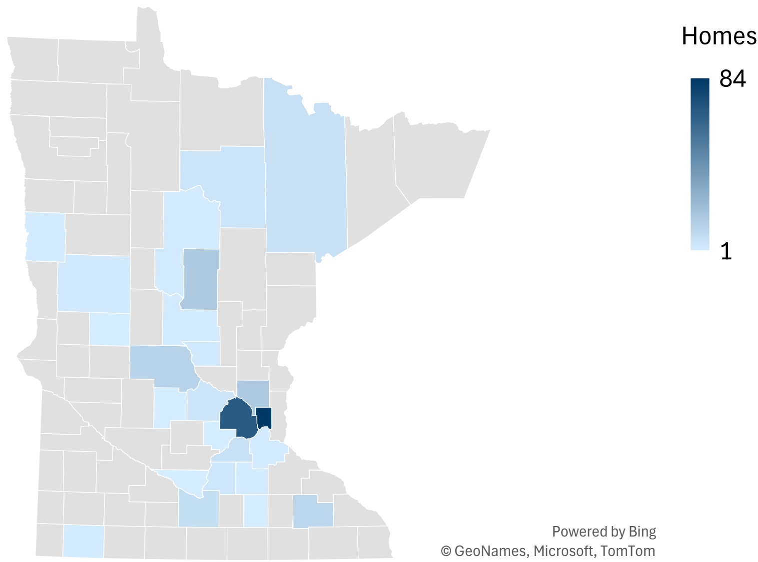

Figure 1 – Heat map of respondents' open sober homes by county

Survey respondents reported how many residents their open homes could serve; added together, open homes could serve a maximum of 3,358 residents(Figure 2). Like the proportion of total homes, almost two-thirds (64 percent, or 2,148) of the beds reported were in the seven-county metro region.

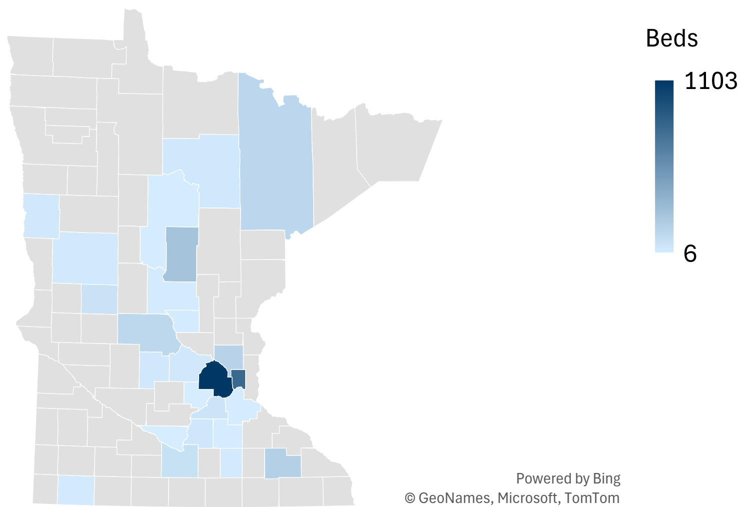

Figure 2 – Heat map of maximum number of residents that can be served in respondents' sober homes by respondents by county

See Appendix table 1 in Appendix B for a list of open sober homes and maximum number of residents reported by respondents by county.

Respondents’ homes were generally full, with residents staying 12 months or less on average.

Nearly three-quarters of respondents (73 percent) reported that most or all of their beds are generally full, as shown in Figure 3. Another 23 percent reported that some of their beds are generally full, and only five percent reported that no or almost no beds are generally full.

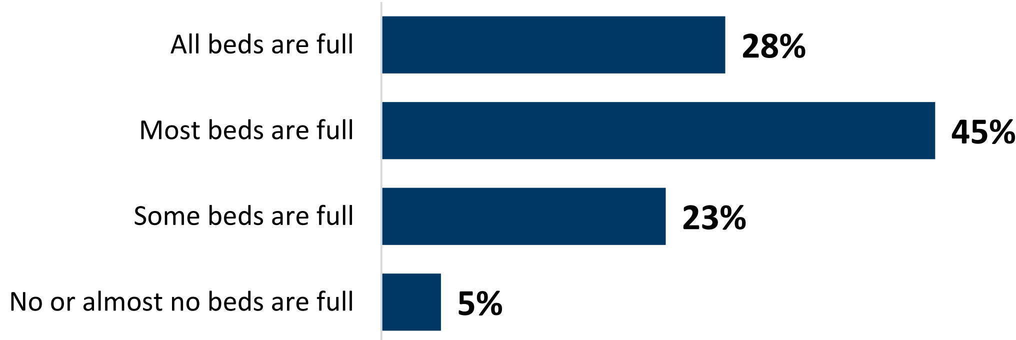

Figure 3 - General capacity levels of sober home operators (n=83)

Most respondents (88 percent) indicated they do not have a policy about the maximum length of stay for residents. When asked to estimate the average length of stay for their residents, over three-quarters of respondents noted that residents stayed less than 12 months, as shown in Figure 4.

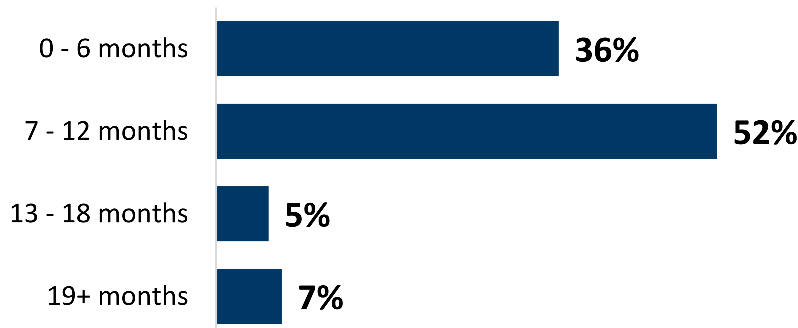

Figure 4 - Estimated average length of stay for residents (n=73)

Almost a third of respondents had closed a sober home in the previous year, mostly in the seven-county metro region.

Operators reported the number and locations of homes they had closed within the 12 months before taking the survey. Fourteen respondents did not operate any sober homes at the time of the survey—they had operated sober homes in the past. (The intended audience for the survey was all people or organizations that provided sober housing in Minnesota in the previous 12 months). In addition to these 14, four current single home

operators and 12 current multi-home operators reported closing homes in the last year. These 30 respondents reported closing a total of 61 homes, with most (79 percent) in the seven-county metro region (Figure 5). When considering all sober homes that respondents reported were open a year ago, 61 closed homes represent almost one-fifth of homes (18 percent).

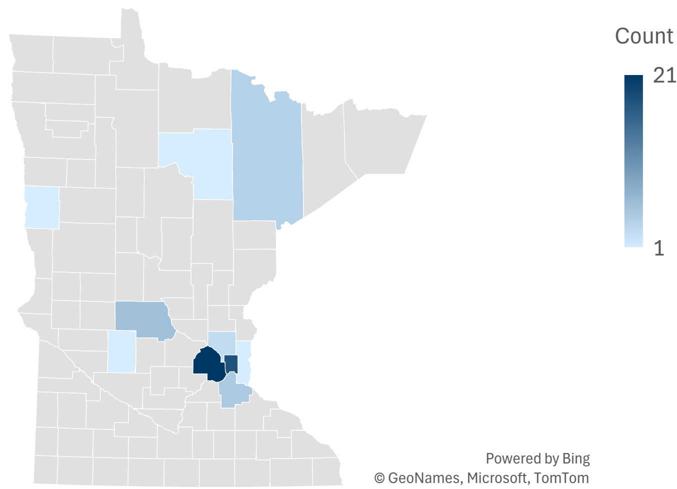

Figure 5 – Heat map of respondent's closed homes by county

Survey respondents reported that the 61 homes that closed in the last year had the capacity to serve a total of 506 residents. Most of these beds (78 percent) were in the seven-county metro region (Figure 6). See Appendix table 2 in Appendix B for a list of closed homes and beds by county, as reported by respondents.

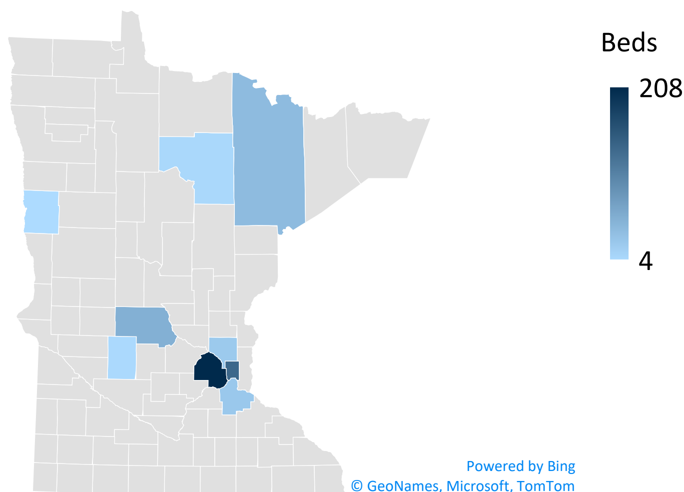

Figure 6 – Heat map of respondents' total lost capacity (beds) by county

Most operators were at least somewhat confident that their sober homes would be operating one year from now, though this may be stronger for multi-home operators.

To assess the risk of closure, operators were asked to rate their level of confidence that their sober homes would be operating one year after taking the survey. Most respondents reported being very confident (25 percent) or somewhat confident (36 percent) that their sober homes would be operating in a year (Figure 7).

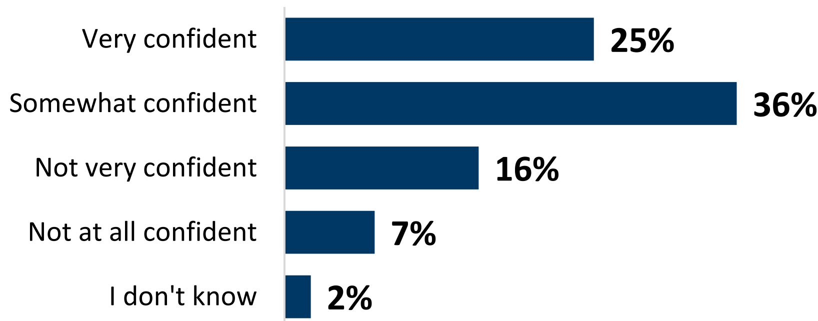

Figure 7 - Operators' confidence in their ability to continue operating over the next year (n=83)

However, confidence levels slightly differed between single home operators and multi-home operators, with single home operators expressing less confidence. Fifty-four percent of multi-home operators (n=52) indicated that they were very confident about operating in a year, compared to only 26 percent of single home operators (n=31). Conversely, 2 percent of multi-home operators were not at all confident about operating in a year, compared to 16 percent of single home operators.

Respondents who indicated that they were somewhat, not very, or not at all confident had the opportunity to share the number and locations of homes they believed to be at risk. Respondents reported several homes that are at risk of closure or planned to close; most of these homes were in the seven-county metro area.

Q2. What operational structures, models, and processes do sober homes use?

To better understand the wide variety of ways that sober homes operate, the survey included many questions about operations, including funding, housing models, staffing and staff qualifications, rules and requirements, feedback and data, and referrals.

Monthly costs to live in sober homes ranged a great deal but tended to be between $500 and $999 per month and were more expensive in the metro area.

Respondents had the opportunity to share the monthly cost for a resident to live in their sober homes, including rent, utility shares, and/or fees. The survey asked about monthly costs in three ways. Single home operators reported how much residents pay monthly to live in their sober homes. Due to the variation in housing options and costs that multi-home operators may have, multi-home operators shared the highest and lowest monthly costs across their homes. Respondents reported the estimated monthly cost to live in sober housing. It is

important to note that sources of funding vary (e.g., residents may not pay the full amount directly out of pocket), as discussed further in the next section.

Over half of single home operator respondents reported that residents pay between $500 and $999 per month to live in the sober homes they operate, as shown in Table 1. For respondents who operate multiple homes, two-thirds reported that residents in their sober home with the *lowest* cost, and 61 percent reported that residents in their sober home with the *highest* cost, paid between $500 and $999.

Cost for residents per month	Single home operators' homes (n=30)	Multi-home operators' homes with the lowest cost (n=51)	Multi-home operators' homes with the highest cost (n=49)
$0 – $499	13%	20%	4%
$500 – $999	57%	67%	61%
$1,000 – $1,499	27%	12%	18%
$1,500+	3%	2%	16%

Table 1 – Ranges of monthly costs for residents in sober homes operated by single home operators, as well as monthly costs for residents in multi-home operators' homes with the lowest and highest costs

Average costs for residents of sober homes across operator types also tended to be between $500 and $999, as shown in Table 2. For single home operators, the average total monthly cost for residents was about $800, ranging from $0 to $1,650 per month. On average, the lowest monthly cost for homes operated by multi-home operators was nearly $700, while the highest monthly cost was almost $1,000.

Item	N	Minimum	Maximum	Mean	Standard Deviation
Single home operators: Total monthly cost for residents	30	$0	$1,650	$802.93	$361.97
Multi-home operators: Total monthly cost for residents in the home with the **lowest** cost	51	$0	$1,500	$663.73	$316.19
Multi-home operators: Total monthly cost for residents in the home with the **highest** cost	49	$0	$3,000	$985.29	$477.97

Table 2 – Descriptive statistics of monthly costs for residents at homes operated by single home operators and multi-home operators

Across operator types, respondents who operated homes in the seven-county metro reported higher monthly costs than those who operated homes in greater Minnesota, by about $200 per month (Table 3). The difference in costs between metro and non-metro homes was greater for multi-home operators than single home operators.

Item	Average cost in seven-county metro	Average cost in greater Minnesota	Cost difference
Single home operators: Total monthly cost for residents	$901.85 (n=13)	$727.29 (n=17)	$174.55
Multi-home operators: Total monthly cost for residents in the home with the **lowest** cost	$730.28 (n=32)	$504.33 (n=52)	$225.95
Multi-home operators: Total monthly cost for residents in the home with the **highest** cost	$1027.84 (n=31)	$811.60 (n=15)	$216.24

Table 3 – Average costs for residents at homes operated by single home operators and multi-home operators in the seven-county metro and in greater Minnesota

Respondents reported a mix of funding sources for their sober homes, with most relying on residents' own financial resources to some extent. About half receive funding through government assistance programs.

Sober home operators reported a variety of funding sources and combinations to pay for the costs of operating their sober home(s). About half of the 80 respondents who answered a question about their funding sources reported funding from only one source; of these, 78 percent indicated that their sole funding source was residents' own financial resources (e.g., employment earnings, savings, family resources, individual donations to the resident, Social Security Income). About half reported receiving funding from multiple sources, most commonly a mix of residents' own financial resources and funding from government assistance programs that residents apply for and manage (e.g., Housing Support, Housing Assistance). Sometimes, funding sources for these operators included donations or charity to the sober home itself.

As shown in Table 4, 84 percent of respondents indicated that they receive at least some funding directly from residents. More than half indicated that they receive 75 percent or more of their funding from residents. Almost half of respondents reported receiving at least some funding through government assistance programs, though it was generally a smaller proportion of their total funding. Less than a quarter of respondents said government funding accounted for 75 percent or more of their funding. Almost a quarter reported donations or charity to the sober home as a funding source, though this accounted for a small proportion of funding overall. Residents' insurance (private or public) was rarely used as a funding source. Just under 10 percent of respondents reported having another source of funding; these included the owners' financial resources, a retail establishment, the Department of Corrections, a treatment provider, and a partner organization.

Funding source	Receive any funding from the source	Receive 25% or more of funding from the source	Receive 50% or more of funding from the source	Receive 75% or more of funding from the source	Receive all of funding from the source
Residents' own financial resources	84%	70%	59%	51%	40%
Government assistance programs	48%	41%	40%	23%	9%
Donations or charity to the sober home	23%	6%	3%	0%	0%
Residents' insurance	5%	3%	3%	3%	1%
Other	9%	6%	1%	1%	1%

Table 4 – Percent of operators receiving varying levels of funding for their sober home(s) by funding source (n=80)

On average, respondents indicated that 59 percent of their costs are paid through residents' own financial resources, while 31 percent of funding comes from government assistance programs. However, it is important to note that the amount of funding received from different sources varied a great deal across operators, as described above.

Respondents also had the opportunity to share other information about funding in their sober homes; 32 respondents provided additional information. Several of these respondents described their funding sources/models in more detail. Some respondents described challenges or hopes related to funding. Some respondents discussed challenges for operators and sober homes themselves, such as

- The inability to bring in enough funding to cover all operational costs,
- delays in receiving funding,
- poor reimbursement, and
- Changes to funding practices related to outpatient treatment with lodging that negatively impacted their sober homes and residents, with a couple noting that they may need to close their sober homes because of this.

In addition, some respondents described funding-related challenges for residents and how difficult it is for residents to self-pay, especially when first moving from treatment into a sober home. A few stressed the need for "bridge" funding to cover the period from when residents initially move into a sober home until they can secure employment. A couple of respondents also raised that even when residents access government assistance programs to fund sober living, these funds are cut when they begin to earn money, often before residents are earning enough to pay for housing without support.

Finally, a handful of respondents noted the need for more/better funding for sober housing generally.

Almost half of respondents indicated that their homes were certified through the Minnesota Association of Sober Homes (MASH), though participation in state-sponsored programs was lower.

As shown in Figure 8, 42 percent of single-home operators reported that their homes were certified through the Minnesota Association of Sober Homes (MASH). In terms of connections to state systems, about one-third reported that their homes were registered as a Boarding and Lodging Establishment or Lodging Establishment Providing Special Services (BLSS), while about a fifth had homes that were approved as Free Standing Room and Board (FSRB) programs.

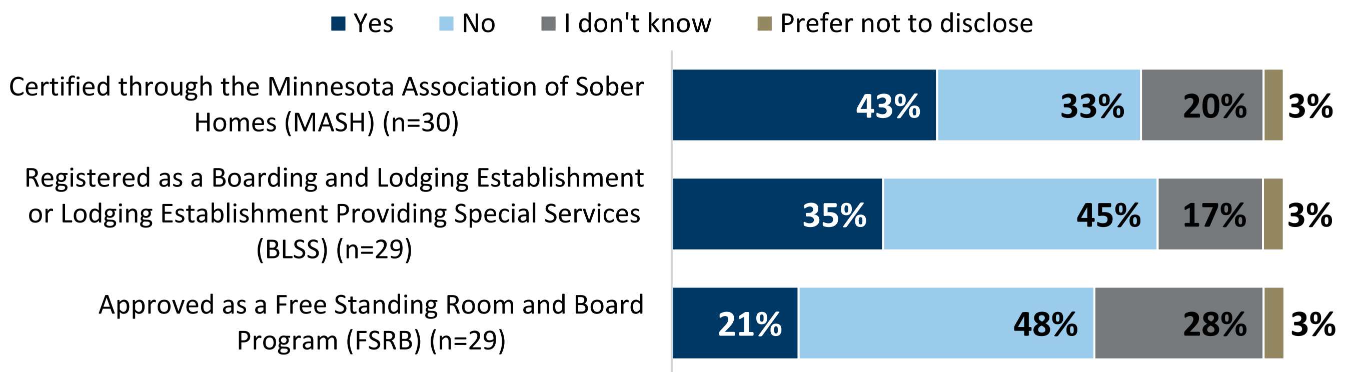

Figure 8 – Statuses of sober homes operated by single-home operators

Half of multi-home operator respondents noted that all of their homes were certified through MASH, while only 2 percent indicated that some of their homes were. This may indicate a tendency for multi-home operators to pursue MASH certification for all or none of their homes. Like with single home operators, participation in state-sponsored programs was lower. Only 30 percent of multi-home operators reported having all or some of their homes registered through BLSS, and 22 percent reported having all or some approved as FSRB programs. For both of these, there is more variation in whether an operator had all or some of their homes participating in these programs than with MASH certification, which may suggest that operators make decisions about BLSS and FSRB on an individual home basis.

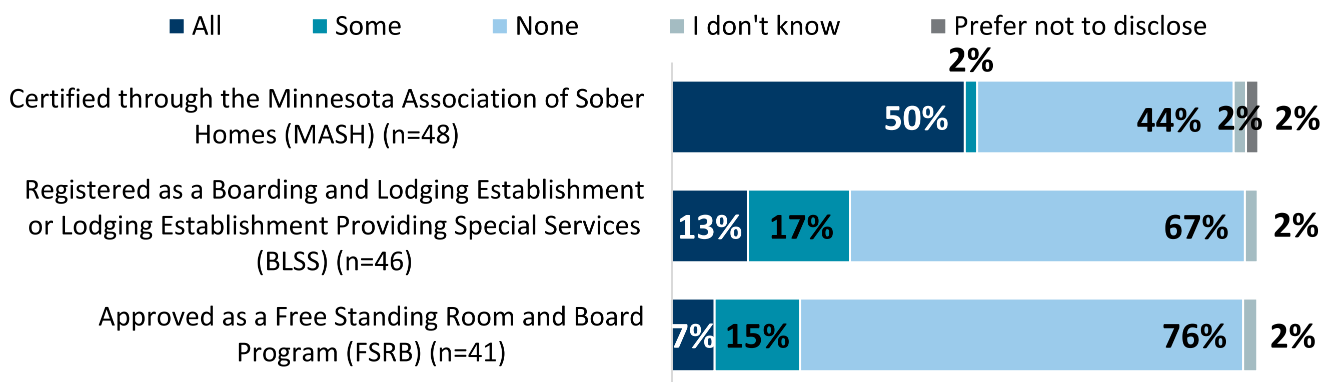

Figure 9 – Statuses of sober homes operated by multi-home operators

Almost half of respondents reported that the homes they operate are owned by an individual.

When asked about the ownership model of the sober home(s) they operate, almost half of respondents reported that their homes are owned by an individual (Figure 10). Conversely, almost half were owned by organizations; of those, about two-thirds were owned by non-profit organizations, and the remaining third were owned by for-profit organizations. A few respondents indicated their homes had other ownership models; two noted that the homes were leased, and one noted that multiple individuals owned the homes.

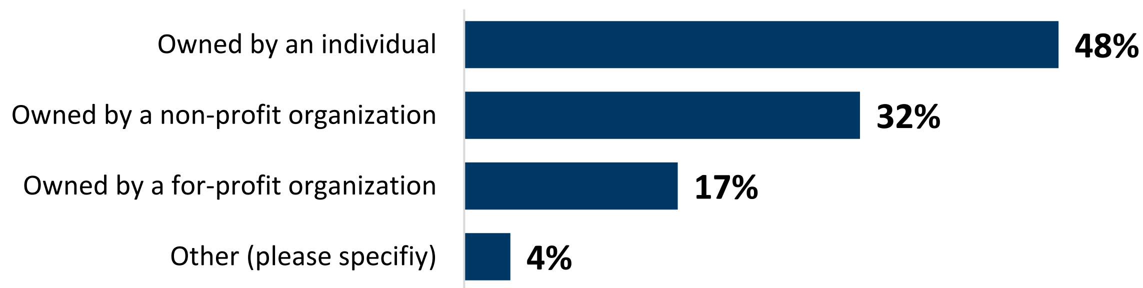

Figure 10 – Ownership models of the sober home(s) that respondents operate (n=82)

Almost two-thirds of respondents reported having at least one home that was managed by an on-site house manager.

As shown in Figure 11, about half of single home operators reported that their sober homes were managed by an on-site house manager. A smaller portion, 29 percent, said someone who does not live on site manages their homes. No respondents indicated that residents managed their home. Almost one-fifth noted an “other” management model; these included the use of both on-site and off-site staff, having operators act as managers (on and off-site), and having multiple management roles.

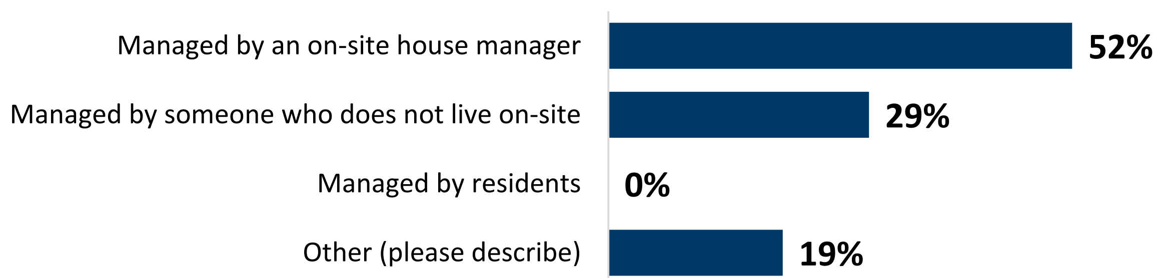

Figure 11 – House management models reported by single home operators. Note: Operators could choose only one response (n=31)

Multi-home operators had the opportunity to indicate how many of each of their homes used the listed management models. Many indicated using multiple models across their homes or within a single home. Seventy-one percent of multi-home respondents indicated that at least one of their homes had an on-site house manager, while 56 percent reported that at least one of their homes was managed by someone who lives off-site (Figure 12). Almost one-fifth reported operating a home managed by residents. A few respondents noted having an “other” management model; these included a mix of models (e.g., on-site manager and residents managing together), multiple management roles, and having different individuals fulfill the house manager role throughout the week (e.g., day versus night/weekend).

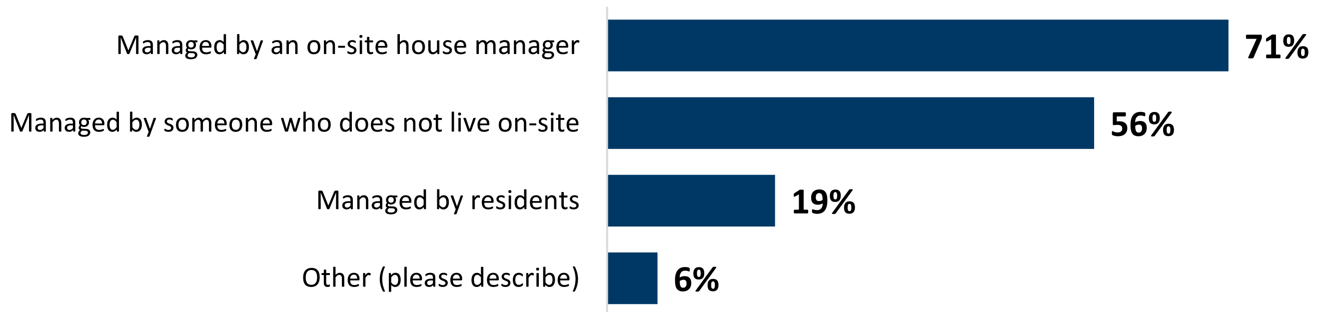

Figure 12 – House management models reported by multi-home operators. Note: Operators could indicate multiple responses (n=52)

Almost all respondents with on-site house managers reported that managers had lived experience in recovery and in sober homes.

Those respondents who reported operating at least one sober home that used an on-site manager had the opportunity to indicate which training/experiences those managers had related to the role.[2] As shown in Figure 13, almost all respondents reported that on-site managers had lived experience in recovery and in sober homes. Although sober homes do not provide counseling or treatment services to residents, almost half (43 percent) reported that on-site house managers were certified as Peer Recovery Specialists. A small portion (8 percent) indicated that house managers were licensed in alcohol and drug counseling or mental health.

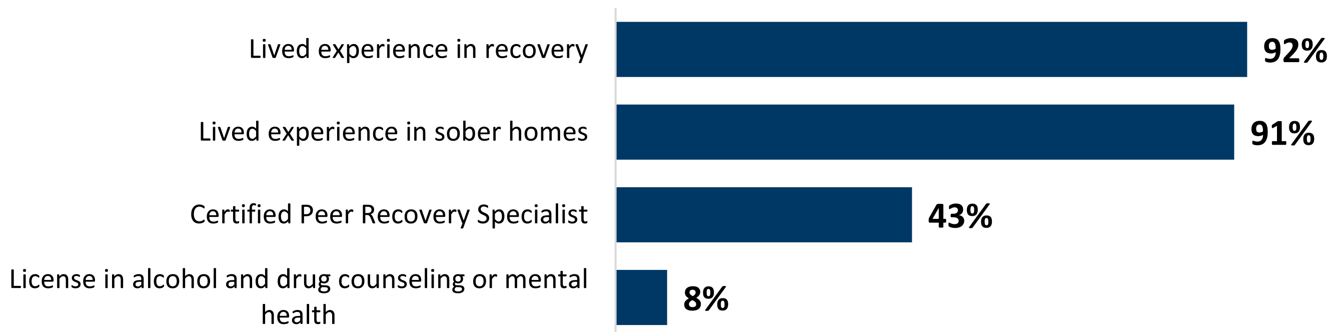

Figure 13 – Training/experiences of on-site house managers working for respondents who reported operating at least one sober home that included an on-site house manager (n=53)

[2] Multi-home operators were instructed to select all the manager training/experiences that apply to their homes, even if they are not applicable to managers in all of their sober homes.

When asked what else they wanted to share about staffing, several respondents noted that their house managers attend manager trainings through MASH. In addition, a couple of respondents noted requirements around minimum sobriety time for house managers.

Most respondents reported using some amount of paid staff (non-resident) time to perform house operations or provide support for their sober home(s). The amount of time paid staff, volunteers, and compensated residents spent performing house operations varied widely.

When asked who performs house operations or provides supports for their sober homes, almost 71 percent of respondents indicated that they hire paid staff, including employees or contractors (Figure 14). In addition, almost half reported that residents, in exchange for a stipend or reduced rent, performed house operations or provided support for their sober homes. Just under a third of respondents noted that residents do these tasks as part of the expectation for living in the home (rather than for compensation). Twenty percent of respondents also receive support from unpaid volunteers.

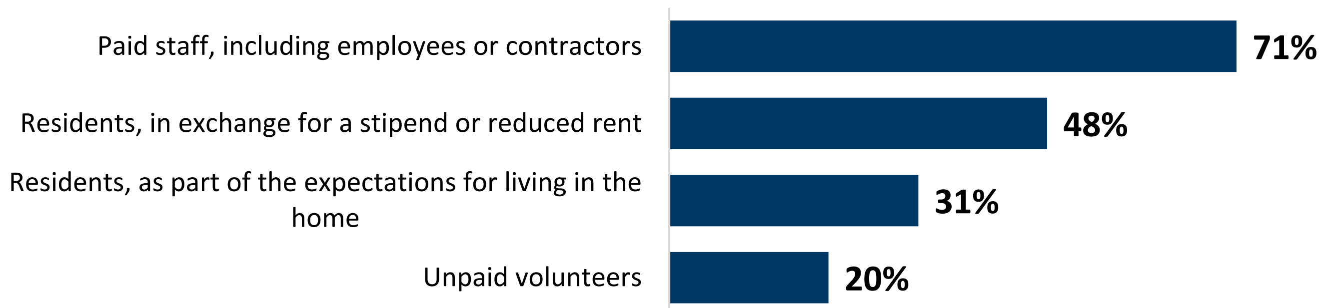

Figure 14 – People who perform house operations or provide support for respondents' sober homes (n=80)

Most common forms of support varied based on geographical region. More homes in greater Minnesota (82 percent) said they hire paid staff than in the seven-county metro (60 percent). Conversely, giving residents a stipend or reduced rent in exchange for support is more common in the metro (51 percent of respondents) compared to greater Minnesota (39 percent).

All respondents who indicated using paid staff, volunteers, or residents receiving financial compensation could also share the total hours per week that these individuals performed house operations. Multi-home operators were instructed to provide information for an average or "typical" home. For the 65 respondents who reported that paid staff, volunteers, or compensated residents performed house operations or provided support for their sober homes, the total number of hours per week varied greatly (Table 5). For example, 20 percent of respondents reported these individuals worked fewer than 10 hours per week, while a similar amount (18 percent) reported these individuals worked more than 50 hours per week. Overall, almost half of respondents (48 percent) reported that paid staff, volunteers, and/or compensated residents performed house operations for less than 20 hours per week.

Hours per week that paid staff, volunteers, and/or compensated residents performed house operations	Number of responses	Percentage of responses
0 – 9 hours per week	13	20%
10 – 19 hours per week	18	28%
20 – 29 hours per week	8	12%
30 – 39 hours per week	4	6%
40 – 49 hours per week	10	15%
50+ hours per week	12	18%

Table 5 – Hours per week that paid staff, volunteers, and/or compensated residents performed house operations (n=65)

This aligns with other data regarding 24-hour awake staff. While most respondents reported using paid staff to perform some house operations, only 17 percent reported having 24-hour awake staff in any of their homes (n=63[3]).

Most respondents with paid, on-site staff working in their sober homes required them to have skills related to first response and conflict management, and about half required training as a Peer Support Specialist.

Almost two-thirds of operators who reported having paid staff indicated they require on-site staff to have training or competency related to emergency first response, such as CPR or naloxone administration (Figure 15). Similarly, almost two-thirds of these respondents required staff to have skills related to conflict management/resolution. Nearly half required paid, on-site staff to be trained as Peer Support Specialists.

[3] Due to a survey routing error, respondents were inconsistently asked about 24-hour awake staff. For single home operators, only those who indicated that their homes were managed by an on-site house manager had the opportunity to indicate whether their homes had 24-hour awake staff. For multi-home operators, those who entered any number (including 0) in response to the question about number of houses with on-site house managers had the opportunity to indicate whether their homes had 24-hour awake staff.

Fewer operators reported requirements related to working with specific populations (41 percent), case management (30 percent), or understanding religious accommodations (24 percent). Thirteen percent indicated they had other requirements for paid staff. Those who specified those requirements described various other types of knowledge and skills, such as state systems/programs (e.g., HB101, Coordinated Entry) and particular practices or content areas related to service provision (e.g., Motivational Interviewing, Vulnerable Adult training, Traumatic Brain Injury training). Eleven percent of operators with paid staff indicated having no requirements related to any of the areas listed.

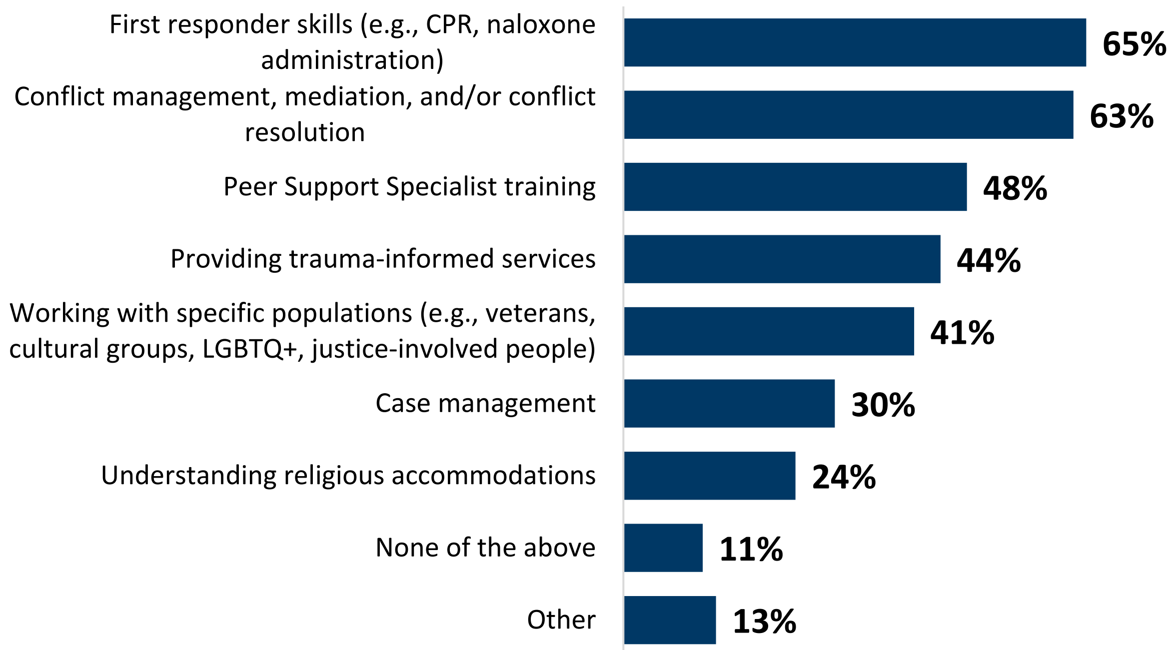

Figure 15 – Training/competency requirements that operators have for paid, on-site staff in their sober homes (n=54)

Most operators reported multiple requirements for admission into their sober homes, with drug screening and sobriety time the most common admission criteria.

Operators had the opportunity to share about the rules or standards that residents must meet for admission into their sober homes. Overall, 75 percent of respondents indicated that they require multiple admission criteria from a provided list, with 60 percent having two or three listed admission requirements.

As shown in Figure 16, 62 percent of respondents noted that residents must pass a drug screening to be admitted into their sober homes. Fifty-nine percent required a minimum amount of sobriety time. Less than half required refundable deposits or other fees for admission, and 12 percent required non-refundable deposits or fees. Just over a quarter of respondents required completion of a treatment program prior to entry.

Twenty-three percent of respondents indicated other admission requirements for their sober homes. A few of these requirements were that residents express a desire for sobriety or show the ability to pay costs to live in

the home, either out of pocket or through other means (e.g., insurance, Section 8). A couple of respondents had requirements around taking a tour of the house, interviews, admission of substance use disorder, or enrollment in other programs. Requirements named by individual respondents included:

- Willingness to follow rules.
- Attendance at 12-step meetings.
- Medical stability.
- Ability to live independently.
- Completion of an application.
- A letter from the resident about their interest in and goals for living at the house.
- A letter of support from a case manager or provider.
- Work requirements.

Also, a couple of respondents noted that admission decisions are made on a case-by-case basis. In a later question about other information to share related to rules and requirements, one respondent noted that they are lenient on some admission requirements as able because they understand that individual circumstances vary.

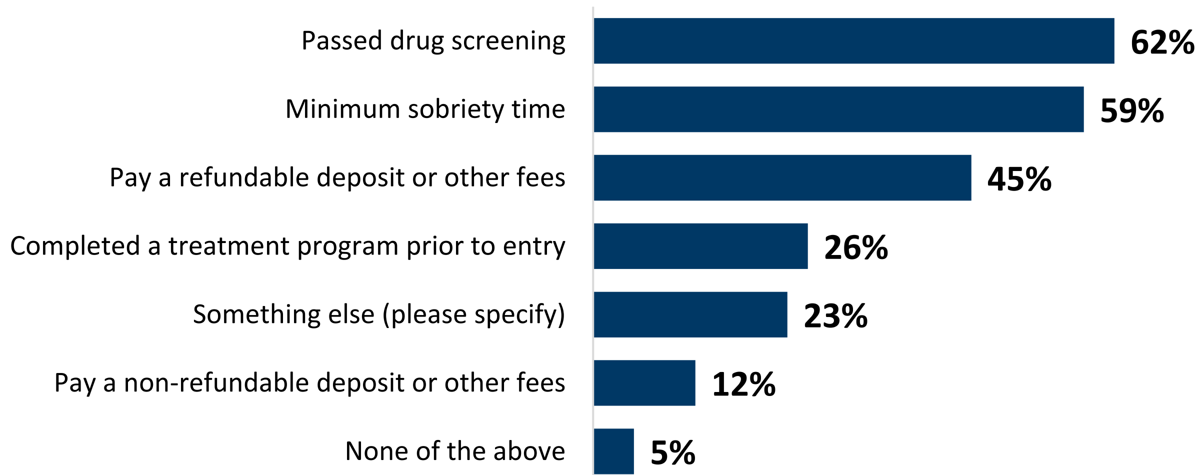

Figure 16 – Rules and standards that residents must meet for admission into respondents' sober homes (n=82)

Most respondents reported several 'house rules' for residents in their sober homes, most commonly related to contributing to the home, maintaining/ensuring sobriety, and personal well-being.

As shown in Figure 17 below, most operators reported having several rules or standards that residents must follow to live in their sober homes. Most operators reported rules related to house functioning, such as attending regular house meetings (95 percent) and doing household chores (93 percent). In addition, most operators had rules related to maintaining sobriety (93 percent) and participating in regular drug screening (82 percent). Finally, most operators indicated that they had house rules related to personal well-being, such as

participating in “productive time” activities (77 percent) or participating in self-help and/or treatment services or meetings (73 percent). Almost half required that residents meet regularly with a sobriety sponsor, and just over a quarter required that residents sign in and out of the sober home. Only seven percent had house rules related to attending religious or worship services.

Several respondents indicated “something else” for house rules. These included rules related to visiting hours, work requirements, room inspections, time away from the house (i.e., “active time” during the day), and sleeping elsewhere (i.e., getting permission and providing information about where they will be). In addition, when asked if there was anything else they wanted to share about rules and requirements, several respondents added other house rules, including related to:

- Respect and appropriate conduct to ensure a positive experience for all residents.
- Use of a buddy system to support new residents.
- Reporting of suspected drug/alcohol use and participation in additional drug screening if concerns arise.
- Managing visitors (e.g., no significant others in the house).
- Exchanging money between residents (e.g., no borrowing or lending).
- Vehicle storage on the property.

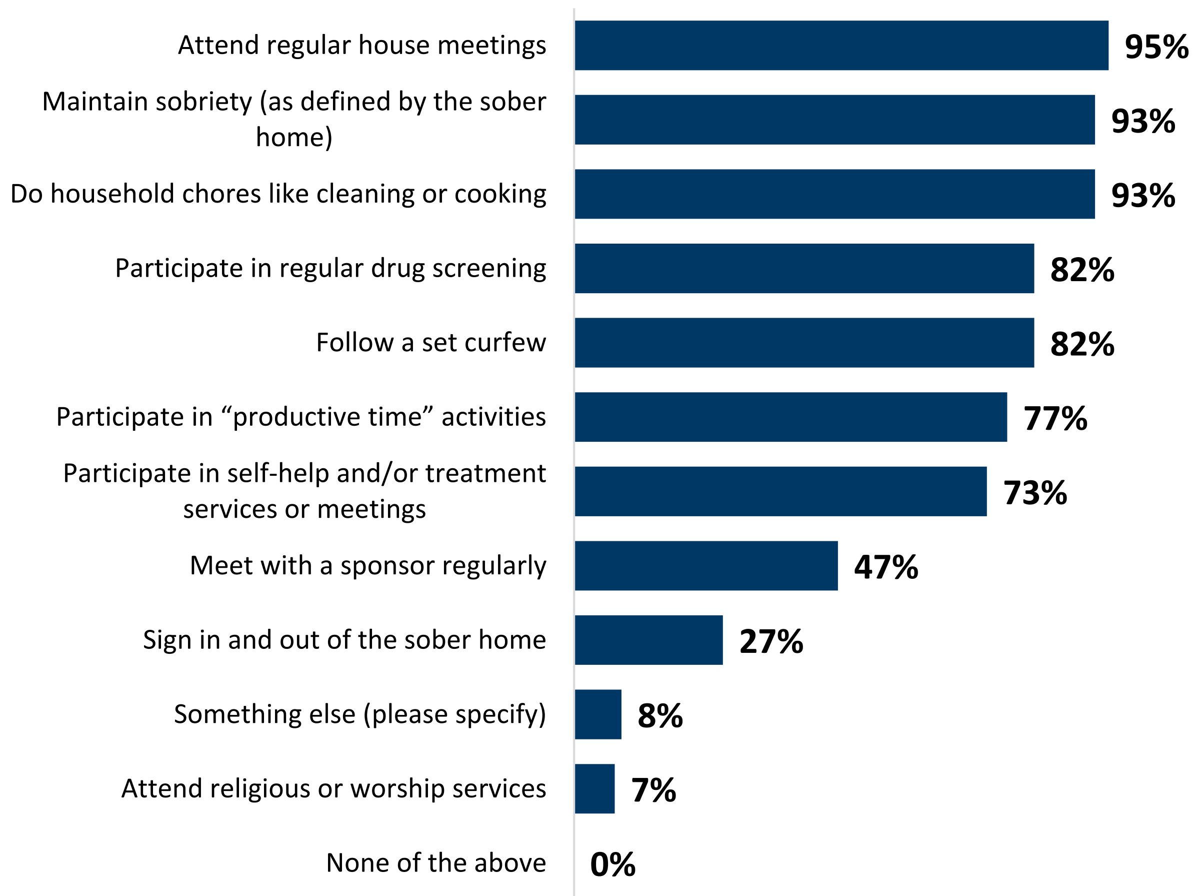

Figure 17 – Rules or standards that results must follow to live in respondents' sober homes ("house rules") (n=83)

In addition, a handful of respondents provided more information about their approach to rules and requirements when asked if there was anything else they wanted to share about rules and requirements at their sober homes. A few described a more lax or flexible approach than others; one noted that this is because their residents are close to returning to "real life," while another shared that they continue to try to work with residents around rules to support sobriety. Conversely, one noted that they have a "zero tolerance" substance abuse policy.

Most respondents had some process to collect feedback from residents, including both formal and informal avenues that could be initiated by either the sober home or by residents.

About two-thirds (68 percent) of respondents reported that they have a process to collect feedback from residents. In response to another question about gathering feedback and data, many respondents expanded on the processes they use to collect feedback. Avenues for formal and informal one-on-one communication with house managers, operators, or other staff were common; they included communication initiated by sober home staff/representatives (e.g., regular check-ins, exit interviews) or by residents (e.g., contact information for staff

posted, house manager available for discussion). Several respondents described house meetings as a common strategy for collecting feedback and discussing issues or complaints as a group. In addition, several respondents mentioned using surveys, including surveys at certain points during residents' stays (e.g., quarterly, semi-annually, six months after entry, exit). A handful of respondents reported using a digital app or software to support their work that includes an opportunity for feedback, and a few had feedback/suggestion boxes.

Some respondents also described how they use resident feedback. Respondents shared that they use resident feedback to understand residents' experiences, identify opportunities for improvement, and inform decision-making to better support residents.

Most respondents reported collecting some information about residents, often related to their time in the sober home.

As shown in Figure 18, most respondents reported that they collect basic data about residents' time in the sober home, including

- length of stay (73 percent),
- reasons for leaving (63 percent), and
- instances of residents' return to substance use (63 percent).

Just over half of respondents reported collecting information about residents more generally, including demographic characteristics (57 percent) and how residents became connected to the sober home (57 percent). About a third of respondents reported collecting information about residents after they leave the sober home. Collecting data on residents after they leave the sober home is difficult because of the transient nature of the population, one respondent noted elsewhere in the survey. A few respondents indicated that they collect other information, such as the substances residents were in recovery from using, and if they continue to use supportive services.

One respondent noted that they partner with a treatment provider who manages information about residents. Sixteen percent of respondents indicated that they do not collect any of the listed information about residents. In another question, two respondents expressed interest in collecting more data using software but noted challenges with cost and staff capacity.

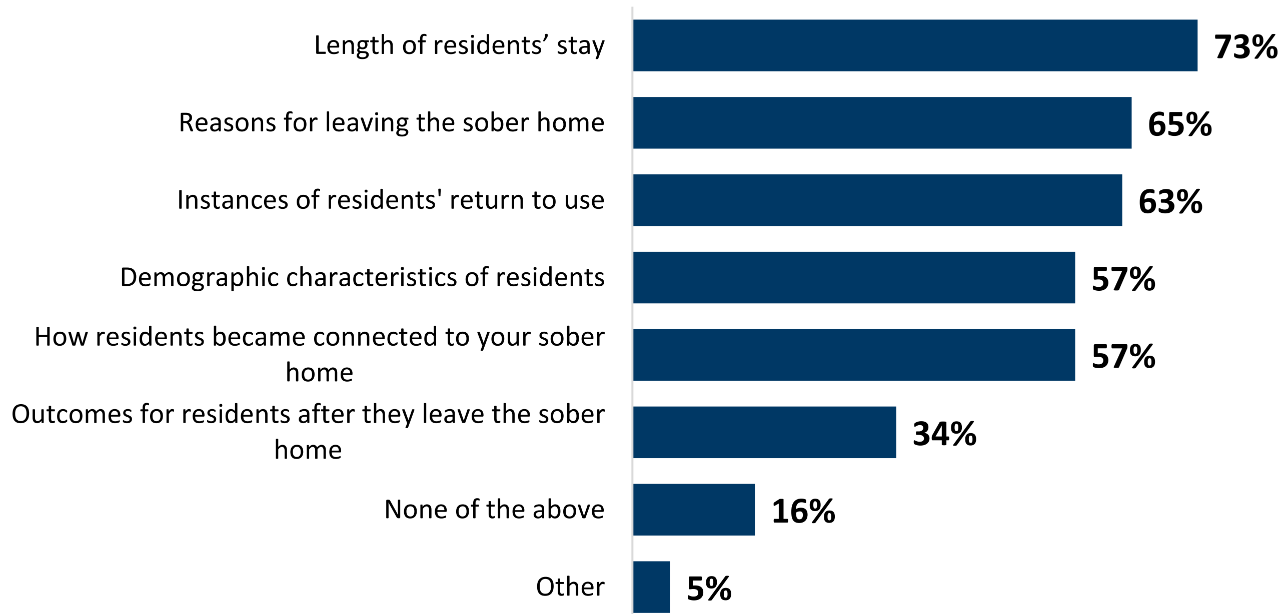

Figure 18 – Data/information collected by respondents about residents in their sober homes (n=82)

Respondents had multiple ways of getting connected with residents, most commonly through treatment providers and word-of-mouth.

Respondents noted multiple ways in which they become connected to residents of their sober homes, with almost all (87 percent) indicating that they “often” or “sometimes” received referrals from three or more of the listed sources.

Most respondents reported that they "often connect with residents through referrals from substance use treatment providers (Figure 19). Word-of-mouth referrals from residents’ personal and social networks were also common, with 63 percent of respondents indicating these referrals happen often. About half often received referrals through the justice system, while a third often became connected with residents through Recovery Community Organizations (RCOs).

Less than a quarter of respondents indicated that they often connect with residents as a result of Google searches or other advertising. A handful of respondents specified other referral sources that they experience often or sometimes. A few noted that they often or sometimes receive referrals from current/former residents, one often receives referrals from mental health providers, another sometimes receives referrals from other sober home operators or the MASH directory, and another sometimes becomes connected with residents through HB101. In response to another question, some respondents offered more information about referral sources, including MASH, Craigslist ads, and current residents.

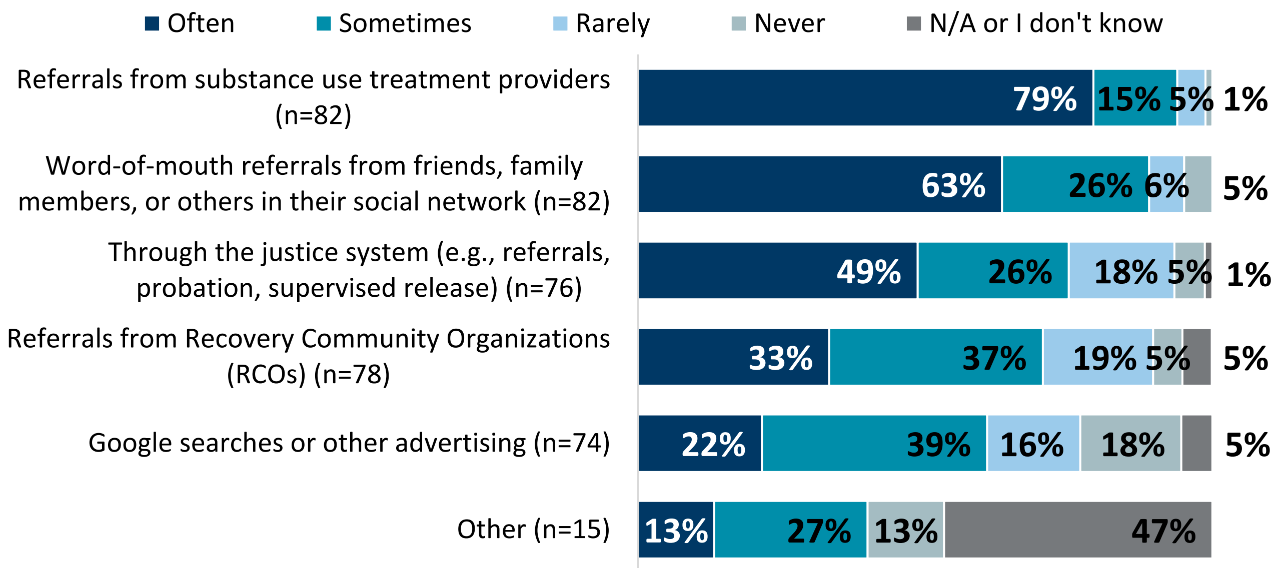

Figure 19 – Ways that respondents become connected with residents and how frequently these connections occur

Q2a. What operational barriers or challenges do sober homes experience?

To better understand the barriers related to sober housing, the survey included questions about operational, financial, and other challenges that respondents experience in operating sober homes.

Almost all respondents reported challenges related to managing funding and bringing in enough funding to pay for expenses.

As shown in Figure 20, almost half of respondents reported that managing funding and bringing in enough money to pay for expenses was very challenging, with another 43 percent indicating funding was somewhat or a little challenging. This was emphasized for operators with homes in the seven-county metro (n=46), as 76 percent reported that managing funding was somewhat or very challenging, and only 4 percent indicated it was not at all challenging. Alternatively, 56 percent of operators with homes in greater Minnesota noted that managing funding was somewhat or very challenging, and 19 percent indicated that it was not at all challenging.

Respondents experienced the remaining listed operational challenges at different levels, though over half experienced every challenge at least a little. After managing funding, the most commonly experienced very or somewhat challenging operational issues were related to managing legal aspects (such as zoning restrictions, local ordinances, and employment law), handling household upkeep and maintenance, and overseeing residents and resident interactions. Working with substance use/behavioral health treatment providers and responding to judgment or lack of support from neighbors or the local community were the least challenging for respondents. Two respondents described “other” challenges as very challenging; one noted that they experienced an expensive legal battle related to establishing a sober home, while another described challenges with getting referrals from treatment providers as an independent sober home owner.

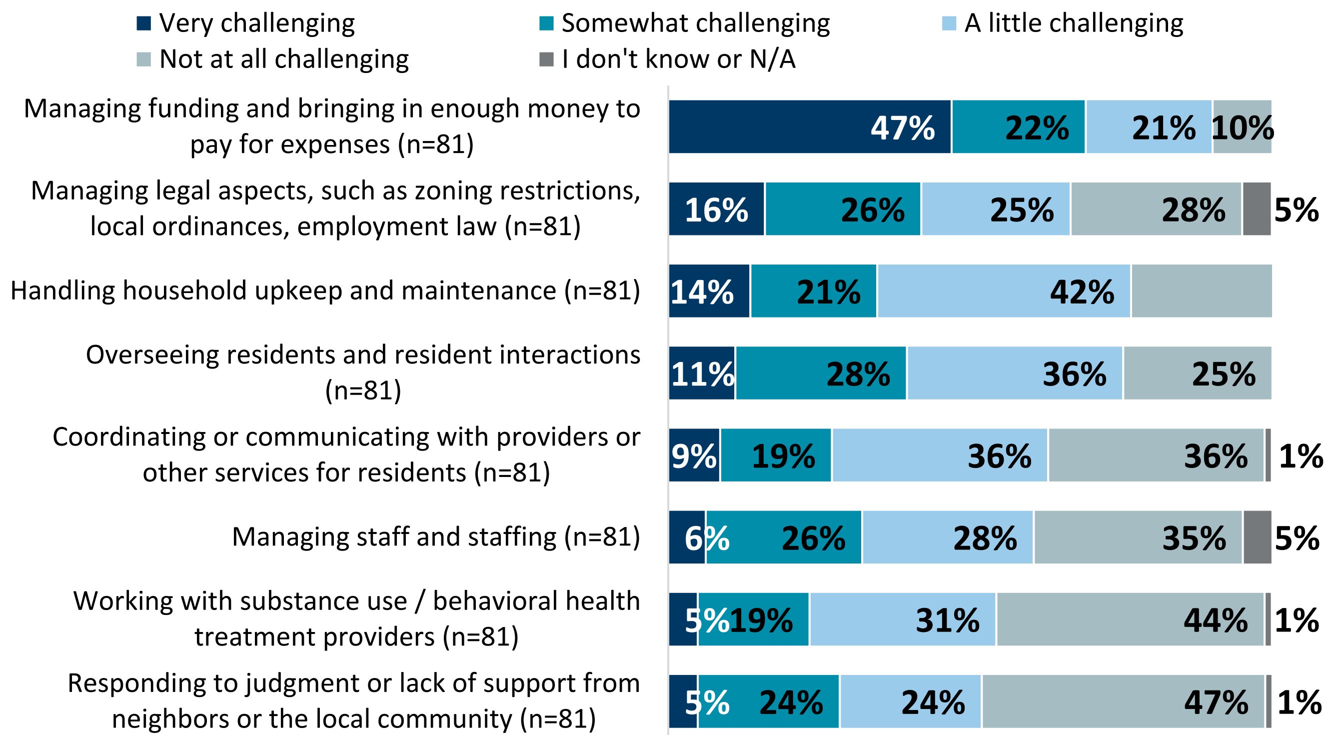

Figure 20 – Operational challenges and level of challenge for respondents

Multi-home operators expressed more challenges handling household upkeep than single home operators. Forty-two percent of multi-home operator respondents (n=50) indicated that household upkeep was somewhat or very challenging, compared to 23 percent of single home operators (n=31). Similarly, 18 percent of multi-home operators noted that handling household upkeep and maintenance was not at all challenging, compared to 32 percent of single home operators.

When asked what else they would like to share about operations in their sober homes, several respondents further described the operational challenges they experience. Again, some noted the need for funding, especially amid rising costs for operators and rising needs for sober housing.

Respondents experienced several financial challenges in operating their sober homes, though they generally felt confident in their homes' financial stability.

In addition to general operational challenges, the survey included a question about the level of challenge that respondents experienced related to financial aspects of operating a sober home. For all items listed, a majority of respondents indicated that the aspect was very or somewhat challenging (Figure 21), suggesting that financial challenges are common across respondents. Just over three-quarters of respondents indicated that residents having access to funds for payment was very or somewhat challenging, with only 9 percent indicating that this was not at all challenging. The cost of providing housing (e.g., mortgage payments, utilities, taxes, etc.) and housing repair or maintenance costs were also challenges for many, with 70 percent and 73 percent indicating

these were very or somewhat challenging, respectively. A handful of respondents indicated "other" challenges, though the responses they described were not related to finances.

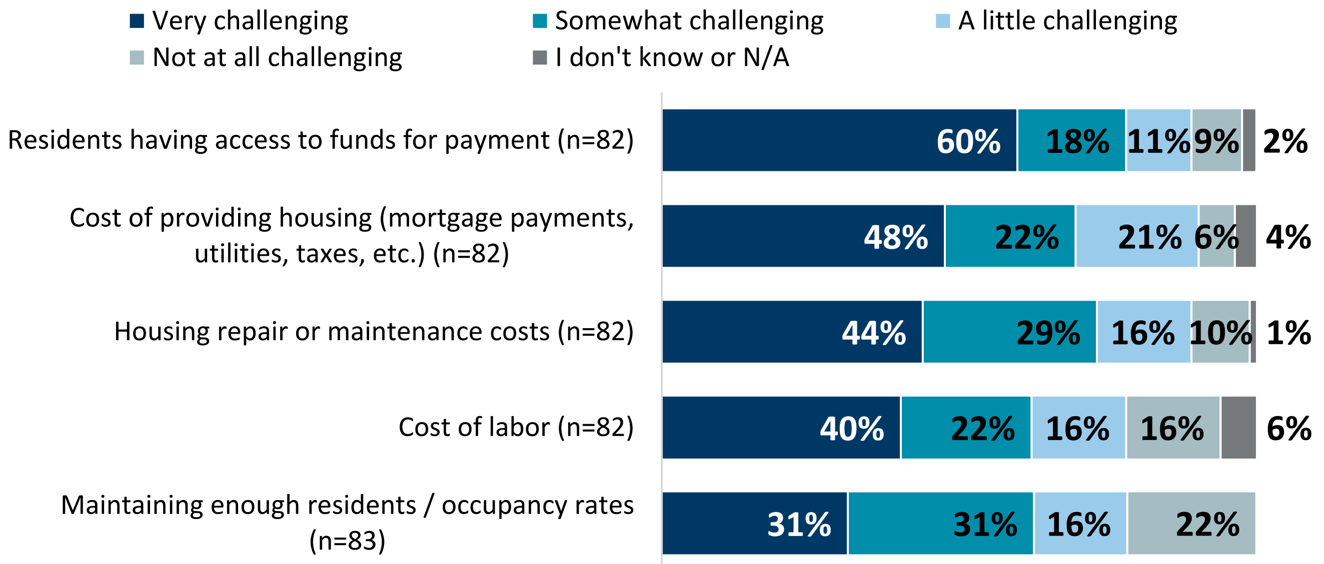

Figure 21 – Financial challenges and level of challenge for respondents

Some differences in response patterns emerged based on geography:

- Residents having access to funds for payment was very or somewhat challenging for 87 percent of respondents who operated homes in the seven-county metro (n=45), compared to 64 percent of respondents who operated homes in greater Minnesota (n=33).
- Eighty-seven percent of respondents who operated homes in the seven-county metro (n=45) indicated that housing repair or maintenance costs were very or somewhat challenging, while 52 percent of respondents who operated homes in greater Minnesota reported the same (n=33).
- Maintaining enough residents was very or somewhat challenging for 67 percent of respondents who operated homes in the seven-county metro (n=46), compared to 52 percent of respondents who operated homes in greater Minnesota (n=33).

These differences suggest that respondents whose homes are in greater Minnesota have a wider range of experiences with the financial aspects of operating a sober home.

In addition, single home operators and multi-home operators differed in their experience with the cost of labor. Seventy-four percent of single home operators (n=51) indicated that cost of labor was very or somewhat challenging, while 55 percent of multi-home operators (n=31) said the same.

Despite the financial challenges that respondents experienced, a majority were very or somewhat confident in the financial stability of their sober homes. Just under a quarter indicated that they were not very or not at all confident about their homes' financial stability (Figure 22). However, confidence level varied based on number

of homes operated, with 39 percent of single home operators (n=31) reporting feeling not very or not at all confident about their homes' financial stability compared to 19 percent of multi-home operators.

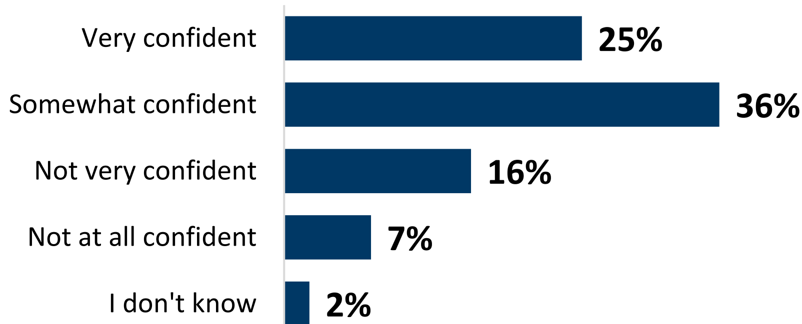

Figure 22 – Respondents' level of confidence in the financial stability of their sober homes (n=83)

Most respondents who had closed sober homes in the previous year said the loss of funding in the wake of changes to legislation and funding practices for sober homes caused the closures.

Thirty respondents reported that they had closed at least one sober home in the previous 12 months. Of these, 26 shared the reasons they decided to close their sober homes.

Most respondents named a lack of funding as a reason for sober home closures, with several pointing directly to anti-kickback legislation and/or the loss of funding for residents through treatment centers. Similarly, a few noted that reductions in the availability/capacity of treatment centers (due to anti-kickback legislation, fraud allegations, and/or DHS not renewing contracts with treatment providers) impacted their sober homes, both in terms of loss of referrals and loss of funding. A couple of respondents noted that attempts to pursue other funding sources, such as Free Standing Room and Board or Housing Support, were unsuccessful due to state or local barriers.

Beyond these themes, other reasons expressed for closing homes included:

- Zoning misinformation.
- Dissatisfaction with home location/condition.
- A flooded market.
- A lack of clarity about the future of the field.
- Challenges with housing laws that don't align well with the sober home context (e.g., requirement to provide a "notice to vacate" when a resident's behavior risks the safety/sobriety of other residents).
- Resident behaviors (e.g., verbal abuse, theft).

Despite operational challenges, many sober home operators expressed dedication to providing this key service.

While most operators described significant challenges in navigating funding and policies, many also emphasized the importance of sober housing and their commitment to working in the recovery field. Operators expressed that access to safe and affordable housing is essential for ensuring people stay sober. Some operators shared that their own long-term recovery journeys give them a more personal stake in providing sober housing to people in early recovery. Some described the work of sober home operation as more of a mission than a business, adding that it can take an emotional toll but is also rewarding to be part of the recovery community. The survey did not ask about operators' motivation for being in this field, so the emergence of this theme of commitment to providing sober housing despite challenges is noteworthy.

Q3. Who are sober homes able to serve and in what ways? Who are sober homes not able to serve and why?

To understand who is and is not served in Minnesota's sober homes, the survey included questions about the populations that sober homes either specifically serve or are able to serve, as well as barriers to serving clients. The survey also included questions about the services that sober home staff, volunteers, or compensated residents provide to residents.

Most respondents operated homes that served specific populations, most commonly based on gender.

Survey respondents had the opportunity to indicate, from a list, whether their sober home(s) specifically served certain populations. "Specifically serving" means that the sober home is intended for that group of people; those who are not part of that group generally do not live there.

Most respondents reported that their sober homes specifically serve at least one group, with only 4 percent indicating that their sober homes do not specifically serve any population. As shown in Figure 23, the most common populations specifically served were based on gender. Most respondents (71 percent) reported having at least one home that specifically serves men, while just under half indicated the same about homes that serve women. Thirty-seven percent of respondents operated at least one home that serves people who are involved with the justice system, and 30 percent indicated at least one home that serves members of the LGBTQIA+ population.

Few respondents indicated that their sober homes served specific racial, ethnic, or cultural groups, and no respondents reported specifically serving people who speak languages other than English. Respondents who in the survey selected "another population" specified that they served people experiencing homelessness, couples living in scattered sites, low-income individuals, and people with cognitive challenges such as mental illness or brain injury.

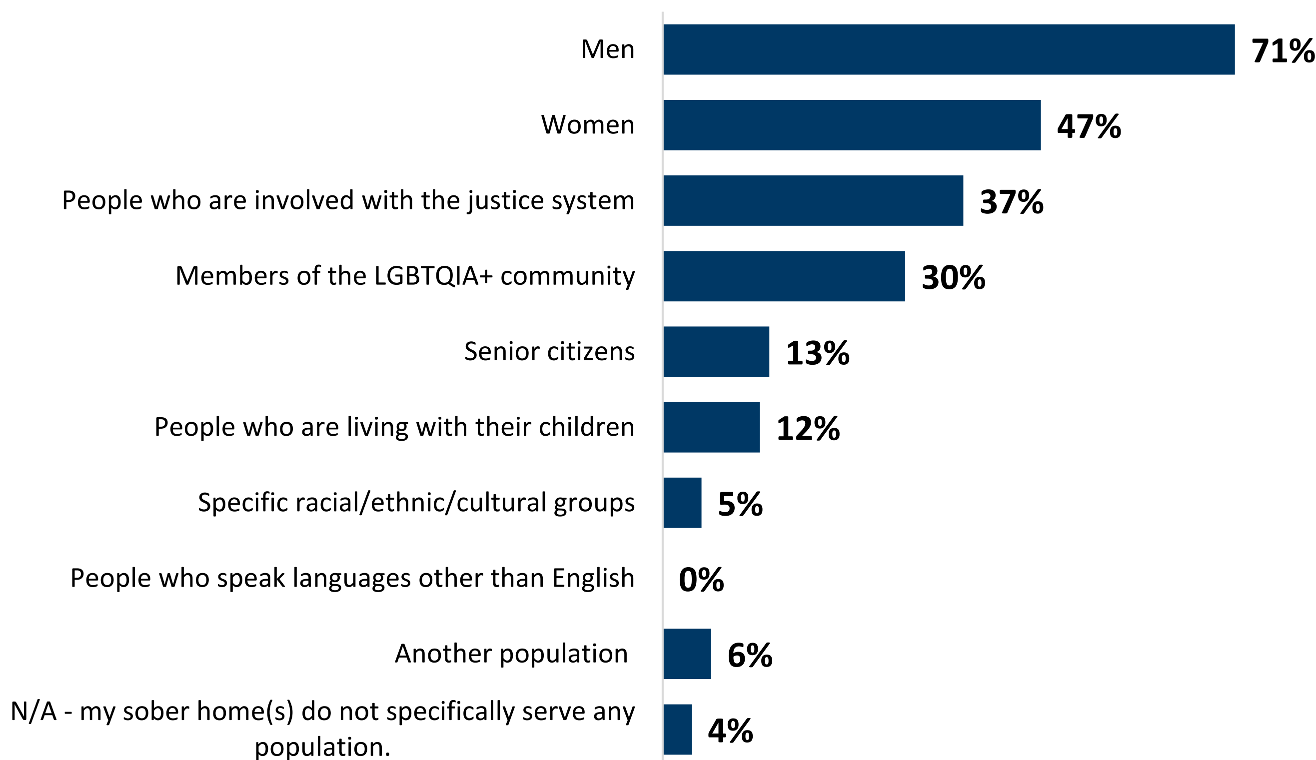

Figure 23 - Populations specifically served by sober homes operated by respondents (n=83)

While patterns in populations served were similar across regions, one noteworthy difference emerged. Of the 25 operators who indicated they have a home that specifically serves individuals in the LGBTQIA+ community, 18 (72 percent) operated in the Twin Cities.

While most sober home operators said they can serve individuals in the LGBTQIA+ community and people with a dual diagnosis of chemical dependency and mental health, fewer respondents said they were able to serve residents with other specialized needs, especially people living with children, physical disabilities, and pets.

In recognizing that the sober living system has historically presented barriers for people with certain identities or characteristics, the survey asked operators to identify, from a list, who they are able to serve. In this instance, being "able to serve" means that though the sober home may not be specifically intended for that certain population, it could support their specialized needs.

As shown in Figure 24, most respondents reported being able to serve members of the LGBTQIA+ community (77 percent) and people experiencing co-occurrence/dual diagnosis of chemical dependency and mental illness (74 percent) in at least one of their homes. However, being able to serve other populations with specialized needs was less common. Thirty-nine percent of respondents indicated that they were able to serve people with certain spiritual/religious practices, such as needing a halal or kosher kitchen, and 31 percent were able to serve

people who speak languages other than English. Less than a quarter reported being able to serve people on the Predatory Offender Registry or people convicted of arson. Fewer than one in five respondents were able to serve people living with pets, people with physical disabilities, and people living with their children. The three operators who specified that they can serve another population named couples and people involved in the criminal justice system.

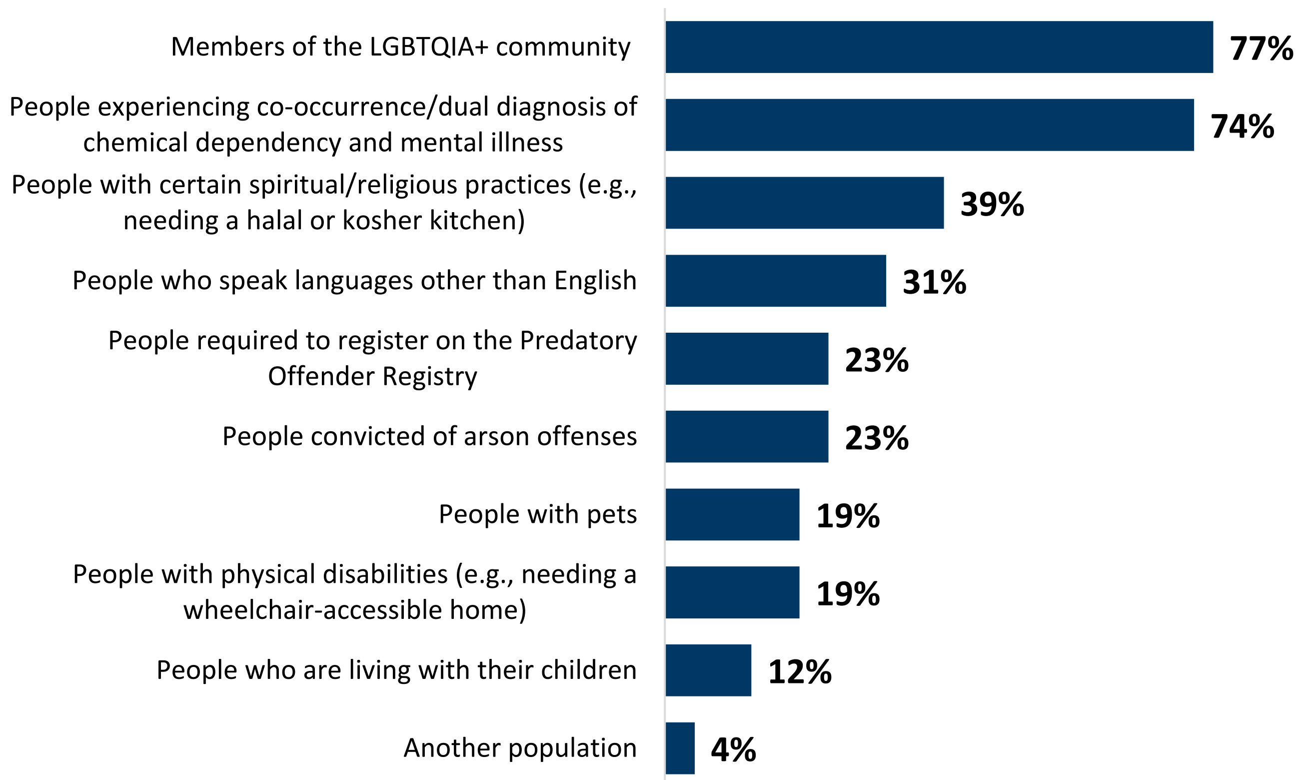

Figure 24 - Populations able to be served by sober homes operated by respondents (n=74)

In alignment with the regional split in homes that specifically serve the LGBTQIA+ community, there was a difference in ability to serve this population. Of the operators who said they were able to serve the LGBTQIA community, most (61 percent) were in the metro, compared to 35 percent in greater Minnesota. There was also a regional difference in homes that can serve people with physical disabilities. Of those who reported at least one home that could serve people with physical disabilities, 57 percent operated homes in greater Minnesota, 29 percent operated homes in the seven-county metro, and 14 percent operated homes in both regions.

When asked what populations operators were unable to serve, most mentioned people with physical disabilities or mobility challenges.

The survey asked respondents to describe any specific populations that they are unable to serve. Of the people who answered this question (n=57), 67 percent said they could not serve individuals with disabilities. Most

elaborated that their homes are not accessible by wheelchair, and/or that homes or bedrooms are only accessible by stairs.

The second most common response, shared by around half of respondents, was that they could not serve predatory offenders, violent offenders, or others who have been convicted of sex crimes. Some elaborated that this was due to either insurance or location-based restrictions.

Some operators shared that they are unable to serve people with high medical needs or others who cannot live independently. A few respondents shared that they are not able to serve people living with children or pets.

Respondents identified limited funding and/or limited income, transportation, and background checks as the most common barriers to serving individuals.

Operators who reported serving specific populations had the opportunity to describe the barriers they experience in serving those residents. Overwhelmingly, respondents pointed to general barriers like limited funding and financial barriers as the top challenges, rather than barriers specific to these populations. Some elaborated that certain stipends do not cover the cost of monthly charges, or that there are limited funding options generally. Some shared that having enough up-front money to cover deposits is a challenge, and that there are fewer supports to cover security deposits than rent.

Relatedly, many residents do not have employment or are not employed at a high enough level to cover costs privately. Some respondents described barriers related to getting employment, such as

- limited references,
- stigma from having been incarcerated, or
- not being able to pass background checks.

Respondents also named lack of transportation options between sober homes and potential employment as another layer to these interconnected challenges.

Some respondents named barriers related to zoning or pushback from neighbors as barriers to serving residents. Some noted that local zoning ordinances may limit the number of people who can reside in a home, regardless of the number of beds available. Some zoning ordinances restrict the number of people from different families who can live together. Other operators named pushback from neighbors as a barrier, typically related to prejudice rather than any actual conflicts.

Lastly, some operators identified challenges associated with serving people in recovery, generally. Some described this as the ups and downs related to recovery, or losing commitment to a recovery journey. Others elaborated on associated challenges, such as discrimination, stigma, mental health challenges, or trauma.

Most respondents reported offering a variety of services or supports through their sober homes, most commonly access to opioid overdose reversal medications, support groups or meetings, and/or help accessing community services.

Although sober homes do not provide counseling or treatment services to residents, they may offer supports, resources, or other types of services to support their residents. Respondents had the opportunity to review a list of services or supports and identify which are provided by their sober home staff, volunteers, and/or compensated residents. Around two-thirds of operators reported providing in at least one of their homes access to opioid overdose reversal medications (such as naloxone), support groups or other meetings, and help accessing community services (Figure 25). Sixty percent indicated offering employment support, and almost half (46 percent) noted that transportation was provided in at least one of their homes. A smaller proportion of respondents reported providing life skills classes (31 percent) or medication monitoring or administration (17 percent). Thirteen percent of respondents said that they did not provide any services beyond housing.

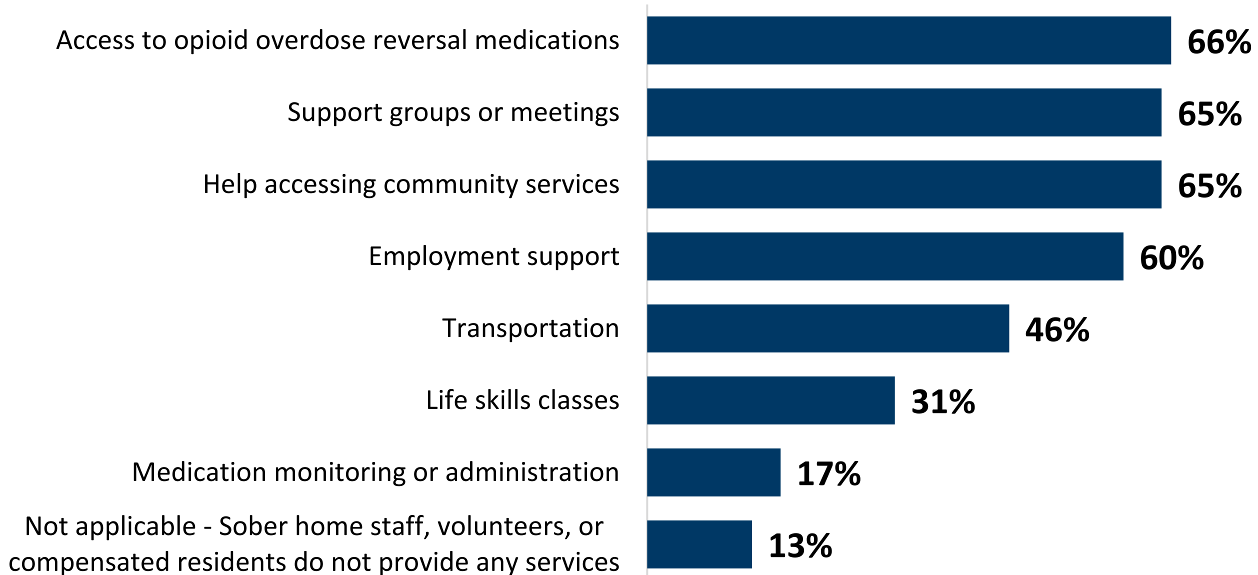

Figure 25 – Services provided by respondents’ staff, volunteers, or compensated residents (n=83)

A difference in service provision patterns emerged between those who operated sober homes in the seven-county metro and those in greater Minnesota. While 6 percent of respondents in greater Minnesota said they did not provide any services, 20 percent of operators with homes in the seven-county metro said the same. This difference—of greater Minnesota homes more often providing services—emerged with every service listed in the survey, as shown in Figure 26.

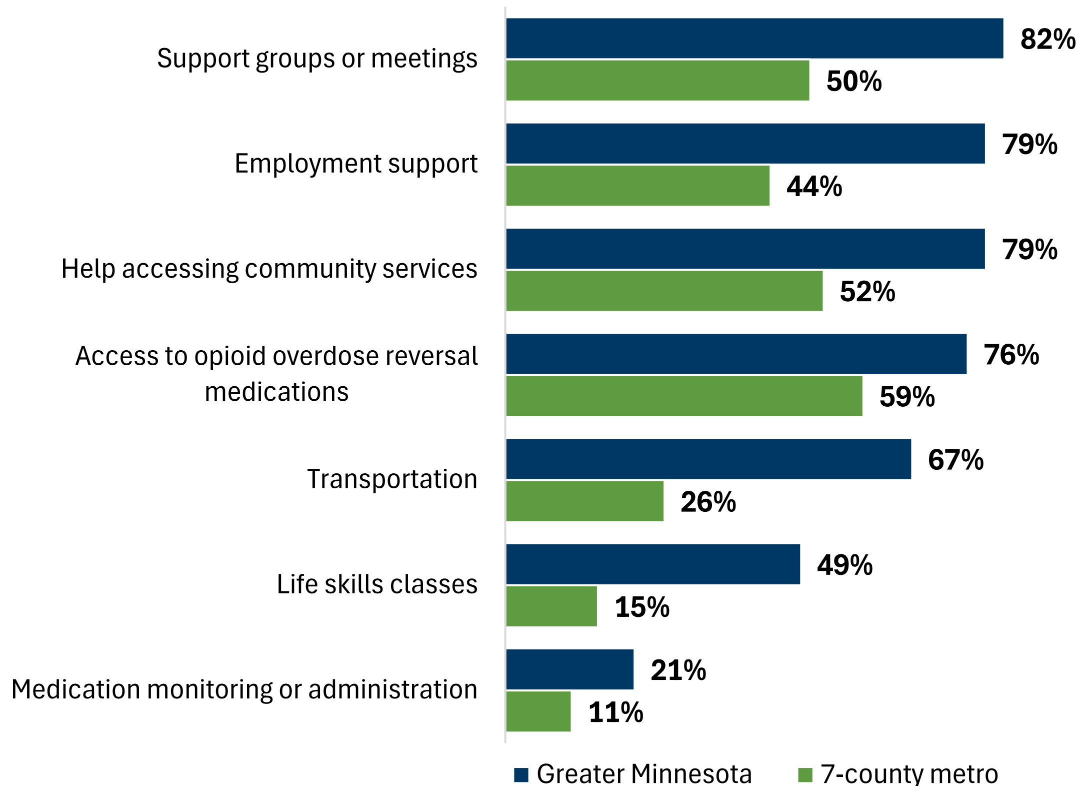

Figure 26 - The percentage of respondents, by region, with homes that have services provided by sober home staff, volunteers, or compensated residents

Respondents also had the opportunity to share what other services would be beneficial to residents of their sober home. Ideas varied, but most commonly included financial resources or funding for services, generally. Some operators suggested life skills training or classes, either related to finding and retaining employment, or with things like cooking, cleaning, and other home maintenance. Some operators again named transportation, either as a direct service or supports related to obtaining a vehicle or license.

Q4. What could the State or others do to strengthen sober housing in Minnesota?

To better understand needs and opportunities related to sober housing, the survey included open-ended questions about what would make it easier to operate existing or open new sober homes. The survey also asked what supports, resources, policies, or other changes would strengthen sober housing in Minnesota. The themes that emerged in these and other responses related to opportunities to strengthen sober housing are reported below.

Many operators mentioned funding, primarily to support residents but also for operational expenses, as the most needed resource.

Respondents most frequently pointed to potential changes to the state funding sources for sober home residents as important for strengthening sober housing. In particular, respondents asked that funding be made available to support treatment and housing for individuals in early-stage recovery, as opposed to only relying on general housing programs like Board and Lodging or Housing Support. Many respondents also mentioned the need for funding that provides essential services to residents during their transition between treatment and sober housing, like employment support and transportation. They described the intensive support many residents need during early recovery to become financially stable and pay rent without assistance.

In addition, some respondents mentioned the need for funding opportunities to help offset operating expenses not directly tied to rent or resident services. Some examples included access to capital for purchasing homes and funding for ongoing home repairs or upgrades.

Many operators described challenges with existing policies and administrative requirements, while also expressing desire for sober housing certification and monitoring that is aligned with recovery standards.

When asked what would make it easier to operate and/or open new sober homes, respondents frequently mentioned challenging policies around sober housing. Respondents said that it is challenging to operate under the same requirements as traditional housing. For example, traditional lease rules may not support the unique circumstances in a sober home, where residents who violate sobriety rules may need to be immediately removed from the home for the safety of other residents. Many respondents said that they experience a heavy administrative burden trying to comply with these policies.

While operators shared that existing policies and regulations were frustrating, many operators also expressed the need for sober housing to be certified and monitored to ensure that homes remain a compliant and supportive recovery environment. Some respondents suggested that the State work more closely with the Minnesota Association of Sober Homes and/or the National Association of Recovery Residences as certifying partners.

Some operators requested technical assistance to help them better operate within the existing regulatory systems.

When asked about supports and resources to strengthen sober housing, some operators also pointed to a need for more technical assistance and better communication from the cities, counties, and state agencies with which they need to interact. In particular, operators requested technical assistance navigating funding sources, local zoning laws, and policy compliance, especially for operators opening new homes. Operators also asked for clear communication from these agencies about expectations for compliance, especially for upcoming policy changes.

Operators who recently closed their sober homes may be willing to reopen if supported with funding and policy changes.

The survey asked respondents who did not at the time operate a sober home but had in the previous 12 months whether they would consider opening a sober home again in the future. While the number of respondents to this question is small (n=13), these operators were equally likely to say yes or it depends, as shown in Figure 27.

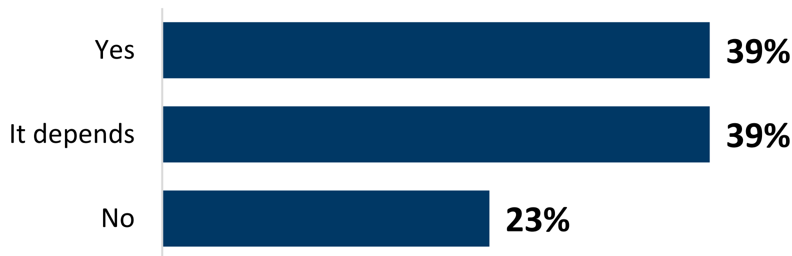

Figure 27 – Operators of recently closed sober homes on willingness to reopen homes in the future (n=13)

Respondents who said "it depends" were asked what would make it possible to reopen a sober home in the future. Most of these respondents said changes in either funding sources or the rules and regulations for sober homes would be needed to reopen homes.

Recommendations for future research

This Sober Home Scan provided an initial, descriptive view of the sober housing landscape in Minnesota. However, there is still much to explore about sober housing. Based on the results of this survey, some recommendations for future research are to:

- **Continue efforts to identify sober homes**. While the 97 respondents of this survey reported 269 open sober homes, this is undoubtedly an undercount. Especially alarming is that sober homes were reported in only 25 of Minnesota's 87 counties, with most homes concentrated in the seven-county metro. Lack of clarity about sober home options and lack of access to sober housing are challenges for those in recovery who may be seeking sober housing, as well as for any system that intends to provide oversight or regulation in the field. Therefore, continued efforts to identify sober homes across the state are critical.
- **Further investigate regional differences among sober homes**. This study attempted to uncover differences between respondents operating in the seven-county metro and those in greater Minnesota. While some interesting differences emerged, this categorization is simplistic and likely does not capture the varied experiences of operators in different contexts, including rural, urban, and suburban areas. In particular, this survey uncovered differences in services provided by sober homes based on geographical region; it would be helpful to better understand the causes and effects of those differences.

- **Further explore the different experiences and needs of single home operators versus multi-home operators.** This study also attempted to identify differences in responses for single home and multi-home operators, and some differences emerged. Of note is that single home operators were less confident in their homes' financial stability and in their expectations for operating their homes in a year. Additional information on contexts in which single home and multi-home operators function (e.g., operating as part of a treatment network versus fully independent) could illuminate these different experiences. Additionally, further exploration into the different pressures or challenges that single home operators experience would be helpful for identifying tailored solutions or supports to address them.
- **Further investigate the need for sober housing among specific populations.** For most populations identified in the survey, respondents did not operate homes that specifically served them. In addition, there were several populations that a few respondents were not able to serve. Given the diverse needs and characteristics of those in recovery, it is important to better understand how those needs align with what sober homes can offer and to identify opportunities for ensuring that all people can access sober housing that is comfortable, safe, and appropriate for them.
- **Continue to consider how to fund residents and/or sober homes**. A strong theme throughout the survey was challenges with finances in the wake of changes to funding practices in the sober housing field. Since those changes, residents and operators seem to have few options for sufficient and sustainable funding. For example, the survey showed that most respondents relied on residents' own financial resources for funding, but most also said that residents having access to funds is very or somewhat challenging. Given this tension, it is clear that other funding sources or methods are needed. While about half of respondents did get some funding from government assistance programs, it was not a robust source of funding for many. Therefore, it would also be useful to examine the barriers and challenges for accessing/increasing funding through government assistance programs.
- **Continue to gather operators' needs and preferences related to certifying and regulating sober homes.** Respondents described challenges operating within state regulations, yet they also expressed the need for sober homes to be certified and monitored to ensure alignment with recovery standards. This suggests an opportunity for appropriate regulation and oversight without over-burdening operators, though it is not clear what this looks like. One option could be partnering with MASH, as almost half of respondents indicated that their homes are already certified through MASH, and participation in state-sponsored programs was less common among respondents. It would be helpful to learn more from operators about how they would like a regulatory system to function.
- **Learn about residents' experiences.** While sober home operators were the focus of this survey, the thoughts and experiences of residents at sober homes are also critical. Most operators in this survey reported that they collect feedback from residents and have house rules that residents need to follow. Almost half of responding operators reported that residents support their house operations in exchange for a stipend or reduced rent. These findings suggest that residents play a key role in successful sober home operations beyond the role of paying rent.

Conclusion

This Sober Home Scan provided valuable insights into the sober housing landscape, as required in S.F. No. 2934 61/4/26. The scan identified 269 open sober homes across 25 counties in Minnesota, with most concentrated in the seven-county metro. These sober homes served a variety of residents, and most respondents did not report specifically serving any populations besides some focused on men. However, there were several groups that many respondents were unable to serve, including people living with children, people with physical disabilities/mobility challenges, and people with pets. Sober home operators reported providing a mix of services or supports to their residents, especially access to opioid overdose reversal medications, support groups or meetings, and/or help accessing community services. In terms of funding, respondents reported a mix of funding sources for their sober homes, though most rely on residents' own financial resources to some extent and only about half receive funding through government assistance programs.

In addition to the specific questions from the legislation that spurred this study, respondents shared additional valuable information. The scan summarized learnings about sober home operations, including operational and financial barriers and challenges, as well as respondents' suggestions for how to better support sober housing. Such input is vital to inform policies to strengthen sober housing in the State of Minnesota.

Appendix A: Survey Protocol

Introduction

Background

The Minnesota Department of Human Services (DHS) – Behavioral Health Administration is working with The Improve Group to conduct a scan of the state's current sober home (recovery residence) landscape. The Minnesota State Legislature has required DHS to complete the scan to learn more about sober homes in the state. DHS also wants to hear from sober home operators about how Minnesota can strengthen its sober housing communities across the state.

While Minnesota law provides a definition of sober homes (254B.181), DHS understands the sober housing landscape is changing. Because of this, the survey is for anyone providing sober housing in Minnesota, whether or not your residence fits the official definition.

About the survey

Who should complete the survey?

People or organizations that have provided sober housing in Minnesota in the last 12 months should complete the survey.

Sober home operators/owners are encouraged to complete the survey. If you own a sober home but are not involved in day-to-day operations, please send the survey to the person who is most closely involved in these operations to ensure accuracy. If you own/operate more than one sober home, you only need to complete the survey once.

What will the survey ask?

The survey will ask questions about the sober home(s) you operate or recently operated in Minnesota. This includes how many homes you operate, their locations (county or Tribal reservation/community), and the number of residents that can live in each home. The survey will also ask you to provide general information about the populations you serve, services you provide, funding sources, financial stability, and sober home(s) operations, like housing, staffing, and management models.

The survey is anonymous; you will not provide your name or the name of your sober home(s). The survey will ask you to provide the county name or Tribal reservation/community of where your sober home(s) are located to gather geographical data on sober home availability and services.

How long will the survey take?

This survey is estimated to take less than 15 minutes to complete. You can save your progress in the survey and continue later by clicking "Save & Continue Later" at the bottom of any page.

Use of survey results

Your participation and engagement in this process are essential to ensuring that future policies are both responsive and grounded in the lived experiences and insights from the field.

The Department of Human Services is committed to making data-informed decisions that will lead to policies and internal processes that better support this important work. The broader and more detailed the data collected, the more strategic and informed DHS's policy decisions can be in supporting those who live and work in the sober housing field.

The Improve Group will share the results of the survey with DHS in the form of analysis (summary report) and raw data. They will also provide a comprehensive report to DHS with learnings from the survey. Because the sober home scan is required by Minnesota statute, it is possible the data could be shared with other agencies in the future.

To keep survey-takers and the public informed, DHS and/or The Improve Group will share a summary of findings publicly as well.

Contact

If you have questions about the survey, please contact Taryn Mortimer at tarynm@theimprovegroup.com or 612-806-0980.

Sober Home Status

1. **How many sober homes do you currently operate in Minnesota?** Select one.

   - None, but I have operated a sober home in the last 12 months. [skip to Closed sober homes]
   - One sober home [skip to Sober home location (single home operator)]
   - More than one sober home [skip to Sober home locations (multi home operator)]

Sober Home Locations

Sober home location (single home operator)

2. **In which county or Tribal reservation/community is your sober home located?** Select one. [drop-down]

3. **What is the maximum number of residents that can live in your sober home?** Enter the number below.

4. **Have you closed any sober homes in the last 12 months?** Select one.
   - Yes [route to Recently closed sober homes]
   - No [route to Populations]

Sober home locations (multi home operator)

5. **For each sober home you operate, please indicate the county or Tribal reservation/community in which the sober home is located and the maximum number of residents that can live in the sober home.** This will provide valuable information about the capacity of sober homes across the state. Complete one row for each sober home you operate. Leave unused rows blank.

	County or Tribal reservation/community of the sober home	Maximum number of residents that can live in the sober home
Sober home 1	[select MN county]	-
Sober home 2	[select MN county]	-
Sober home 3	[select MN county]	-
Sober home 4	[select MN county]	-
Sober home 5	[select MN county]	-
...	[select MN county]	-
Sober home 20	[select MN county]	-

6. **Have you closed any sober homes in the last 12 months?** Select one.
   - Yes [route to Recently closed sober homes]
   - No [route to Populations]

Recently closed sober homes [If respondent answered "yes" to sober homes closing in last 12 months]:

7. [If respondent answered "yes" to closing a sober home in last 12 months]: **For each sober home you have closed in the last 12 months, please indicate the county or Tribal reservation/community in which the sober home was located and the maximum number of residents that could live in the sober home.** Complete one row for each sober home you operate. Leave unused rows blank.

	County or Tribal reservation/community of the sober home	Maximum number of residents that could live in the sober home
Closed sober home 1	[select MN county]	-
Closed sober home 2	[select MN county]	-
Closed sober home 3	[select MN county]	-
Closed sober home 4	[select MN county]	-
Closed sober home 5	[select MN county]	-
...	[select MN county]	-
Closed sober home 10	[select MN county]	-

8. [If respondent answered "yes" to sober homes closing in last 12 months]: **What reasons led to you closing your sober home(s)?** [open-end]

[continue to Populations]

Populations

9. **Which of the following populations are specifically served by your sober home(s)?** "Specifically serving" a population means that the sober home is intended for a specific group of people and those who are not part of that group generally do not live there. Check all that apply. If you operate multiple sober homes, check all populations you specifically serve. For example, if you operate one home specifically for women and one home specifically for men, check the boxes for both women and men.
   - ○ Not applicable - my sober home(s) do not specifically serve any population.
   - ❑ Women
   - ❑ Men
   - ❑ Members of the LGBTQIA+ community
   - ❑ People who are living with their children
   - ❑ Senior citizens
   - ❑ Specific racial/ethnic/cultural groups (Please indicate which racial/ethnic/cultural groups below)
   - ❑ People who speak languages other than English (Please indicate which language below):

- ❑ People who are involved with the justice system
- ❑ Another population (please specify):

10. [If did not choose "Not applicable" in previous question] **For populations you <u>specifically serve</u> in your sober home(s), what barriers do you experience in serving them?** Please describe the population and the challenges you have experienced serving that specific population that you may not experience if you were serving a different population. For example, a sober home serving people involved with the justice system may experience a barrier around city ordinances or unaccepting neighbors. [open-end]

11. **Which of the following populations are you <u>able to serve</u> by your sober home(s)?** "Able to serve" means that the sober home is not specifically intended for a certain population, but can support their specialized needs. Check all that apply. If you operate multiple sober homes, check all populations you are able to serve. For example, if you operate one home that can serve people living with children and a different home that can serve people with certain spiritual/religious practices, check both boxes.
    - ❑ Members of the LGBTQIA+ community
    - ❑ People who are living with their children
    - ❑ People with certain spiritual/religious practices (e.g., needing a halal or kosher kitchen, needing a private space for prayer)
    - ❑ People with pets
    - ❑ People who speak languages other than English
    - ❑ People experiencing co-occurrence/dual diagnosis of chemical dependency and mental illness (CD/MI)
    - ❑ People with physical disabilities (e.g., needing a wheelchair-accessible home)
    - ❑ People required to register on the Predatory Offender Registry
    - ❑ People convicted of arson offenses
    - ❑ Another population (please describe):

12. **Are there any specific populations you are <u>unable to serve</u> in your sober home(s)?** If so, please describe the population and the barriers to serving that specific population that you experience. For example, a sober home may be unable to serve people with physical disabilities if the home is not wheelchair-accessible. [open-end]

13. **Does your sober home have a policy about the maximum length of time that residents can stay at the sober home(s)?** Select one. If you operate multiple sober homes, choose the answer that best applies to the majority of your sober homes.
    - ○ Yes
    - ○ No

14. **On average, how long do residents stay at your sober home(s)?** If you operate multiple sober homes, estimate the average length of stay across all homes. ___

15. **Generally, how full is/are your sober home(s)?** Select one.

- ○ No or almost no beds are full
- ○ Some beds are full
- ○ Most beds are full
- ○ All beds are full

16. **Is there anything else you would like to share about populations served at your sober home(s)?** [open-end]

Services

17. **Which of the following services or supports, if any, are <u>provided by your sober home(s) staff, volunteers, or compensated residents</u>?** Select all that apply. If you operate multiple sober homes, select the services offered in <u>any</u> of your sober homes, even if they are not offered in all of your sober homes.
    - ○ Not applicable - Sober home staff, volunteers, or compensated residents do not provide any services.
    - ❑ Support groups or meetings
    - ❑ Life skills classes
    - ❑ Medication monitoring or administration
    - ❑ Employment support (e.g., help with job searching, resume-building)
    - ❑ Help accessing community services (e.g., public benefits, community transportation, peer supports, mental health treatment)
    - ❑ Transportation (e.g., offering rides, providing a bus pass)
    - ❑ Access to opioid overdose reversal medications (i.e., naloxone)
    - ❑ Another service (please specify):

18. **What other services would be beneficial to residents of your sober home(s)?** Describe the services and the reasons you do not provide them. [open-end]

19. **Is there anything else you would like to share about sober home services or supports?** [open-end]

Funding

20. [If respondent owns only one home] **Approximately how much is the total monthly cost for a resident to live in your sober home?** Include recurring costs like rent, utility shares, or monthly fees. $______

21. [If respondent owns multiple homes] **Approximately how much is the total monthly cost for a resident to live in your sober home <u>with the lowest cost</u>?** Include recurring costs like rent, utility shares, or monthly fees. $______

22. [If respondent owns multiple homes] **Approximately how much is the total monthly cost for a resident to live in your sober home <u>with the highest cost</u>?** Include recurring costs like rent, utility shares, or monthly fees. $______

23. **Approximately how much of the total costs related to your sober home(s) are paid by each of the following sources?** If funding sources are different for each resident, estimate the average percentage of each source for all residents. If you operate multiple sober homes, estimate an average across all homes.
    - _ Residents' own financial resources (e.g., employment earnings, savings, family resources, individual donations to the resident, Social Security Income)
    - _ Residents' insurance (private or public)
    - _ Government assistance programs that residents apply for and manage [e.g., Housing Support (formerly called Group Residential Housing or GRH) Free-Standing Room and Board (FSRB), Housing Assistance]
    - _ Donations or charity to the sober home
    - _ Other (please specify below):

24. **Is there anything else you would like to share about funding of your sober home(s)?** [open-end]

Financial sustainability

25. **How challenging are each of the following financial aspects of operating a sober home?** Select one response per row. If you operate multiple sober homes, select the answer that best applies to your general experience across all of your homes.

	Not at all challenging	A little challenging	Somewhat challenging	Very challenging	I don't know or N/A
Maintaining enough residents / occupancy rates	-	-	-	-	-
Cost of providing housing (mortgage payments, utilities, taxes, etc.)	-	-	-	-	-
Cost of labor	-	-	-	-	-
Housing repair or maintenance costs	-	-	-	-	-
Residents having access to funds for payment	-	-	-	-	-
Other (please specify):	-	-	-	-	-

26. **In general, how confident are you in the financial stability of your sober home(s)?** Select one. If you operate multiple sober homes, select the answer that best applies to your general experience across all of your homes.
    - ○ Not at all confident
    - ○ Not very confident
    - ○ Somewhat confident
    - ○ Very confident

- I don't know

27. **How confident are you that your sober home(s) will be operating one year from now?** Select one. If you operate multiple sober homes, select the answer that best applies to your general experience across all of your homes.
    - Not at all confident
    - Not very confident
    - Somewhat confident
    - Very confident
    - I don't know

28. [If "Not at all confident," "Not very confident," OR "Somewhat confident" about operating one year from now] **If you operate multiple sober homes, please indicate the number of sober homes for which you may have concerns about operating one year from now and in what county or Tribal reservation/community they are located.** [open-end]

29. **Is there anything else you would like to share about the financial sustainability of your sober home(s)?** [open-end]

Operations

30. **For each of the following aspects of operating a sober home, indicate how challenging it is for you in operating your sober home(s).** Select one response per row. If you operate multiple sober homes, select the answer that best applies to your general experience across all of your homes.

	Not at all challenging	A little challenging	Somewhat challenging	Very challenging	I don't know or N/A
Managing funding and bringing in enough money to pay for expenses	-	-	-	-	-
Overseeing residents and resident interactions	-	-	-	-	-
Managing legal aspects, such as zoning restrictions, local ordinances, employment law	-	-	-	-	-
Handling household upkeep and maintenance	-	-	-	-	-
Managing staff and staffing	-	-	-	-	-
Working with substance use / behavioral health treatment providers	-	-	-	-	-

	Not at all challenging	A little challenging	Somewhat challenging	Very challenging	I don't know or N/A
Responding to judgment or lack of support from neighbors or the local community	-	-	-	-	-
Coordinating or communicating with providers or other services for residents	-	-	-	-	-
Other (please specify):	-	-	-	-	-

31. **What would make it easier to operate <u>existing</u> sober homes?** [open-end]

32. **What would make it easier to open <u>new</u> sober homes?** [open-end]

33. **What State-level supports, resources, policies or other changes would strengthen sober housing in Minnesota?** [open-end]

34. **Is there anything else you would like to share about operations at your sober home(s)?** [open-end]

Housing models

35. **Which of the following best describes the ownership model of the sober home(s) you operate?** Select one.
    - Owned by an individual
    - Owned by a non-profit organization
    - Owned by a for-profit organization
    - Other (please specify)

36. [If respondent operates only one home] **What housing management model does your sober home use?** Select one.
    - Managed by residents
    - Managed by an on-site house manager
    - Managed by someone who does not live on-site
    - Other (please describe):

37. [If respondent operates more than one home] **What housing management model(s) do your sober homes use?** Identify the number of homes that use each type of management model.
    _ Managed by residents
    _ Managed by an on-site house manager

_ Managed by someone who does not live on-site

_ Other (please describe below)

38. [If respondent operates more than one home] **If you entered a number greater than 0 in the "other" house management model above**, briefly describe. [open-end]

39. [If respondent operates only one home] **Which of the following statuses apply to your sober home?** Select a response in each row.

	Yes	No	I don't know	Prefer not to disclose
Certified through the Minnesota Association of Sober Homes (MASH)	-	-	-	-
Registered as a Boarding and Lodging Establishment or Lodging Establishment Providing Special Services (BLSS)	-	-	-	-
Approved as a Free Standing Room and Board Program (FSRB)	-	-	-	-

40. [If respondent operates more than one home] **For each of the following items, indicate what proportion of your sober homes meet each status.** Select a response in each row.

	None	Some	All	I don't know	Prefer not to disclose
Certified through the Minnesota Association of Sober Homes (MASH)	-	-	-	-	-
Registered as a Boarding and Lodging Establishment or Lodging Establishment Providing Special Services (BLSS)	-	-	-	-	-
Approved as a Free Standing Room and Board Program (FSRB)	-	-	-	-	-

41. **Is there anything else you would like to share about the ownership or housing model used at your sober home?** [open-end]

Staffing and staff qualifications

42. **Which of the following people, if any, perform house operations or provides support for your sober home(s)?** Select all that apply. If you operate multiple sober homes, select all the staffing situations that apply to your homes, even if they are not offered in all of your sober homes.

- ❑ Paid staff, including employees or contractors
- ❑ Unpaid volunteers
- ❑ Residents, in exchange for a stipend or reduced rent
- ❑ Residents, as part of the expectations for living in the home

43. [If have paid staff, volunteers, or compensated residents] **In total, about how many hours per week do paid staff (employees/contractors), volunteers, and/or <u>residents receiving financial compensation</u> perform house operations or provide support for the sober home?** Estimate the total hours per week across all individuals, regardless of role. Do not include the sober home's owner or residents who do these activities as part of expectations for living in the home in the calculation. If you operate multiple sober homes, provide information for an average or "typical" home. ___

44. [If respondent operates only one home AND indicated "Managed by an on-site house manager" in above question about housing management models] **Does your home have 24-hour awake staff?** Select one.
    - ○ Yes
    - ○ No

45. [If respondent operates more than one home] **How many of your homes have 24-hour awake staff?** Enter the number of homes. ____

46. [Shown as default; hidden if respondent <u>did not</u> indicate "Managed by an on-site house manager" in above question about housing management models:] **What training or experiences does the on-site house manager have?** Select all that apply. If you operate multiple sober homes, select all the manager training/experiences that apply to your homes, even if they are not applicable to managers in all of your sober homes.
    - ❑ Lived experience in recovery
    - ❑ Lived experience in sober homes
    - ❑ Certified Peer Recovery Specialist
    - ❑ License in alcohol and drug counseling or mental health

47. [If have paid staff] **Do you require paid, <u>on-site</u> staff (employees or contractors) to have training or competency on the following topics or other topics to help them better serve residents?** Select all that apply. If you operate multiple sober homes, select all the staff training/experiences that apply to your homes, even if they are not required for staff in all of your sober homes.
    - ❑ Providing trauma-informed services
    - ❑ Understanding religious accommodations
    - ❑ Working with specific populations (e.g., veterans, cultural groups, LGBTQ+, justice-involved people)
    - ❑ Conflict management, mediation, and/or conflict resolution
    - ❑ Case management
    - ❑ Peer Support Specialist training
    - ❑ First responder skills (e.g., CPR, naloxone administration)
    - ❑ Other (please specify):

- ○ None of the above

48. **Is there anything else you would like to share about staffing at your sober home?** [open-end]

Rules and requirements

49. **Which of the following rules or standards must residents meet for admission into the sober home?** Select all that apply. If you operate multiple sober homes, select all the requirements that apply to your homes, even if they are not required in all of your sober homes.
    - ❑ Minimum sobriety time
    - ❑ Passed drug screening
    - ❑ Completed a treatment program prior to entry
    - ❑ Pay a non-refundable deposit or other fees
    - ❑ Pay a refundable deposit or other fees
    - ❑ Something else (please specify):
    - ○ None of the above

50. **Which of the following rules or standards must residents follow to live in your sober home (i.e., what are the "house rules")?** Select all that apply. If you operate multiple sober homes, select all the requirements that apply to your homes, even if they are not required in all of your sober homes.
    - ❑ Attend religious or worship services
    - ❑ Attend regular house meetings
    - ❑ Meet with a sponsor regularly
    - ❑ Participate in self-help and/or treatment services or meetings
    - ❑ Participate in regular drug screening
    - ❑ Participate in "productive time" activities (e.g., work, school, treatment)
    - ❑ Maintain sobriety (as defined by the sober home)
    - ❑ Do household chores like cleaning or cooking
    - ❑ Sign in and out of the sober home
    - ❑ Follow a set curfew
    - ❑ Something else (please specify)
    - ○ None of the above

51. **Is there anything else you would like to share about the rules and requirements at your sober home(s)?** [open-end]

Feedback and data

52. **Do you have a process to collect feedback from residents about your sober home(s)?** Select one. If you operate multiple sober homes, select the answer that best applies to the majority of your sober homes.
    - ○ Yes
    - ○ No

53. [If respondent answers “Yes” to collecting feedback]: **Please describe how you use the feedback you collect from residents.** [open-end]

54. **Which of the following data or information about residents, if any, do you collect or keep?** Select all that apply. If you operate multiple sober homes, select all the data/information you collect about residents in your homes, even if you do not collect it in all of your homes.
    - ❑ Demographic characteristics of residents (e.g., gender, age, race/ethnicity)
    - ❑ How residents became connected to your sober home (i.e., referral source)
    - ❑ Length of residents’ stay
    - ❑ Instances of residents’ return to use
    - ❑ Reasons for leaving the sober home
    - ❑ Outcomes for residents after they leave the sober home
    - ❑ Other (please specify):
    - ○ None of the above

55. **Is there anything else you would like to share about gathering feedback and data at your sober home(s)?** [open-end]

Referrals

56. **How do you and your residents become connected? For each of the following potential ways, share how frequently residents use each to learn about your sober home(s).** Select one response per row. If you operate multiple sober homes, select the answer that best applies to all of your homes.

	Never	Rarely	Sometimes	Often	I don’t know
Word-of-mouth referrals from friends, family members, or others in their social network	-	-	-	-	-
Referrals from substance use treatment providers	-	-	-	-	-
Referrals from Recovery Community Organizations (RCOs)	-	-	-	-	-
Through the justice system (e.g., referrals, probation, supervised release)	-	-	-	-	-
Google searches or other advertising	-	-	-	-	-
Other (please describe):	-	-	-	-	-

57. **Is there anything else you would like to share about how residents become connected to your sober home(s)?** [open-end]

Closed sober homes [only for those who have no open sober homes]

58. [If respondent answered "None, but I have operated a sober home in the last 12 months" to question 1]: **For each sober home you have closed in the last 12 months, please indicate the county or Tribal reservation/community in which the sober home is located and the maximum number of residents that could live in the sober home.** Complete one row for each sober home you operate. Leave unused rows blank.

	County or Tribal reservation/community of the sober home	Maximum number of residents that could live in the sober home
Closed sober home 1	[select MN county]	
Closed sober home 2	[select MN county]	•
Closed sober home 3	[select MN county]	•
Closed sober home 4	[select MN county]	•
Closed sober home 5	[select MN county]	•
...	[select MN county]	•
Closed sober home 10	[select MN county]	•

59. **What reasons led to you closing your sober home(s)?** [open-end]

60. **Would you consider opening another sober home in Minnesota in the future?** Select one.
    - ○ Yes
    - ○ No
    - ○ It depends (please describe below)

61. [if respondent selects "it depends" to the question above] **What would make it possible for you to open another sober home in Minnesota?** [open-end]

62. **In general, what would make it easier to operate a sober home in Minnesota?** [open-end]

63. **What State-level supports, resources, policies or other changes would strengthen sober housing in Minnesota?** [open-end]

Wrap-up

64. **What else would you like to share about operating a sober home in Minnesota?** [open-end]

Thank you! Please click “Submit” below to submit your response.

End page

Thank you for completing this survey.
Please help us reach more sober home operators for this important project.
Share the link below with other Minnesota sober home operators in your network:
www.theimprovegroup.questionpro.com/SoberHomeScan

Appendix B: Data tables

County	Open homes	Maximum number of residents that can be served
Anoka County	17	162
Benton County	3	16
Blue Earth County	8	87
Carver County	1	6
Cass County	2	13
Clay County	2	34
Crow Wing County	17	255
Dakota County	2	12
Douglas County	1	74
Hennepin County	68	1103
Itasca County	5	38
Le Sueur County	4	44
Meeker County	1	37
Morrison County	2	17
Nicollet County	1	6

County	Open homes	Maximum number of residents that can be served
Nobles County	2	24
Olmsted County	11	182
Otter Tail County	3	31
Ramsey County	84	806
Rice County	2	15
Saint Louis County	7	137
Scott County	7	59
Stearns County	13	136
Steele County	1	25
Wright County	5	39
Total	**269**	**3,358**

Appendix table 1 – Open sober homes and beds reported by respondents by county

County	Closed Homes	Maximum number of residents that could have been served
Anoka County	3	24
Clay County	1	4

County	Closed Homes	Maximum number of residents that could have been served
Dakota County	5	26
Hennepin County	21	208
Itasca County	1	8
Kandiyohi County	1	6
Ramsey County	18	136
Saint Louis County	4	41
Stearns County	6	53
Washington County	1	*blank*
Survey Total	**61**	**506**

Appendix table 2 – Closed sober homes and beds reported by respondents by county