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Lived Experiences of Oxford House Residents Prescribed Medication-Assisted Treatment

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**Lived Experiences of Oxford House Residents Prescribed Medication-Assisted
Treatment**

A Dissertation

Presented in

Partial Fulfillment of the
Requirements for the Degree of
Doctor of Philosophy

By

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August, 2021

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Biography

The author was born in Tijuana, Mexico, on November 23rd, 1987. He graduated from Desert Pines High School, in Las Vegas, NV, 2005. He received his bachelor's degree from University of Nevada Las Vegas in 2013.

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Abstract

Qualitative studies have examined the recovery experiences of individuals prescribed medication-assisted treatment (MAT), including their experiences within treatment facilities. However, the literature lacks qualitative studies exploring the recovery process of individuals prescribed MAT while living in recovery housing, such as Oxford House (OH). The purpose of this study was to explore how OH residents, who are prescribed MAT, make sense of recovery. Interpretative phenomenological analysis (IPA) was used to document the lived experiences of individuals prescribed MAT in OH. The sample included: 5 women and 3 men, prescribed either methadone or Suboxone, that were living in an OH in the U.S. Participants were interviewed on four topics: their recovery process, their transition to OH, their experience living in and outside of an OH. Analysis of results followed the recommendations for IPA from Smith, Flowers, and Larkin. Four general themes emerged from the data: Recovery Process, Managing Logistics of MAT Utilization, Personal Development, and Familial Values. In conclusion, individuals prescribed MAT could benefit from living in an OH in order to manage their recovery as well as stay compliant with their medication.

Keywords: methadone, buprenorphine, Oxford House, recovery housing, substance use

Lived Experiences of Oxford House Residents Prescribed Medication-Assisted Treatment

Literature Review

In recent years there has been an influx of residents that are prescribed medication-assisted treatment (MAT) in recovery homes. Research on their entry into recovery homes, specifically Oxford House (OH), is currently lacking. Several studies have examined the history of MAT, the attitudes towards it, opinions on how to manage course of treatment, and differing attitudes toward whether MAT falls under the spectrum of substance use recovery (Joseph & Langrod, 2000; Joseph & Woods, 2018; Majer et al., 2020; Majer et al., 2018). However, there are no studies that have examined the entry of MAT residents in recovery homes and their lived experiences while residing in an OH. The purpose of this study is to explore how OH members who are prescribed MAT make sense of recovery while in residence.

History of Opioid Epidemic

There were a multitude of reasons why the opioid epidemic began in the first place. Three phases were attributed to the development and continuation of the opioid epidemic (Dasgupta, Beletsky, & Ciccarone, 2018). The first phase started in the 1980s with the decline of behavioral therapy as treatment for pain and advances in medicine. This led to increased rates of survival, and the development and frequency of invasive surgeries that required potent opioids to quell post-surgical pain. In the early 2000s, prescription drugs that were not opioids (e.g., rofecoxib and valdecoxib) were taken off the markets due to safety concerns; meanwhile pharmaceutical companies minimized the safety concerns of opioids as part of marketing campaigns (Conaghan, 2012; Dasgupta et

al., 2018). Pharmaceutical companies incentivized physicians to prescribe opioids through free meals, speaking fees, and other types of payment (Hadland, Krieger, & Marshall, 2017). Additionally, physicians did not have official and/or research based guidelines for opioid prescription prior to 2010. This combined with opioids being prescribed to patients with acute non-cancer pain led to prescription rates three times higher than they were allotting per patient in 1999 (Guy et al., 2017). The second phase included the introduction of agents to opioid medication that deterred abuse (e.g., reformulation of OxyContin). This had the unforeseen effect of encouraging individuals that abused opioids to shift substance use towards more accessible heroin (Cicero, Ellis, & Surratt, 2012).

The third, ongoing phase starting in 2013 involves the introduction of powerful opioids such as fentanyl. The toll of the opioid epidemic led to over 40,000 deaths from overdose in 2016 (Hedegaard, Warner, & Miniño, 2017), and also has drained medical resources (e.g. emergency room visits; Hsu et al., 2017). Individuals originally were entering treatment for prescription opioid abuse and have leveled off with a spike in treatment for heroin (Fischer & Rehm, 2018). Because of the deadly properties of fentanyl and unexpected addition in the heroin supply, treatment efforts have expanded the use of naloxone to reverse overdoses (Moss & Carlo, 2019). In fact, many state agencies have pushed initiatives to educate the public and provide naloxone as a cost-saving measure to help prevent accidental deaths from overdoses (Mitchell & Higgins, 2016).

COVID-19 Pandemic

The emergence of the novel coronavirus (SARS-CoV-2) that leads to COVID-19 had an unexpected impact on the opioid epidemic within the U.S. There also have been a number of policy changes that have affected individuals prescribed MAT including the increased take home dosage ranging from 14 days to 28 days (Bao, Williams, & Schackman, 2020). There was a more than 40% increase in overdose-associated cardiac arrests in the West and South regions of the U.S., which includes Texas and Washington (Friedman et al., 2021). The CDC estimated over 93,000 overdose deaths during the calendar year of 2020, which is a 29.4% increase from 2019 (Ahmad, Rossen, & Sutton, 2021).

Additionally, the restrictions placed on communities by local governments had an effect on interactions. Safety protocols that were recommended by the Centers for Disease Control and Prevention (CDC), as well as fears from individuals, led to isolation for many, which contributed to a decline in mental health. Adults in April 2020 demonstrated eight times more serious mental distress compared to 2018 (Twenge & Joiner, 2020). Social support may reduce the negative effects of isolation during this pandemic based on literature from coping after disasters (Saltzman, Hansel, & Bordnick, 2020). In addition, those in good romantic relationships fared better with their mental health during the pandemic than those with poor or no relationships (Pieh et al., 2020).

Development of MAT

Methadone, a synthesized opioid developed in Germany during the late 1930s, was first used in the late 1940s as an effective treatment for assisting heroin dependent people with withdrawal (Isbell & Vogel, 1949). Prior to methadone, opioid use disorder

was treated with daily morphine administration, which all but guaranteed relapse; despite a switch to methadone treatment, relapse rates were high once patients were discharged from in-patient methadone treatment, as it only assisted with the withdrawal process (Joseph, Stancliff, & Langrod, 2000; Joseph & Woods, 2018). Ineffective treatment methods necessitated research on evidence-based treatment that would save lives, reduce the likelihood of relapse, and increase functioning. Research on methadone maintenance led by Dr. Vincent P. Dole demonstrated methadone's effectiveness on treating opioid-addicted patients and provided support for the medical disease model of addiction (Dole, 1965; Dole & Nyswander 1965; Dole & Nyswander, 1967; Dole, Nyswander, & Kreek, 1966; Ho & Dole, 1979).

It was not until several decades later that the scientific community advocated for the continued use of methadone to treat opioid use disorder. Reports from the Institute of Medicine (IOM) and National Institutes of Health (NIH) in 1995 and 1998, respectively, helped expand the use of methadone maintenance treatment (MMT) through recommendations of providing greater access to individuals afflicted with opioid use disorder, increasing funding for MMT, and decreasing stigma through public education (Joseph & Woods, 2018). In the 1990s, buprenorphine was introduced as an alternative to methadone, and in the early 2000s, physicians were permitted to prescribe it out of their offices (Hatcher, Mendoza, & Hansen, 2018; Veilleux et al., 2010; Woods & Joseph, 2018). Individuals that are compliant with buprenorphine/naloxone medication regimens are more likely to remain abstinent than those that are not compliant; in addition, abstinence rates increase over time with compliance (Blum et al., 2018). Discontinuing buprenorphine/naloxone can lead relapse rates greater than 50% and can occur within one

month of discontinuance (Bentzley, et al., 2015). The high risk for relapse makes long-term, even indefinite, medication seem like a viable strategy to treat opiate use disorder to both physicians and their patients. When used therapeutically, methadone has no significant impact on daily functioning, including the ability to work and drive (Gordon & Appel, 1995; Woods & Joseph, 2015). However, there are reported differences by patients among the specific types of medication-assisted treatment (e.g. methadone and buprenorphine/naloxone), due to their pharmacodynamics (i.e., full agonist vs partial agonist respectively), and how they affect their quality of life (Bishop, Gilmour, & Deering, 2019). Quality of life indicators suggest that users of buprenorphine/naloxone (e.g., Suboxone) have higher sensitivity toward emotions, improved cognitive performance, and increased motivation.

Exploration of MAT experiences

A qualitative study explored the metaphors that recovering individuals prescribed methadone use to describe their experiences with challenges during recovery (Redden, Tracy, & Shafer, 2013). Participants (n = 68) ranging in ages from 22 to 82 years of age were interviewed in focus groups (5 – 15 participants) to answer questions regarding their recovery. Questions included: “What is the best and worst thing about taking MAT,” “Who do you turn for support in managing your health & recovery from substance abuse,” and “What do your friends and family say about using medication to manage substance abuse?” Participants used metaphors like “being in the closet” to describe hiding their addiction from others, and having “money in my pocket” to describe the benefits of MAT. When discussing recovery and MAT, participants used language such as MAT being like a “security blanket” to describe MAT as lifesaving and a safety net.

They also discussed how others view their utilization of MAT as a “crutch.” The authors also reported how participants had difficulty with defining MAT as either a “medication” or “drug.” The metaphors used to describe maintaining recovery consisted of using “armor” to “battle” their challenges and using “defenses” to remain sober. However, there was also the metaphor of “liquid handcuffs” to describe how their daily schedule revolves around their medication regimen.

Notley et al. (2015) interviewed 27 participants in rural UK that were treatment compliant with methadone maintenance for at least 5 years as part of a grounded theory study. Participants reported stability from illicit drug use and criminal activity to fund their drug use. Participants also reported how over time, they became more reliant on MAT and saw it less of a safety net when they could not obtain heroin. In addition, the authors reported how participants normalized their methadone prescription and perceived it as any other medication, along with seeing their prescription as part of their identity. The authors were also able to group participants into two groups, one “identifying drug user,” and “chronically ill” due to half of the sample suffering from chronic pain and ill health. Participants that fell in the “chronically ill” group had less difficulty perceiving themselves as “recovered” compared to the other group. Within social barriers, aspects of unemployment and lack of quality housing put them at risk for relapse. The authors reported how some participants had difficulty separating their past drug use from their self-identity.

Lindgren et al. (2015) interviewed 11 participants from Sweden who were prescribed MAT for at least 3 years. Their sample consisted of five women and six men that had opiate dependency ranging from 8 - 25 years. The themes the authors touched

upon included “from resistance to existence,” “seizing the chance of a life with dignity,” “struggling with hidden challenges,” and “feeling freed from the past.” The authors explained that the themes were a non-linear process that participants navigated. Under “seizing the chance of a life with dignity,” participants discussed how MAT allowed them to get away from opioid dependency. However, they also had to deal with the regrets and losses they suffered through their opioid dependency. Along with MAT came the blunting of emotions. Participants reported feeling more stable, being able to manage their life, and being able to work, which not only raised their self-esteem but also made them feel like life was worth living. Participants then had to deal with challenges, such as the lack of support from their treatment program, which included the inability to process their trauma. In addition, participants reported the struggle of living with a “double stigma,” due to their past opioid dependency and their current prescription to MAT, which would lead them to hiding it from society, including friends and family.

Participants also reported the perception of risk of relapse because of how medication distribution was open in their treatment program. This would lead participants to compare their medication regimen to others, which was perceived as negative and risky behavior. Finally, participants described how their perception about their opioid dependency changed by viewing it as a disease that they will have to battle for the rest of their lives. They viewed their recovery as a process made possible through MAT, where they are able to function and feel normal through the acquisition of new social networks, employment, and housing. They also discussed how making amends to the people in their lives was an important part of their recovery process as they sought to re-establish these relationships.

From January 2005 to September 2016, about 80% of the population that entered opioid treatment programs identified as White (Pouget, Fong, & Roseblum, 2018). Hatcher et al. (2018) examined racial/ethnic differences in perceived stigma among patients receiving buprenorphine in different treatment settings. The authors found that those receiving treatment in outpatient substance dependent clinics were more likely to be Latino/a than White. Buprenorphine treatment centers were more likely to be found in higher proportion White and higher income neighborhoods than otherwise (Hansen et al., 2016).

Those seeking alternatives to pharmaceutical treatment can attempt to seek treatment from a mental health professional that can provide different modalities, including cognitive-behavioral and mindfulness-based therapies (Romo et al., 2018). This option may not be available for all, depending on availability of mental health professionals within their community, lack of access due to inadequate insurance coverage, and/or ability to pay. Other non-traditional approaches also include acupuncture (Wu, Leung, & Yew, 2016). In addition, individuals prescribed MAT may decide to supplement their current treatment with evidence-based interventions. However, Amato et al. (2011) conducted a review of literature on outcomes of MAT with structured-psychosocial interventions versus MAT alone (programs offer counseling) and found that adding specific interventions to MAT did not provide any significant benefits to outcomes.

Social Identity Theory

Social Identity Theory (Tajfel & Turner, 1979) and Self-Categorization Theory (Turner et al., 1987) are important to look at when exploring how individuals utilizing

MAT interact and how they perceive themselves when living in an OH. Social Identity Theory posits that individuals identify discrete groups, choose the group(s) they believe they belong to, and make positive evaluations that distinguish their in-group from out-groups. Categorization has demonstrated to show much more significant difference in discrimination than similarity alone (Billig & Tajfel, 1973). In other words, individuals that are explicitly categorized into a group without similarities are more likely to discriminate others that are not categorized into a group but share similarities.

Considering this, one would believe that those that identify themselves as being in recovery would show favoritism towards each other. However, individuals who are prescribed MAT face barriers when processing their perceived identity (Doukas, 2011). In fact, they might face opposition from in-group members, as they are not perceived as being in recovery (Buckingham, Frings, & Albery, 2013). If individuals feel that the group they perceived they belong to no longer contributes positively toward their social identity, then they are likely to leave that group (Tajfel, 1972). This happens when individuals that are prescribed MAT are not allowed to fully participate in Narcotics Anonymous (NA) or Alcoholics Anonymous (AA); instead, they leave and join and/or form a Methadone Anonymous group (Ginter, 2012). The perception of social-connectedness within a group facilitates recovery as individuals change their identity from “addicts” to “in recovery” (Buckingham, Frings, & Albery, 2013).

Defining Recovery

There are different definitions of recovery among individuals that are in recovery from substance use. Definitions can be based on what clinicians observe or what affected individuals report about their experiences (Best et al., 2016). Over the past decades,

researchers have used different terminology to describe the various stages of abstinence including recovered, in recovery, and recovering (Doukas & Cullen, 2009). Studies have looked into differentiating different types of people in recovery based on self-reported definitions of recovery (Witbrodt, Kaskutas, & Grella, 2015). Researchers found that almost all of the participants agreed, “Recovery is a continuous process that never ends” and “being able to enjoy life without alcohol or drugs like I used to” (Kaskutas et al., 2014). In addition, individuals can choose abstinence without using the label of recovery or even dropping the label after previously adopting it (Kelly et al., 2018). However, research demonstrates that individuals keep their definition early on in the process (Kaskutas, Witbrodt, & Grella, 2015). Therefore, these individuals still believe in the same definition of recovery, but do not perceive themselves to fit within that definition despite being abstinent.

Stigma

Individuals who are prescribed medication-assisted treatment often face stigma from family, friends, and healthcare workers (Earnshaw, Smith, & Copenhaver, 2013). Not only are they stigmatized from their past use, but also perceive that others view their utilization of medication-assisted treatment is considered substituting one drug for another, despite the medical utility and pharmacology properties behind methadone and buprenorphine/naloxone (Woods & Joseph, 2018). Despite MAT studies demonstrating significant increases in functioning, individuals who are prescribed medication-assisted treatment perceive social rejection and prejudice such as being stereotyped as untrustworthy and denied certain responsibilities, including handling money (Earnshaw, Smith, & Copenhaver, 2013; Woods & Joseph, 2018). Those receiving MAT perceive

employment as a major factor of a good quality of life (Maeyer et al., 2011). Coviello et al. (2009) investigated the effectiveness of an intervention aimed at increasing employment outcomes for individuals prescribed MAT and compared it to those just receiving drug counseling. Results demonstrated that both groups did not differ significantly in employment rates or barriers. At 6-month follow up, 59% of the total sample reported employment. However, both groups perceived daily MAT as a barrier to work at baseline (82% v 60%). The authors found that participants' perceived barrier of inability to pay for MAT was related to whether they were employed or not at 6-month follow up. However, those receiving MAT perceive disclosure of MAT and/or being in recovery as a perceived barrier toward employment (Van Hout & Bingham, 2014).

Social rejection is not only perceived with family and friends but also with those within parts of the recovery community. Individuals prescribed MAT report perceived stigma within recovery communities, such as some 12-step programs. Individuals have reported perceived stigma due to a reduction of participation and restrained disclosure of their medication regimen from some groups (White et al., 2013; Woods & Joseph, 2015). 12-step programs such as AA and NA allow individuals who are prescribed MAT to attend meetings, and groups have shown openness and support to them (Narcotics Anonymous, 2016). However, some AA/NA groups admonish discussion of MAT or the sponsoring of members. These experiences have been pervasive enough to justify the creation of a Methadone Anonymous, a separate 12-step program that caters to those utilizing MAT (Ginter, 2012). Buprenorphine is perceived to be less stigmatizing than methadone and in many cases preferred by those in treatment (Bishop et al., 2019; Hatcher et al., 2018). Some individuals that self-identify as being in recovery report

negative views on the utilization of methadone and disregard its utility in the recovery process (Senker & Green, 2016). Studies have explored the concept of recovery through the perspective of MAT clients (Notley et al., 2015). However, these studies did not examine how living in a recovery home affected their perception of recovery.

Some of these negative perceptions stem from individuals having difficulty discontinuing substance use while prescribed MAT and/or diverting their medication. Individuals prescribed MAT could benefit from support systems that understand the stigma they face and have similar experiences. If they are perceiving stigma from friends and family they live with, recovery-based housing may be a better alternative for housing among those prescribed MAT.

Oxford House

OHs are democratically run recovery homes that prohibit the use of substances including alcohol while residing as a tenant (Jason et al., 2006). The exemption to this rule is the legitimate use of controlled substances for psychological/physical illness. Due to federal regulations, OHs are prohibited from discriminating against persons with medical illnesses. Every OH is different. There could be houses that do not vote in individuals prescribed MAT because of negative perceptions toward MAT. Each house may have different rules regarding how they may go about handling controlled substances being present in the house, including securing medication in locked cabinets. OH is an empowering setting (Maton, 2008). It also has shown to improve successful remission after residing for at least 6 months (Jason et al., 2007). Qualitative studies that used both interpretative phenomenological analysis and grounded theory reported how residents benefited from OH, which included the forming of bonds in the house that led

to increased length of stay, as well as development of skills and feeling a sense of community (Alvarez et al., 2009; Chavira & Jason, 2021)

Studies have demonstrated that abstinence from illicit substances leads to better treatment retention rates within MAT clients (White et al., 2014). OH could help facilitate engagement in treatment due to the nature of maintaining abstinence to reside in the house. However, the introduction of individuals prescribed MAT into OH is contentious. Prospective residents require an 80% vote majority to before being able to move in. OH residents hold different beliefs and not all houses might be welcoming to those utilizing methadone or buprenorphine/naloxone. Recent studies on attitudes of MAT in OH demonstrate some negative attitudes toward individuals prescribed MAT, even among those currently prescribed MAT (Majer et al., 2018). Another study by Majer et al., found that OH residents' attitudes were more favorable toward individuals prescribed MAT when living with them (Majer et al., 2020a). OHs have been found to assist individuals prescribed MAT develop social support networks, which increases abstinence self-efficacy (Majer et al., 2020b). Lastly, studies have looked at how OH improves recovery outcomes for those prescribed MAT when they live with at least another person prescribed MAT (Majer, Bobak, & Jason, 2021). Currently, the literature lacks any studies detailing how individuals prescribed MAT gain OH residency despite the negative attitudes toward them.

Rationale

The purpose of this study was to explore how residents in OH, who are prescribed MAT, make sense of recovery. Several qualitative studies have examined the recovery experiences of individuals prescribed MAT, including within treatment

facilities. However, the literature currently lacks any qualitative studies exploring the recovery process of individuals prescribed MAT while living in recovery housing.

Exploring their transition into OH, their current residence, and interactions with other residents would also add to the current literature on how different recovery communities assist and/or serve as barriers to the recovery of individuals prescribed MAT. This study also provides narratives of residents prescribed MAT to the OH community itself. This study addressed these gaps in the literature and focused on the following research questions. 1) How do individuals that are currently prescribed MAT in OH define recovery? 2) What are their experiences living in an OH? 3) What are their experiences with their in-groups and out-groups? And, 4) How does OH affect their recovery?

Secondary research questions will explore the following: How they transitioned into OH and what their current needs are within OH.

Method

Study Design

IPA

Interpretative phenomenological analyses was used to document the lived experiences of individuals prescribed MAT in recovery settings, (IPA; Smith, Flowers, & Larkin, 2009). IPA is widely acknowledged as a useful analytic approach for qualitative studies in psychology, education, and health. This study did not seek to confirm nor refute any hypotheses (Smith, 2004); instead, it sought to compare and add to the current literature that examined the lived experiences of individuals prescribed MAT outside of recovery settings and in 12-step programs in the context of OH.

Participants

Individuals who identified as men or women, who were prescribed MAT, and were living in an OH were approached to be part of this study. Participants were selected through convenience and purposive sampling in order to foster recruitment of men and women of diverse backgrounds in terms of race/ethnicity. Inclusion criteria for the study required participants to be men or women between the ages of 18 and 65, speak English, currently live in an OH, and have a current prescription for MAT (either methadone or buprenorphine/naloxone) that was active prior to OH residency. English-speaking criteria was necessary due to the entire research team not being fluent in Spanish or any other language. A minimum length of stay was necessary to saturate data on relationships with other OH residents. Therefore, only participants that have stayed in their current OH for a minimum of 60 days were considered for this study. The inclusion criteria kept the focus on MAT residents in OH while not being restrictive enough to hamper recruitment efforts.

Exclusion criteria included a prescription to Naltrexone, both currently and before entering OH. Naltrexone is considered a full antagonist and as such, does not have the chemical properties that produce the euphoric effects of opioids. In addition, participants were excluded from the study if they currently resided in an OH with all MAT residents. Participants that live with solely MAT residents would have significantly different experiences from those that lived in a mixed house. It would have added complexity to the study that would have been difficult to thoroughly analyze given the targeted sample size.

Several strategies were used to recruit participants. An OH official from Maryland attempted to assist with recruitment, and unfortunately there were no individuals that declared interest from that state. A former research staff member also assisted with recruitment efforts. She was a former OH resident, instructs OH residents how to administer Narcan for the state of Texas, and disseminates information about MAT to the recovery community. She provided information about the study to chapters in Texas and Washington including its purpose, the approximate interview length, compensation, and contact information for those that are interested in participating. Potential participants were screened to ensure they met the inclusion criteria. The screening process noted the potential participant's name, age, race/ethnicity, English fluency, city of residence, OH residence, MAT prescription, and their contact information.

There are no official benchmarks for appropriate samples sizes in IPA; however, Smith and colleagues (2009) have cited IPA studies ranging in sample sizes of 3-10 individuals (Smith, 2004). Additionally, Smith (2004) suggests that small samples are necessary to conduct a nuanced and detailed study. Furthermore, previous IPA doctoral studies of OH have used 10 participants (see Chavira & Jason, 2021). Given the aforementioned recommendations and studies, a sample of 8 participants was found sufficient. The similarities and differences within the sample can be analyzed when the sample is as similar as possible through factors relevant to the study (Smith et al., 2009). Efforts were made to recruit gender evenly, in total 5 women and 3 men prescribed Suboxone or methadone were recruited.

The participants of the study were informed of my research/academic background and current credentials, along with my rationale for the study. They were informed about

what I currently know about the sample and how any possible bias will be mitigated through extensive analyses and careful note taking. Additionally, participants were informed about the approximate length of the interviews which was targeted between 60 and 90 minutes. Interviews ended up ranging between 64 and 77 minutes. Participants provided informed consent before any data collection. Participants were compensated with a 25 USD gift card from Amazon for their participation.

Materials

For the purposes of this study, participants were interviewed once. An interview guide was used to conduct the interviews with the participants. The interview guide collected data on four topics which included their recovery process, their transition to OH, their experience living in an OH, and their interactions outside of OH. This guide allowed the interviews to have some flexibility and capture data that otherwise would not be accounted for when restricted by the scope of the interviewer. In other words, the interviewer allowed the participant to naturally guide the interview process while also accounting for the topics of interest by gently guiding the interview to those topics when appropriate (e.g., the participants starts talking about how they think others perceive them and guide them toward how they believe OH residents perceive them). Some of the questions within the guide were informed through theory of social identity and consultation with members of the MAT and recovery community. For instance, there were questions about how the participants define recovery, how they have heard others define recovery, and if that impacts their views and/or recovery process. A draft of the interview guide was presented to a member of the MAT community for consultation purposes. This community member consulted with the author to help formulate questions

that helped capture relevant data and removed questions that did not help with the interview process. The community member agreed with all of the questions, especially those regarding the recovery journey (e.g., when did recovery start, where would they like to be). The interview guide was further refined during a team meeting. Feedback from several research assistants was incorporated into the interview guide before starting the process of conducting pilot tests of interview guide. The interview guide was first pilot tested with research assistants to measure length of interview and to get a feel for the interview process. Test pilots were with a research assistant with a dissimilar background to the desired sample. The pilot test consisted of getting a feel for the interview guide, as well as refining questions. Based on this pilot, questions were rephrased and transitions were added to the protocol. The guide was then pilot tested with two individuals with similar backgrounds to the desired sample. Additional edits were made to the interview guide based on their suggestions. These edits include changing the wording of the questions to make them more neutral, sensitive, and casual to facilitate a natural conversation and less of an interrogation/academic study that might make participants uncomfortable.

Procedure

All interviews were conducted during the unanticipated COVID-19 pandemic from April 2020 through June 2020 via Zoom (telecommunications software). Participants were given dial-in numbers and passwords to protect their identity. Waiting rooms were enabled in the software so only the participant could be allowed to enter the meeting, and restrict unauthorized guests from joining (e.g., “Zoom bombing”). Additionally, video was disabled and participant name was never mentioned during the

recorded interview. Recordings were saved locally and online storage was disabled to reduce possibility of a confidentiality breach. Recordings were monitored and played back after the session to ensure data was captured successfully. In order to facilitate confidentiality and openness, the participant and I were the only individuals present for the interviews. Some time prior to the interview was spent disclosing information about myself and “warming up” the participants through some “ice breakers.” The participants were also informed that the questions were purposely “broad” in order to not bias them in a certain direction with their answers. Each interview was planned to last between 60 and 90 minutes, with a margin of error of 10 minutes per participant. The digital files were immediately stored onto a password protected computer to prevent any data loss and then transferred to secure campus servers for research team members to access. Field notes were made during and after the interviews. The notes during the interview were brief and served as cues to write more in-depth notes afterward.

The research team had access to the audio files that were stored on secure University servers (e.g. DePaul’s W: Drive). All audio files were transcribed into word documents. Those documents were password protected and de-identified with a participant ID number. Access was limited to only research team members by providing members with the password for the documents. Research team members carried out proper transcription through quality assurance (QA) checks. QA checks consisted of listening to the audio for correct transcription, which included correct spelling and transcription of word repetitions. Edits were made through track changes with time stamps in Microsoft Word comments so the research team could verify these changes. In addition, research team members checked instances of inaudible portions that were listed

in the transcripts to verify if other team members could deduce what was said by participants.

Analytical Approach

The analysis followed recommendations on conducting IPA analysis from Smith, Flowers, and Larkin (2009). The authors reported that the literature does not have a single prescribed method of conducting the analyses. What is important is that the focus remain on the participants attempting to make sense of their lived experiences. The analytic process that the authors described involved the participant and the analyst making sense of the experience together. This study had three data coders including myself. In order to make the process more streamlined and simple, emergent themes were analyzed separately and then team members documented emergent themes on a secured shared document. The first step of analyses involved the research team familiarizing themselves with the data (e.g. audio recordings and transcripts) through repeated exposure (e.g. re-reading). The research team listened to the audio recordings at least one-time to familiarize themselves with how the interview flowed, how rapport was built, and became familiar with how the participant talked (e.g., tone, pitch, speech rate, and moments of silence). The process of reading the transcripts repeatedly prevented the research team from trying to rush and summarize the large amount of data collected. In addition, the research team wrote their initial notes on word documents. The initial noting assisted the research team with focusing on the participant without the fear of losing any questions, comments, or ideas through the reading.

The second step was the initial noting and was done in tandem with the re-reading. However, initial noting is more than just writing down whatever comes to mind.

Analysts are not required to follow a prescribed set of rules when conducting initial notes. As Smith, Flowers, and Larkin (2009) state, “[the] aim is to produce a comprehensive and detailed set of notes and comments on the data” (p. 83). In order to achieve this aim, the research team maintained an open mind and note anything of interest. Analyzing the transcript with distinct sets of notes assisted the research team to conduct a comprehensive analysis that prevented a biased analysis of the transcripts.

The first set of comments the research team noted were descriptive comments, which focused on describing the context of what the participant says in the transcript. Specifically, this step involved examining the participant’s experiences for important relationships they have with things/people/places/events within the transcript. The next set of comments the research team noted were linguistic comments, which focused on exploring the specific use of language by the participant. Specifically, the research team examined how content presented throughout the transcript involving the use of, but not limited to, pronouns, pauses, laughter, repetition, tone, fluency, and metaphors. Lastly, the research team noted conceptual comments, which focused on engaging at a more interrogative and conceptual level. The research team noted conceptual comments as questions during the early stage of the reading when the team was still learning about the participant. As the research team became more familiar with the participant, the research team followed up on the conceptual comment and interpreted the participant’s experiences through their own experiences and knowledge of relevant literature. The research team checked in with their self to ensure that they remain focused on the participant’s experiences and not their own. Team members convened weekly to come to a consensus about superordinate themes and check any biases.

Descriptive comments were noted in normal text in the word document.

Linguistic comments were noted in all capital text. Conceptual comments were noted in underlined text. Having all of the comments on the same transcript assisted the research team with making connections between all of the different comments, which provided a much richer and complex analysis.

The third step involved developing emergent themes. This step involved finding connections and patterns in discrete chunks of text using the initial notes. In other words, the research team looked at the descriptive, linguistic, and conceptual comments at the same time while they were reduced it into meaningful phrases. The themes were a concise statement, such as a phrase, of what was important in the various comments attached to the chunk of text. The emergent themes reflected the participant's original words and thoughts as well as the research team's interpretation. The research team had weekly meetings to review emergent themes each member develops through their readings of the transcripts. During the meetings, research team members came to an agreement on the labels for each emergent theme in case similar themes overlap between research members. This allowed the analysis to be parsimonious.

The fourth step involved searching for connections across emergent themes. Specifically, this step involved examining how the themes fit together. Emergent themes were not used if they did not fit within the scope of the overall research questions. The research team used different methods suggested by Smith, Flowers, and Larkin (2009) of finding connections between themes, including the following:

- Explored spatial representations of how emergent themes relate to each other within a spectrum.

- Developed “super-ordinate” themes through the identification of patterns between emergent themes.
- Gave emergent themes a super-ordinate status when they are found to bring together a series of related themes.
- Took account of the frequency a theme is presented within the transcript.

The fifth step involved moving to the next participant and repeating the previous four steps. By analyzing each participant one by one instead of altogether, the research team focused on finding new emergent themes. The final step involved looking for patterns across participants. The research team examined patterns across all participants by visually examining all of the super-ordinate themes each participant has and finding similarities between them. Matrices with participant superordinate themes were created to find similarities across all participants. Once similarities were found, team members sought relevant quotes that best illustrated the theme. The super-ordinate themes that the research team agreed to be of most importance were shared. Quotes were de-identified with randomly generated pseudonyms and demographic data is included to make comparisons. The themes are organized and presented by how they address the research questions. In addition, unique differences that most participants did not share are also presented.

Research Team

I conducted all interviews as part of the process for successful candidacy towards dissertation defense. The research team for this study consisted of two post-baccalaureate research assistants and myself. They have taken a research methods course and have some qualitative research experience through OH projects and other through other

research labs. The two research assistants worked under my supervision. Unfortunately, one research assistant had to take a leave of absence during the final stages of coding. I prevented as much bias as possible from influencing my observations and interpretations through consultation with my team and research colleagues within the Center for Community Research that were familiar with this population. In addition, the team kept notes on their thoughts and feelings when reading and coding the interviews. These notes were discussed during weekly team meetings as a means to ensure proper analysis (i.e., going over terminology used by participants and making sure the focus is on the participant).

Consultation

I consulted with Dr. John Majer about working with this specific sample; he has experience conducting studies with this population and obtained contact information of a community member willing to provide consultation and guidance in the development of the interview guide. Dr. John Majer is a Professor of Psychology at Harry S. Truman College, and has examined attitudes toward individuals prescribed MAT with OH residents and published several quantitative articles on OH. He has over 13 years of experience working with individuals afflicted with substance use disorders, and has co-written a grant focused on participation action research. In addition, he is affiliated with the OH research team at the Center for Community Research, has attended OH conventions, where individuals affiliated with OH meet to share experiences as well as get the opportunity to hear from professionals in the field of substance use and recovery.

Reflexivity

I am a sixth-year graduate student in the clinical-community PhD program at DePaul University. As part of my graduate research experience, I was exposed to OH data and projects throughout my graduate tenure at DePaul. I familiarized myself with the way houses operate and their related outcomes through working on OH projects. In addition, I was exposed to viewpoints from current and former OH members that served as research staff on an OH research project in which I was involved. The interactions with these members were pleasant. While OH uses an abstinence-based model toward recovery, I did not have a preference toward abstinence or harm-reduction. I believed that each individual should use the method that they believe works best for themselves, as they are the expert of their own lives and experiences. My experience with individuals who have tried either method, as well as friends that report on the current state of opioid use and recovery shaped this view. Based on the literature and my conversations with people that are in recovery from opioid abuse, I believed that the process of recovery is extremely difficult and complete abstinence is not feasible for everyone, at the very least not in the short-term. My definition of recovery included MAT, such as methadone or buprenorphine/naloxone, which are used to therapeutically assist with functioning and reduce cravings associated with withdrawal. I believed that the OH residents that live with MAT residents are open to having them in their community since new residents require an 80% approval from current house residents to gain entrance. However, I did not have any hypotheses about how MAT residents might be treated within OH settings.

Mary Abo

I am currently a volunteer research assistant at DePaul's Center for Community Research. For the last ten months, I have been exposed to various datasets, literature pieces, and ongoing projects that are centered around better understanding the experiences of those living in OH. Being involved in this lab has given me the opportunity to learn more about individuals recovering from Substance Use Disorder (SUD) in a democratic and communal setting. During this period of exploration, I have not had direct contact with any of the participants. From what I have learned, recovery looks different for everyone. Aside from the physical symptoms, recovery can be challenging on a social and financial level. For these reasons, I will refrain from defining recovery in order to respect the differences that each recovering individual brings forth during the study. I currently have little knowledge and experience with MAT and did not have any hypotheses as to how individuals on MAT would be treated.

Mackenzie Hudson

I completed my first year in the Master of Science in psychology program at DePaul University. I was interested in a variety of community psychology research topics, and as part of my graduate work, I connected with Dr. Jason and the Oxford House research project several months ago. Before learning about Oxford Houses through my involvement with Dr. Jason's team, my main source of knowledge regarding opioid use and medication-assisted treatments stemmed from reading books, news articles, and relevant literature about the American opioid crisis. I am interested in both traditional abstinence-based addiction treatment modalities, such as OH and NA, as well as more harm-reduction approaches, including needle exchanges and safe injection sites.

I believe that both methods (abstinence or harm reduction), or combinations of both methods, is appropriate for an individual definition of recovery and that both methods can better inform public health treatments of addiction. I believe that individuals attempting to stop or reduce their use of opioids should be provided with a variety of options, including MAT, if these treatments fit the individual's personal recovery goals. I also acknowledge the value of traditional abstinence-based approaches, especially the peer support, connection, and goal-orientation provided by abstinence groups. I was unsure how MAT might affect individuals in Oxford House, although I would have thought the combination of MAT use and OH peer support would prove effective at preventing relapse in these individuals.

Results

The aim of this study was to explore the lived experiences of individuals in OH who utilize MAT, specifically methadone and Suboxone. Participants elaborated on their road to recovery, transition into OH, experience with roommates, and life outside of OH. Four general themes emerged from the data: Recovery Process (1.0), Managing Logistics of MAT Utilization (2.0), Personal Development (3.0), and Familial Values (4.0). The subtheme Validation of Recovery Identity (1.1) fell under Recovery Process, while Navigating Counterspaces (2.1) and Implicit and Explicit Disclosure (2.2) fell under Managing Logistics of MAT Utilization. In regards to how individuals prescribed MAT in OH define recovery, participants factored their history of recovery and identification with 12-step programs. Their perceptions of MAT were influenced by their experiences in and out of OH.

Research Question 1

Recovery Process (1.0)

Five participants endorsed 12-step ideology as part of their definition of recovery, ranging from giving back to others, to “taking back power” from substances. Participants discussed executing specific steps of 12-step ideology as a big part of their recovery, despite not completely agreeing with 12-step views. Noah expressed how he liked 12-step programs and used their framework to give his recovery structure:

Noah: I guess what I would say is I define recovery... because I do like 12 step programs. I disagree with a lot of their stuff, but I agree with a lot too... So what I believe, being in recovery is getting your life back to being manageable and taking that power back from whatever you know whether it was alcohol or substance, and taking that power back in your life.

Noah used specific tenets of 12-step that resonated with him in order to stay on the path of recovery. Many participants viewed recovery as a unique possession, where one has to tailor their sobriety to their own needs, rather than adhering to the “one size fits all” ideology. They all endorsed MAT as a recovery tool and thus fitting into the definition of recovery. There was not universal agreement on acceptance of methadone among the participants.

In contrast, two participants described recovery as a period of self-discovery and renewal of identity. Patrick expressed that recovery is about finding your true self and being genuine. Helen’s focus of recovery was shedding her prior persona and striving to

become a “better person” that differed from an identity of being self-centered and unproductive to society.

Helen: ...I think that recovery is working on yourself to become a better person... having a place that is productive in society or you're doing things for other people and um versus the life of addiction where it's all self-centered on just taking care of yourself in that moment.

OH promoted productivity by placing residents in various roles to assist in house operations throughout their residency. Additionally, OH expected residents to keep up with chores and maintain employment to pay rent. Patrick noted discovering his true self without the aid of substances to alter his emotions. Participants highlighted the importance of stability and safety in their recovery definition, as well as going beyond physical dependence and choosing not to use substances.

When prompted, all participants stated that MAT was part of recovery. However, their endorsement of MAT varied in intensity. Patrick stated that MAT has its merits, however questioned how long one can be prescribed MAT and still be in recovery.

Patrick: ...I do recognize that it does have like some psychological effects, and probably psychological, physiological effects. Ideally to not require it. I mean despite, I don't know, I still see it as maybe not as blunt as some addictions, but I still see it as a dependence. I mean, I'm all for harm reduction but... it's still being reliant on something.

Intent is what separates substance use and recovery for Patrick. While one could technically abuse MAT, the intent was to use it as a tool to help them stay in recovery.

Participants expressed their rationale for choosing their current prescription for MAT, which included effectiveness of combating cravings, ease of access, and treatment of chronic pain. Additionally, five participants endorsed a history of using Suboxone to detox/taper before using it as long-term MAT.

Noah: ...I had experience with Suboxone when I was a lot younger. I used it to get high, but if you know anything about opiates once you have a massive opiate tolerance Suboxone will not get you high. It will only get people who shouldn't be taking it high ...but I used Suboxone for tapers [decrementing the dosage] and stuff like that but it was pretty much it was always like a negative.

Noah described his first experience with Suboxone, which he did not find helpful in his road to recovery. His prior experiences were negative because he was not able to successfully taper off Suboxone. It was not until he faced the possibility of losing his family that Noah decided to try a maintenance route with Suboxone, until he transitioned to methadone. Similarly, Scott and Amber used Suboxone to detox until a friend suggested using Suboxone or methadone as maintenance while in OH. These were revelations for participants as they heard negative things about methadone and their perception that OH did not allow MAT.

One's stage of recovery included how long they had been prescribed their medication, where they wanted to see themselves in the future, and discussions they had with their physician about managing their dosage. Two participants discussed how their

physician prescribing their MAT has a significant role in helping them make an informed decision. In addition, three participants discussed the need for stability in their life before tapering off Suboxone.

Angela: For right now I just want to keep taking it until... I got a strong recovery base if you know what I mean... a foundation cause once you get off Suboxone that one little safety net you had there is gone. And that scares me so I don't want that to go away.

Angela later described a strong recovery base as maintaining a good job, which they endorsed having, and a stable environment which means living outside of OH with her children for a bit of time. Living in OH while tapering is not enough for participants as they want to make sure they build a foundation first that will keep them from relapsing once they live independently.

Two participants expressed that MAT belongs in recovery as long as individuals adhere to their prescription. Other participants added that MAT is a tool that needs to be supplemented with activity in the community, whether through 12-step meetings and/or other support groups, to process recovery. Angela considered MAT utilization as recovery as long as it keeps individuals from getting high.

Angela: Yes, definitely because if you still feel that you need to take Suboxone every day. You know what I mean, to maintain not getting high, then yeah you're still in recovery.

Research Question 2

Validation of Recovery Identity (1.1)

Reflecting on their experiences within OH, five participants, who were either prescribed methadone or Suboxone, shared that their roommates did not express negative views of MAT. One participant shared that their current roommates do not express negative views, however they experienced stigma from past OH roommates in different houses. Despite this, roommates did not explicitly, or to the knowledge of participants, treat them negatively because of their MAT status. Participants felt comfortable in the home and did not feel pressured to change or stop their MAT. Patrick shared that he did not feel his prescription for MAT had any effect with how his roommates treated him.

Patrick: No, I do not feel like the fact that I take Suboxone that it in any way influences my involvement in the house. I do not feel delegitimized whatsoever because of it.

Throughout his interview, Patrick did not express any concerns regarding how his prescription for MAT affected him in his OH. He shared how his experiences felt like anybody else's would be when living with roommates. Similarly, participants Leah, Angela, Noah, and Grace did not experience stigma from their roommates regarding their MAT status. When asked if she would feel different living in a house with exclusively MAT residents, Grace expressed, "It's not really an issue at all. It's like taking a vitamin. It's just another extra layer of recovery for me that's part of my program."

Managing Logistics of MAT Utilization (2.0)

Managing the logistics surrounding adherence and administration of MAT can be complicated when living in recovery housing with zero tolerance for relapse. As was mentioned earlier, participants had friends that lived in OH which helped them take a step toward applying to housing. However, participants also shared negative experiences when they had previously applied for housing, and were either denied or told they would have to detox before living there.

Patrick: Back then Oxford as a whole, their policy was fairly primitive when it came to medications and specifically like MAT and MAR, so I was on Suboxone then. They had told me that I had to be off of it within 30 days. Which I had agreed to despite knowing that was not pragmatic whatsoever...

Patrick described how as he was transitioning out of rehab, he had to detox himself off Suboxone in order to secure housing. Participants described at some point, whether through their own volition or because of mandates from institutions (e.g., jail or treatment programs), how self-detoxing was not successful for them. In this case, taking a risk with self-detoxing is seen as acceptable when faced with the prospect of being homeless.

Participants had to follow strict guidelines regarding their adherence to medication. OH residents that are prescribed controlled substances including MAT, undergo regular pill counts. Five participants discussed how their house conducts a pill count to make sure residents are taking medication as prescribed. As one participant shared, these counts are for accountability and for the safety of residents.

Leah: Just because the number one priority is our sobriety and having this be a safe place for your sobriety and making sure that I don't put any of the other girls at risk for a relapse... making sure that the safe place for me to not relapse as well. Because it's about everyone's sobriety, not just one of us.

When participants discuss safety, they refer to safety from relapse that can result in eviction from OH. Three MAT prescribed residents initially felt the pill counts were unnecessary or too strict. One participant initially thought the pill check protocol was unfair and expressed annoyance with it. However, after spending more time in the house, she shared an evolving understanding and appreciation of its benefit.

Angela: At first I rebelled, and I think that's a normal reaction. Whenever someone tries to tell you how you're supposed to live when you're 37 years old, it's a little difficult, but once you figure out that it's all for the good of the house then it's pretty easy.

Another participant described their treatment when a pill count was off.

Grace: ...I had somehow missed taking one of my Suboxone, and so when I went to the med count I realized that I had one extra, and it was dealt with rather harshly, which I wasn't expecting... I was met with eight other girls who are shaking their heads like no, this is not okay. I was really upset. At one point I considered leaving, but once I was able to calm down and look at the bigger picture and have the girls explain exactly why these rules are set in place, I was able to look at it from a different perspective and be okay with it...

Grace's treatment initially caused her to consider leaving OH all together. Only when other residents helped explain the purpose of the pill check and how this intervention is designed to ensure resident safety did Grace view this as a positive aspect of the community.

In addition to pill counts, participants also have to manage their medication when they are outside OH. One participant described how they painstakingly make sure they have their medication whenever they have to go on trips. Failure to accurately anticipate the amount of time away from home and the amount of medication needed can have negative effects on their health as well as jeopardize being in the house.

Helen: ...as long as I have steady medication coming in and I take it how I'm supposed to, then I function like a normal person, but if anything is to derail that then I'm sick, I'm down, um it takes a long time for me to recover. If I go to my boyfriend's house and I forget my Suboxone we have to go back to my house. There's no in-between. I can't just be like oh I'll get it later... The first thing I need to do is have all my meds in line... So, for an extended period of time if I'm going to be gone more than 12 hours then I need to do some sort of planning.

Medication is one of the most important things Helen has to have sorted out in her daily life. She has to be consistent with her medication regimen. She further illustrated the importance of steady medication shortly after. She has to take into consideration the effects that the medication has on her body and the risks that come with it if she is not mindful.

Helen: ...traveling with my medication um the pill counts are scary because it has such a long half-life so it's easy to forget a dose, and then have a pill count off because you don't feel it right away. Um, so there is something that makes the program a little bit scarier you know, that your housing can be ripped out underneath you if it's off at any point in time.

Helen experienced losing her housing because her pill count was off. This later affected how vigilant she was when traveling outside of her home as she knew not having enough coverage would affect her health (i.e., feeling sick) and taking more than their prescribed dosage to offset lack of coverage would affect her pill count. The strictness of the pill count policy is a double-edged sword for participants like Helen as it helps keep them accountable and at the same time increases their stress when planning activities outside of the home.

A minority of participants endorsed coexisting chronic pain which affected their management of MAT. Two participants shared how they grappled with the decision to taper off medication. They acknowledged they did not have clear answers to how they would manage their pain and what the future may hold. Leah suffered from chronic pain and expressed uncertainty regarding the possibility of tapering off MAT.

Leah: Right now at least for the next couple of years. I've had several doctors tell me because of my chronic pain I may end up being on it for the rest of my life or for long-term. So as of right now the plan is for sure for at least the next two to three years, and then depending on how things go, maybe new things may come out...

She had the message of life-long medication reinforced which made it difficult to see how she could manage her medication beyond the next couple of years. However, she held hope that things could change positively in the future. For individuals like Leah, OH removed the worry of needing to taper off as it does not have any limits on how long residents can keep their prescription. Instead, they can focus on maintaining their recovery and working with their physician to help them make an informed decision.

Research Question 3

Navigating Counterspaces (2.1)

Participants also shared their experiences in recovery spaces outside of OH. Six participants shared a negative experience concerning MAT in their recovery group. Four participants mentioned how individual 12-step members shunned disclosure of MAT. This did not stop participants from engaging in meetings as they found 12-step vital to their recovery. In addition, OH requires some sort of recovery meeting component as part of the program.

Noah: ...it's literally like not supposed to be done in 12-step programs, so nobody will even bring it up because it's just not meant for there. So that's another reason why I really stopped nearly attending as much.

Noah mentioned how they did not completely stop going to 12-step programs and instead started going less. He expressed how he extracted what he needed from the programs to help with his recovery. He also mentioned switching to other types of recovery groups. OH does not require a specific type of recovery group as long as they focus on recovery. For example, someone can decide to attend SMART recovery which has a cognitive-

behavioral therapy (CBT) component. Noah did not personally like that recovery and wanted a more spiritual recovery program which had some Buddhist practices to approach recovery. Other participants, like Scott, took the approach of pushing aside the criticism.

Scott: ...But now that this is working, for me, I just don't care that other people think that if you're on it you don't belong here. I've grown out of that. And it's sad because I feel like it does drive a lot of people away from the rooms if they're on maintenance medication.

Similar to Noah, he felt that the stigma drives people away. He pointed out that earlier in his recovery he likely would have been driven away from 12-step recovery. However, he felt he was at a point where he could brush it off because he knows what works for him and gets what he needs from 12-step groups.

Implicit and Explicit Disclosure (2.2)

Participants grappled with managing their prescription and disclosure of their status outside of OH. When participants discussed disclosure, they used their experiences to dictate how to navigate that arena. For example, five participants expressed hesitancy toward disclosing their MAT status in 12-step meeting due to their experience of how they and others perceived 12-step attitudes toward MAT. Scott shared how he did not disclose his MAT status in 12-step meetings because of his experience of how it is perceived there.

Scott: I've never talked about it, and... maybe once or twice over the last few years I've heard someone share about it. And when they do it's um... they don't get treated very well.

Attending some sort of recovery program such as 12-step is required when staying at OH. Scott still attended despite his MAT status not being accepted. He acknowledged that earlier in his recovery the stigma would have driven him away from 12-step groups. As participants mentioned during their interview, it is an unspoken truth that there are 12-step members that have MAT prescriptions.

Additionally, participants carefully navigated how they administered their medication. Participants were conscious about when they could use medication as well as how their dosage might disclose their MAT status after administering medication. Certain behaviors, such as nodding off or sleeping, may be perceived as either being high or a sign that they are currently prescribed MAT. Helen shared how this influenced her management of MAT.

Helen: That was part of what motivated me to drop down, because it was embarrassing for the people that we were with that we could not stay awake, something about the lull. I mean I could tell who was on Suboxone by how they were in the meeting.

Helen was mindful about how her dose affected her physiology after perceiving others on high doses. The stigma was a catalyst in managing her dosage in a way that made her blend in to those that were not aware of her MAT status. At the same time, she felt validated by some of the messages that were presented at panels from professionals at

conferences. These messages indicated that it is acceptable to be prescribed MAT as long as it is taken as prescribed.

Research Question 4

Personal Development (3.0)

Participants developed a variety of interpersonal skills in OH which helped them reintegrate into the community. They ranged from increasing prosocial skills like conflict resolution, being inclusive, being accountable, and demonstrating leadership with roommates. The vast majority of participants described OH as a place that represented more than just a shelter setting. Specifically, participants stated OH provided a place to learn how to socialize with others, manage their emotions effectively, and gain a sense of normalcy.

Six participants endorsed growth in prosocial skills from socializing with their roommates. Participants experienced positive peer relations which provided insight on how to form bonds with housemates as well as those outside their OH. Patrick discussed how he tended to self-isolate before going into OH and recognized the importance of gaining and maintaining social networks. He explained earlier in the interview that recovery involves not using substances to mask or enhance emotions. He then described how role modeling and the opportunity to learn socio-emotional skills in OH helps him achieve his recovery goals.

Patrick: Social situations are very crucial to my “recovery” or me getting to know myself better and to be honest with myself of what’s actually going on. I think the social dynamics that are at play, whether it's conflict resolution or learning

legitimate emotional boundaries, or learning to say no, or having self-control in terms of... just social behaviors. I mean these are all things that are very valuable in a group setting...

By living in OH, Patrick practiced interpersonal effectiveness skills to manage emotions without substances. While he is not forced to interact with others besides house meetings, Patrick chose to lean into interactions to keep developing these skills, as he fears not being able to maintain his recovery if he leaves OH without a social network in place. Similarly, Noah and Amber shared how socializing with others and using effective communication skills was important for their growth.

Noah: Whether it's getting into arguments with people, it shows me where I was wrong and helps me grow as a person as a man... Or having a good time with them. In recovery you want to do things that you like and do things that are healthy and having friends that help you do that. It's a mutual thing.

Noah valued conflict resolution and saw their personal growth as mutually benefiting the house they were living in. He also adds similarly to Patrick how prosocial skills are a part of recovery. Amber reflected on how these skills are valuable outside of OH. She explained how she had an incident with a roommate where she brought up roommate's behavior in an aggressive manner. Later on she followed up with:

Amber: ...I have trouble speaking up and holding people accountable and so that part of it has been a little challenging for me, but also its a very good skill to use and to learn so when I leave there I'm able to go out in the world and have these skills of how to resolve conflict and just how to work with other people for

solutions, and I had to communicate without being aggressive, but you know assertive...

Amber shared how learning conflict resolution was not easy and gave examples of how she navigated conflict during her stay. She learned how to communicate with her roommates without being aggressive. Shortly later in the interview, she described an opportunity to gently bring up how to encourage others to clean their rooms without making them feel bad about themselves because she had problems with some of her roommates not doing their share.

Four participants spoke about leadership, which included taking on various roles within the house and providing resources to others. The roles that participants took on included learning how to run different aspects of the house (e.g., treasurer, chore coordinator), even starting a new OH, and gaining access to social and financial capital to benefit the home (e.g. chapters and conventions). Helen networked with people at the chapter level and at OH conventions, where current residents and alumni gather at the regional and national level. This helped her secure a level of autonomy by consulting with people more familiar with how the organization is run whenever she had concerns. Amber described how she was unemployed at the time and how she used resources familiar to her to benefit OH.

Amber: ...I came across some resources through churches and things that could help with rental assistance, and my doctor gave me some information in regards to programs that would not only help with rental assistance, but help with dental and things of that nature. So, passing that on to the people at Oxford House, I've kind

of become like a person that people contact for community resources and things like that. That's my way of trying to be helpful with regard to the Oxford House.

Four participants discussed seeking and learning accountability while residing in OH. They mentioned how accountability was crucial to their growth which not only kept them in recovery but also helped foster relationships and build their self-worth. The benefits of accountability are often likened to a sense of being “normal.” Leah discussed how OH was good for her accountability and how it helps reintegrate back into society.

Leah: ...so I haven't worked in like three years, and so Oxford House just really helped me get back into the groove of routine and structure and normal adult life, like paying rent and just being responsible for certain things and maintaining the accountability and stuff that has just been really helpful in me getting back to doing it well, normal people to per se...

Leah illuminates how before OH, her mother took care of everything and how it made her feel like she was not part of society. OH provided structure and accountability to pay rent, be responsible for chores, and attend to various obligations. Learning accountability gave her a sense of normalcy that she felt was lacking from her life. Noah also expressed a sense of accountability with normalcy while living in OH.

Noah: ...it was much more like kind of having roommates with a bunch of guys who are on the same mission as you, rather than almost still being in a treatment scenario... You still want to have accountability which you get at Oxford House because you're living with guys who are doing the same thing you are, but you still want some freedom.

Noah felt the benefit of OH in contrast to treatment where he gets freedom and is still held accountable to stay in recovery. This gives the perception that they are having a normal life, and it just happens that their roommates have the same goals as them to keep them on track. Similarly, other participants also espoused the same benefits of having roommates that have the same mission/goal. Noah discussed earlier how other recovery housing did not provide freedom nor accountability and how this set OH apart despite the negative things he heard from others prior to living in OH.

Familial Values (4.0)

Emotional family support is important to participants as it affects how long they are willing to stay in OH as well as contributes to their commitment to manage their MAT effectively. OH allows residents overnight passes to spend the night with loved ones. It is one key distinction between OH and other sober living settings such as half-way housing. It was often cited as a benefit to living in an OH. Three participants mentioned using overnight passes to maintain close relationships with loved ones. For Amber, overnight visits played a key role in not feeling pressure to move out of OH at the earliest possible opportunity.

Amber: ...I was surprised that Oxford House allows overnight passes. You can go out or have somebody stay the night, up to three nights per week. So I thought that was pretty lenient and I really like that fact because it allowed me to have sleepovers at my mom's house with my son and things like that. So, it really made it a nice transition to have the separation of being in sober living but yet have um the ability to come and spend time with my son and reconnect with him.

Amber is able to stay the night where her children are several times per week which made it easier for her to stay in OH. This is important because her goal is to eventually live with her children full-time, once she gains full custody and feels stable enough to leave OH. Amber acknowledged that there are OHs that allow staying with family in the house full-time. They did not see it as beneficial for them compared to solely overnight passes.

Amber: ... I have heard that the Oxford Houses that allow for children... it's not that great, like it's kind of hard living in a house full of recovering addicts that have kids that might not be, I don't want to sound judgmental, but just might not be that well behaved...

While the option to live in OH with children full-time is available for mothers, Amber felt it is difficult to control the environment (i.e., the behavior of others) and manage recovery at the same time. The ability to have children live close by and in care of family members allows residents like Amber to focus on their recovery and not be in a rush to move out so they can reunite with their children. Angela recognized that OH normally has this benefit, however because of COVID-19 restrictions their house was not allowing overnight passes.

Angela: It [OH] is pushing me out because everybody is saying that it's going to end soon and all this great stuff, but at the same time I don't know when. I can't put off my kids like that, that's not fair for my kids, that's not okay. So I have to figure that out and not being able to have them over... It's made my recovery very hard but I get it because Oxford House is just trying to follow the law, well they have to follow the law.

She recognized that she will have the ability to have her children over and be able to spend the night where they were staying. However, at the moment it was difficult for her to stay in the house when there was not a definitive timeline. As mentioned before, each OH has different guidelines besides paying rent and being sober. While some OHs allow residents to spend extra overnight passes, others added extra stressors with COVID-19 restrictions. The need for family involvement is an important component in the recovery of women with children. OH facilitates this which helps keep residents on track.

Despite the ability to stay in OH indefinitely, as long as they pay rent and maintain sobriety, participants want to be able to be on their own with their children or partner. Once in OH, participants that were mothers saw their children as a motivator to stabilize themselves in recovery and then find a way to move with their children into independent housing. Being in a place to have independent housing includes having employment and a home that is affordable with that salary. OH allows residents to save money due to splitting rent among several roommates. This helps reduce stress from finances. Angela explained how they were cautious about moving out to be with her children.

Angela: Well one of the things that will make you relapse is stress, and one of the biggest stressors you have in life is having a home and being able to afford it. So, if I can't do that, I'm not going to put myself in the position of... you know... relapse.

Angela wanted to reunite with her children, and at the same time she did not want to put herself in a situation where she would be at risk for relapse. Staying in recovery would

permit her to be there for her children. Several of the participants mentioned a history of either losing their children and/or losing focus of their family. A drive to strengthen their bond has kept mothers in recovery despite some hardships they face of being away from them.

The majority of participants expressed they could identify with their roommates, whether they saw them as a family member or recognized their motherhood, which helped them stay in recovery. Mothers in the same household supported one another. However, Angela could not relate with her roommates as none were mothers. Angela expressed, “I don't really feel involved in my house at all... I work and... I'm a mom so I don't have boyfriends, and I don't have you know stuff like that. I just go to work and I have my kids. So...” For the benefit of her children, she managed amicable relationships with her roommates and worked her steps to advance in her recovery.

Participants reported their families were supportive before moving into OH, financially and emotionally, which continued to develop during their stay. Patrick mentioned how his family was supportive in him going to rehab and supporting him financially. Families approved of participants' recovery strategy, including moving into an OH and their consistency with MAT. Noah felt he had one last chance before losing his family's support which helped motivate him to get into sober living and MAT.

Noah: And then I went back to detox and this time I really wanted to stay sober and it really was on one of my last straw[s], as far as my family helping me out and just in general, and I really thought for the first time ever maybe [utilizing] maintenance Suboxone. I'm going to give it a shot.

Noah looked up OH while he was living with his father. Later in the interview he followed up with his family saying that OH was a great idea. Noah stated of his family, “They know me, and they thought the way that Oxford was structured would have been the best thing for me, and they were evidently right.” Noah also felt accepted by his father after perceiving having one last chance to get his recovery right. His father wanted him to become involved in the family business once he felt stable in his recovery.

Participants reported that their families felt they were in a safe environment that was conducive to their recovery and growth as a person. They discussed how their families were familiar with how OH was organized. Grace shared how her family understood how OH was structured and how she would benefit from it.

Grace: My family is really proud of me. Once they understood what the concept was, they were really excited and relieved to know I was in a safe place, and there was also a place that is motivating more growth.

The support that Grace received from her family and boyfriend helped her stay in recovery. Despite having to spend time away from them to adhere to meetings and chores, their understanding and support enabled her to stay in the house until she is ready to move onto the next step in her recovery. In addition, she also reported she felt that her family was supportive of her MAT management while in OH because they saw it was working for her. Family members also bestowed trust to participants which served as emotional support.

Leah: My brother actually told me that my mom said that for the first time in probably years that she actually depends on me more than she can depend on

anybody else, and for her to say that that's huge. It just makes me feel really good that I'm finally back to my full potential, being a mom and being a friend and being a daughter, and I'm showing up where I'm needed and expected to be.

Not only did Leah feel validated in her growth, but she also saw herself as being at her full potential which included being a mother and daughter. None of the participants expressed that their family members viewed their prescription of MAT unfavorably. In fact, they were accepting that MAT is helping them stay on track. Leah discussed how her family perceived her and MAT as part of her recovery.

Leah: I mean I don't have any... if anything for the better because they know that it's helping me but I don't think that they view me um in any negative way at all at least. Um, they know that this is what helps me in my recovery and so they are accepting of that.

As Leah had mentioned earlier, her family saw the changes she made in her life that led to an increase in trust. Leah's family had been involved in her road to recovery when she reached out to them for help to get her into rehab. Her family was aware of her prescription for MAT and how that had a positive impact on staying in recovery, seeing how she was more successful with methadone than without it.

Secondary Research Question

Acquaintances in OH

Additional research questions that concerned how participants transitioned into OH uncovered that five of the participants knew someone that lived in an OH and that

motivated them to apply and get accepted. Scott acknowledged what held him back from applying for a house was his assumption that they would not accept someone prescribed methadone.

Scott: ...one guy that I knew that lives there, he was on methadone. And, so that's basically the only reason why I even considered going to it. I thought that none of them would take someone on methadone. That's really why I haven't looked at any other Oxford House. I've been in [city name] for a couple of years now and had I known that, I would have gone to an Oxford House long before I did.

This perception that participants would not be accepted due to MAT was common. Participants were aware of OHs not accepting MAT earlier in the last decade. Knowing someone in OH that was utilizing MAT helped participants undergo the application and interview process. One participant in particular expressed how residents knowing her assisted her with securing housing, despite residents' stigma toward MAT. Helen stayed in multiple OHs, in this particular instance she recalled how she moved to a different town because of friends there.

Helen: ...well one has a small town so I had friends there. So the Suboxone wasn't really the issue; they weren't friendly on it, but they knew who I was so that was kind of helpful.

Half of the participants noted how each OH is different in regards to MAT policy. This affected whether they got a chance to interview. Two participants encountered houses that did not accept them or provide an interview because of their MAT

prescription. One participant took this knowledge and ended up leading her own house with MAT friendly policies.

Helen: ...I moved into a position of being a core member and opening a house that runs on Oxford guidelines, the principles, but can also be tailored to what I would like to see in an Oxford House. So, now I'm the top member of my house getting ready to move out, and I fostered an environment that Suboxone doesn't matter. It's not what it's about.

While Helen did not endorse being rejected during interviews, she provided a unique perspective about interviewing incoming applicants. She noted how she could sense they felt shame about their prescription. She learned she had to disclose that her OH is Suboxone friendly because of negative experiences others had from being rejected from other OHs.

Discussion

When the first research question was explored, participants discussed the inclusion of MAT as a fundamental part of their recovery. Participants discussed working specific steps of 12-step ideology as a big part of their recovery, despite not completely agreeing with 12-step views. When prompted, all participants stated that MAT was part of recovery. However, their endorsement of MAT varied in intensity. While not every OH may be accommodating, the consensus seemed that the model worked for people managing MAT. This was demonstrated through participants being able to pick and choose the tenets of recovery they felt were key for their success, as well as how close they wanted to get with roommates. Dingle and colleagues (2019) found that it is not

enough to be a part of a recovery group; individuals need to want to be in recovery. Many of the participants described multiple attempts at recovery and feeling at a point where they needed to do it for themselves. A philosophy that dictates how residents should manage their recovery was not forced upon them. This fostered feelings of acceptance in the OH and by association within a part of the recovery community.

Based on the second research question on how individuals prescribed MAT experience living in OH, participants in general did not feel stigmatized within OH and felt a sense of community with their roommates. Generally, participants did not feel stigmatized within OH. This helped facilitate growth of friendships and feelings of inclusion. Participants disclosed positive feelings when reflecting how they believe their roommates perceive them as a person. They did not feel like they had to be in an exclusive MAT OH, if given the chance. Participants expressed enjoying the mixture of the environment: having at least one other person they can relate to with MAT experiences, having others with different experiences, and being free from concerns of the whole house relapsing. They did not feel rushed to move out as quickly as possible. Participants wanted to stabilize themselves first before becoming entirely independent.

The lack of explicit negative attitudes toward MAT validated that they were all on the same mission together. Participants labeled their roommates as family and/or being close friends. Social-connectedness within a group promotes recovery as individuals transition from identifying as an “addict” to “in recovery” (Buckingham, Frings, & Albery, 2013). Participants reported feeling a sense of community within OH and it having a positive effect on their self-identity. In the instances where they had roommates express negative views toward MAT, participants provided psychoeducation and

defended their prescription as a medical tool for recovery. Despite instances like this, participants did not feel pressured to move out due to stigma. OH helps MAT residents feel connected and part of the recovery community. Participants reported more positive experiences as well as being perceived in a positive light that likely kept them in OH. The one instance that a participant felt like moving out was due to not being able to see their children. Other qualitative studies reported how individuals in treatment with MAT valued a sense of belonging just as much as the treatment (Silva & Andersson, 2021). Participants also recommended OH for those with MAT despite not being asked directly if they would recommend it to others.

For participants that were managing Suboxone, pill counts were a double-edged sword in OH, as they provided a sense of safety as well as a risk when tapering. Despite some early frustrations with their perceptions of being micro-managed, participants largely felt that this accountability was necessary for their safety, which included sobriety and keeping their residence. Adherence to MAT less than 80% of the time can lead to relapse rates 10x more likely than those that have strict compliance (Tkacz et al., 2012). New evidence suggests that successful discontinuation of MAT is associated with long-term consistent use, especially with at least two years of administration (Connery & Weiss, 2020; Eastwood, Strang, & Marsden, 2017; Williams et al., 2020). Additionally, OH residents who stay for at least 6 months have higher rates of abstinence compared to those who leave earlier (Jason et al., 2021). Most of the participants did not express thoughts of staying there for 2 years, although several extended their stay longer than they originally anticipated.

In the event that individuals managing MAT stay long-term, pill counts can become problematic when they decide to taper off their medication. These individuals discover that the decrease in medication is difficult to handle and need to go back up in dosage. This could throw off a pill count, which could then jeopardize their recovery and residency. Participants expressed how the half-life of the medication can make it seem like they can handle a decrease in their medication, and adjustment can be more difficult than they anticipated. Clear communication with their roommates and physician, as well as skills they developed through their tenure at OH, can help with these adjustments to prevent relapse and subsequent dismissal from the house.

When we explored the third research question on the experiences of individuals prescribed MAT with their in-groups and out-groups, we found participants felt supported by family and felt connected to them during their time at OH. As mentioned before, individuals who are prescribed MAT can be perceived as untrustworthy and denied responsibilities (Earnshaw, Smith, & Copenhaver, 2013; Woods & Joseph, 2018). Participants in this study reported this was the case prior to living in OH. As they accumulated time in OH, their family members found them trustworthy as well as bestowed responsibilities to them. Participants credited this to their increased functioning facilitated by their consistent MAT utilization and involvement in the recovery community. This further validated their recovery identity as these endorsements are not congruent with interactions with those perceived as “addicts.”

Participants acknowledged that there is stigma in the recovery community regarding MAT. Several studies have mentioned an unspoken rule that members should not speak about MAT, as it is not seen as behavior consistent with abstinence in the eyes

of the 12-step community (Galanter, 2018; Ginter, 2012; White et al., 2013). As mentioned before, participants expressed identifying with 12-step philosophy, however had difficulty identifying with the groups they interacted with. They shared nuanced views when discussing 12-step groups. They did not want to discredit 12-step groups as they acknowledged they had utility for people and recognized that it has drawbacks and did not completely align with their beliefs.

In a way, 12-step groups can be seen metaphorically as off-label prescriptions for those undergoing MAT. They stand to benefit from attending these groups even with 12-step members that may unfortunately disagree with their recovery process. If OH residents do not feel comfortable attending 12-step meetings, then they can attend other recovery support groups that are not 12-step or that are inclusive of MAT, such as Methadone Anonymous (MA). Participants demonstrated knowledge as well as interest in attending other recovery groups. They were aware that they were not limited to attending solely AA or NA.

Self-disclosure on MAT in recovery groups was not common, as they had either witnessed or been personally admonished by others in 12-step groups. Participants shared their experiences of disclosure and seeing others disclose their MAT status. They also expressed they did not feel it was necessary to disclose their status as they were benefiting from participation. However, this perception did have an effect on some to reduce the amount of days they participated in meetings. Using their own definition of recovery, participants can continue to feel supported in 12-step groups by staying abstinent from their drug of choice. There is no cognitive dissonance because MAT

allows them to become functioning members of society, as opposed to when they were abusing non-prescribed opiates, when they were not able to have that life.

Based on the fourth research question on how OH affected individuals prescribed MAT, participants developed interpersonal skills during their stay which helped with reintegration and provided a sense of living a “normal life.” In addition, participants highlighted their appreciation of the accountability reinforced through pill counts. A sense of normalcy is possible in OH through skill building. OH facilitates the development of interpersonal skills as well as other practical skills that make it possible to successfully reintegrate into society. Previous qualitative research that examined the experiences of veterans in OH found that the leadership roles and socialization with roommates helped them reintegrate back into society (Guerrero et al., 2021). Alvarez and colleagues (2009) also found that Latinas and Latinos in OH described learning interpersonal skills and being held accountable was part of their recovery. Other studies also found that those with MAT want a functional life, which includes securing housing and employment, and fixing bonds with family and friends (Silva & Andersson, 2021). Participants in this study developed emotion regulation and communication skills which resulted in prosocial interactions and close relationships with their roommates. They used these skills to navigate the social dynamics of sharing spaces with others, such as resolving conflicts, advocating for themselves, and addressing concerns they have with others. Environments that foster positive interactions may help those in recovery as negative social interactions are associated with daily cravings (Knapp et al., 2020). Patrick highlighted socialization as a vital component to his recovery that he needed to secure in the community before leaving OH.

Family approval and support of OH residency helps those in recovery stay on track with MAT. Participants' families provided emotional support which was beneficial to them. Their families helped motivate them to start on their journey as well as to try MAT as an effective tool for recovery. As participants executed their recovery strategy in OH, family bonds were repaired and strengthened. For those who identified as mothers, recovery included having their children back in their life. Studies have shown that developing a recovery identity is shaped by motherhood (Gunn & Samuels, 2020). Families provided childcare for participants who identified as mothers while they were staying in OH, as well as allowed them to visit their children. OH allowed overnight stays and visitations after their probationary 30 days, which helped them re-establish motherhood and feel like they were on track to normalcy.

Recovery and motherhood are intertwined, as such, participants needed to stay sober and implement recovery strategies (e.g., attend recovery groups, build sober social support networks) to be present in the lives of their children. This was critical for mothers that sought to retain custody, as MAT helps improve the odds of families remaining intact for mothers in recovery (Hall et al., 2016). In addition, participants kept in mind that they needed to maintain stable employment in order to secure housing suitable for their children when they felt ready to move out of OH. MAT allows participants to function at a level necessary to keep a stable job and engage in activities conducive to recovery. As was mentioned earlier, consistent MAT utilization is associated with long-term recovery outcomes, and recovery significantly improves family functioning (Edwards et al., 2018). Mothers did not express a need to taper off MAT while living in OH. Their focus was to have everything in order for their family, and then think about

that later because they did not want to risk relapse. Participants reported their experiences with other recovery options were not as flexible. While some participants experienced challenges with OH policy due to the COVID-19 pandemic, such as not allowing children to stay the night, participants acknowledged that OH typically facilitated the strengthening of family bonds while establishing a strong recovery base. This knowledge helped provide some hope to stay in OH a bit longer until policy returns to its typical structure.

Limitations and Future Directions

This study is limited by gender representation. The author attempted to evenly represent gender in this study, however men that expressed interest did not follow up for the consent process. Additionally, participants were recruited from two states. The author attempted to recruit from other states including Maryland, however, there was a lack of interested participants. Moreover, the data for this study was collected at the start of the COVID-19 pandemic. That was not the intent of the study. Some of the participants only experienced OH within the pandemic. Some had a mixture of time pre- and during the pandemic. It is quite possible that their experiences could have changed significantly as the COVID-19 pandemic developed throughout the United States. These experiences could be seen as only applicable to extreme circumstances compared to typical OH experiences. Multiple interviews throughout their tenure would have given a richer dataset which would have provided unique perspectives regarding a historic time point in the world. In addition, more questions about 12-step participation would have given deeper analysis. However, given that the focus was on the experiences within OH, emphasis was not given on questions pertaining to matters outside of OH.

Future directions include exploring the experiences of residents attempting to successfully transition off MAT while in OH. While participants discussed adjusting their dosage for the optimum therapeutic effect, none discussed ongoing tapering. The strict pill check and the complexity of tapering MAT leaves questions about OH policies being flexible to achieve successful tapering without risk of eviction. Additionally, tracking self-efficacy during this future study would provide valuable insight on the effectiveness of tapering while in OH. Studies exploring the experiences of those with chronic pain in OH could help those transitioning into recovery settings. While there were a couple of participants that were managing chronic pain symptoms with MAT, there are more individuals that were unfortunately caught in the web of opioid marketing for pain management who will need supportive environments when navigating their recovery.

Conclusion

In conclusion, individuals prescribed MAT could benefit from living in OH in order to manage their recovery as well as stay compliant with their medication. The current surge of opioid deaths due to contamination with fentanyl and other highly potent opiates is concerning for those in the midst of recovery. MAT has been around for over half a decade and has proven efficacy to curb reversion and increase functioning and quality of life. The skills they can build in OH can help those prescribed MAT achieve a sense of belonging and normalcy. In addition, acquaintances affiliated with OH can help with applying and entry into a house. Emotional support provided by family and friends also keeps participants on track with recovery and reduce the need to leave the home early, which also aids with keeping individuals compliant on their medication long-term and maintaining recovery.

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Appendix A

Interview ID:
Date of Interview:
Transcriptionist:

A. DEFINING RECOVERY

- 1. I'd like to get to know more about how your recovery process began. Could you guide me through how your recovery began?**

PROBES:

- What happened that got you to initiate your journey?
- What stage of the recovery process do you feel you are currently at?
- How do you feel about where you are currently at with recovery?
 - Where would you like to be in your recovery?
- How long have you been sober?

- 2. At what point of your journey did you decide to get a prescription for MAT?**

PROBES:

- What helped you decide to get a prescription for [MAT]?

- How was the decision/process for you?
- What does your current medication look like?
- What are your plans for MAT?
- Who has influenced your decision making process for MAT?

3. As you continued to navigate through your recovery process, were there any challenges or obstacles along the way?

PROBES:

- What were they?
- Was there anything that helped your through those challenges and obstacles?

4. As you know, people think about recovery differently. In your own words, how would you define recovery?

PROBES:

- Have you always processed it that way?
 - [If No] what changed?

5. Would you include medication-assisted treatment in your definition?

PROBES:

- [If Yes] Why do you believe MAT should be included in defining recovery?
- [If No] Why do you believe MAT should not be included in defining recovery?

6. How have you heard other people define recovery?

PROBES:

- Who did you hear this from?
- Did it affect the way you thought about recovery?
 - [If Yes] How?
 - [If No] Why not?
- Did it affect the way you interact with them?
 - [If Yes] How?
 - [If No] Why not?

B. TRANSITION INTO OXFORD HOUSE

1. I would like to talk about your transition into recovery homes, specifically Oxford House. How did you find out about Oxford House?

PROBES:

- Were you actively looking for a recovery home?
 - [If Yes] Why?
 - [If No] What made you decide to apply to OH?

2. How would you describe your interview with OH members?

PROBES:

- Did you feel welcome?
 - [If Yes] What made you feel welcome?
 - [If No] What made you feel unwelcome?
- Were there any concerns brought up during the interview?
 - [If Yes] What concerns were mentioned? Were they resolved?
 - Did you have any concerns you did not mention during the interview?
- How did they react to learning you are prescribed MAT?

3. What were your initial impressions about Oxford House?

PROBES:

- What did you think about the structure?
- Do you feel OH is similar to other recovery/transition homes?
 - [If Yes] Why?
 - [If No] How is it different for you?

Recording Time:

C. CURRENT OH RESIDENCE

1. How long have been living in this house?

2. Do you have a current plan for how long you want to stay?

PROBES:

- What do you feel is influencing your current thoughts?
- Is there anything that would change this?

3. Once you got settled into Oxford House, in general, how would you describe your current stay?

PROBES:

- Have you had any experiences within the house that affected you?
 - [If Yes] What were they? Were they resolved?
 - [If No] What do you think has helped prevent any negative experiences?

4. How do you believe other house members see you? Why do you think that is?

PROBES:

- Have you been seen this way before?
 - [If Yes] When, where and from who?
 - [If Not] How does it feel being seen this way?
- Do you believe being prescribed MAT affect the way they see you?
 - [If Yes] Why do you think that is?
 - [If No] Why not?
- Does the way they see you affect how you feel about staying in OH?
 - [If Yes] What specifically about the way they see you affects your feelings for staying?
 - [If No] Why not? What helps?
- Does the way they see you affect your recovery?
 - [If Yes] Why?
 - [If No] Why not?
- How would you like to be seen?

5. How would you describe your relationship with other Oxford House residents?

PROBES:

- Would you consider any of the house residents close friends?
 - [If Yes] What makes them a close friend?
 - [If No] Why not?
- Do any of the house residents have an impact on your recovery?
 - [If Yes] How do they affect your recovery?
 - [If No] Why not?

6. How open do you feel talking to other Oxford House residents?

PROBES:

- Are there certain topics that you feel comfortable or uncomfortable discussing?
 - Why do you feel comfortable discussing that?
 - Why don't you feel comfortable discussing that?
 - Any other topics?

- Do you feel it would be different if you lived in a house that was [all MAT/mixed]?
 - What would you prefer?

7. How would you describe your current involvement with house decisions?

PROBES:

- Do you feel you are able to be involved in all aspects of house decisions? What would you like to be involved with?
 - [If Yes] How does that affect your stay and recovery?
 - [If No] Why not? How does that affect your stay and recovery?
- Do you feel included with other house members?
 - [If Yes] What do you feel included in?
 - [If No] Why do you think that is?
 - Would you like to be included in other things?

8. Would you recommend Oxford House to anyone?

PROBES:

- [If Yes] To who? Why would you recommend it?
- [If No] Why not?

Recording Time:

D. LIFE OUTSIDE OF OXFORD HOUSE

1. How do you see your life outside of Oxford House?

PROBES:

- Was it always like this?
 - [If Yes] How so?
 - [If No] What changed?

2. Has living in Oxford House affected your family and friendships?

PROBES:

- [If Yes] How so?
- [If No] How are your relationships with them currently?
 - Would you like them to change?

3. How involved do you feel in your community?

PROBES:

- Has OH had any effect on your involvement?
 - [If Yes] How so?
 - [If No] Why do you think that is?
- Is there anything you want to be involved/more involved with?
 - [If Yes] What would that be?
 - [If No] Why not?

Recording Time:

Do you have any other comments you wish to make?

Appendix B

Emergent Themes (P01)	Superordinate Themes
Arturo Soto-Nevarez Themes	Social Support
Family Support	Perceived Risk of Substance Use
Methods for Recovery	Navigating OH
Acceptance	Skill Building
Recovery Community Beliefs	
Recovery Group Attendance	
Other Sober Living Experience	
Socializing	
Perceived Risk of Substance Use	
MAT Utilization	
Self-Detox	

MAT Effects	
Acceptance of Others' Recovery	
Value Genuineness	
Sense of Community in Recovery	
Prior Experience with OH	
Change in OH MAT Policy	
OH Residents Facilitated Emotional State	
Honesty about MAT	
Pressure Caused by Circumstances	
Negative Prior OH experience	
Identity	
Appreciation of Higher Education	
Adaptation to Circumstances	
Holding others accountable	
Addict Behavior	
Understanding Social Dynamics	
Pandemic Effects	
Close Friends	
Real World Experiences	
Learning Emotion Regulation	
Mary Abo Themes	
Identity Issues	
Sense of Belonging	
History of MAT use	
Insecure Housing	
Finances	
Social Support	

Emergent Themes (P02)	Superordinate Themes
Mary Abo Themes	
CRJ involvement	Chronic pain

Health Issues/Chronic Pain	Recovery process and planning
Recovery Process/Planning	Relationship Development
Recovery/Coping tools	Perceptions of Others Matter
Social Support	Safety
Familial Values	Pandemic Effects
Relationship Development (peers and family)	Perceptions of MAT
Accountability/Structure of OH	
Perceptions of Others Matter	
SOC	
Pandemic Effects	
Mackenzie Hudson Themes	
Trust	
Family and friends fear relapse	
Building relationships	
Provides structure	
Unity	
Reintegration into society	
Couldn't do it alone	
Chronic pain	
Changing people places and things	
MAT	
12-step groups	
Safety	
Arturo Soto-Nevarez	
Children as motivation	
Family Support	
Chronic Pain	
Difficulties of Sobriety	
MAT legitimacy	
Similar goals	
Transparency	

Safety	
Fear of Stigma	
Opinions Matter	
Accountability	
Positive asset	
Acceptance	

Emergent Themes (P03)	Superordinate Themes
Mary Abo Themes	
Significant Changes (geographical, medication, etc).	Chronic pain
OH downfalls	MAT Perceptions
Personal MAT thoughts and experiences	MAT Management
Leadership	Leadership/Involvement
Soboxone Stigma	Pandemic Effects
OH social support or sense of community	Social Support
Health issue/ chronic pain	
OH/ recovery group involvement	
Familial/Friend Relations	
Mackenzie Hudson Themes	
OH makes P's recovery 24/7	
Token suboxone member	
MAT friendly vs not OHs	
Lowered MAT use due to "nodding"	
Unable to get help reducing MAT	
Distrust of MAT	
Difficult to adjust MAT in OH	
OH members attribute all behavior to MAT	
Seen as glue	
Many close relationships in OH	
Relapse talk taboo	
Leaving due to COVID 19 policies	

No life outside OH	
Improved family relationship	
Leader in recovery community	
Arturo Soto-Nevarez Themes	
OH MAT policy	
Chronic Pain	
Addict Behavior	
Managing MAT	
Serving others vs self serving	
MAT stigma	
Disclosing MAT	
COVID	
Honest communication	
MAT effects	
Future with OH	

Emergent Themes (P04)	Superordinate Themes
Mary's Themes	
CRJ involvement	Stages of Recovery
Emotional support	Motherhood
Stages of recovery	Disconnected from OH
Accountability	MAT Purpose
Social Support	Addict Identity
Obstacles in recovery	Stability
Socially isolated	
Mackenzie Hudson Themes	
Difference bw use and abuse	
Likes structure of OH	
OH/MAT is beginner recovery	
Learn to regulate emotions	

Focused on obtaining housing	
Kids are recovery motivation	
Wants to be better mother	
Wants her kids at OH	
Uses MAT as tool	
MAT is part of recovery	
Feels unfairly treated	
Disconnected from OH	
Not close with OH members	
Stigma against OH members	
Feels nannied	
Suggests OH time limits	
Arturo Soto-Nevarez Themes	
Active Abuser vs Users	
Stages of recovery	
Children as main motivator for recovery	
MAT as form of accountability	
Benefits of Suboxone prescription	
Emotional Support	
Need for Safety	
Getting fixed	
OH for Adjusting not living	
MAT Policy	
Housing instability is a stressor	
Relating to others as a mother	
Lack of Trust	
Addict Identity	
Stigma against Methadone	
Feeling invalidated	
Suboxone disclosure	
Need for Autonomy	

Emergent Themes (P05)	Superordinate Themes
Mary's Themes	
freedom	MAT logistics
leniency	Familial Values
MAT logistics	12-Step Involvement/making life
12-step involvement	Crossroads/ Last shot
recovery diversity	OH Democracy
Power	Spirituality
Family Motivation	Roommates on a mission
Crossroads	No room for relapse
No room for relapse	MAT argument
free spirit/open-minded	
Spirituality	
OH impressions/stigma	
Arturo's Themes	
MAT logistics	
Last straw	
Crossroads	
Suboxone negatives	
Origin of stigma?	
Mat argument	
Stigma	
12-steps as foundation	
life being manageable	
spirituality (karma)	
Mutual learning	
OH stigma	
Roommates on a mission	
Person dependence system	
opportunities with family	
Mackenzie Hudson Themes	

MAT was last chance at recovery	
Fear of losing family support motivates to	
Understanding of MAT biology	
Road to choosing suboxone	
Ibogaine therapy	
AA/12 steps give you tools	
Attracted to OH democratic style	
OH has reputation for leniency	
Bonds with younger people in OH	
Healthy relationship building	
Feels included in house decisions	
Somewhat identifies w AA/12 step	
AA/12 step harsh towards MAT	

Emergent Themes (P06)	Superordinate Themes
Mary's Themes	Healthy clean
sober vs recovery	Suboxone use vs Methadone use
healthy clean	MAT disclosure
Suboxone use vs methadone use	Inclusiveness
MAT disclosure	Sense of Community
Environment matters for recovery	Like a vitamin
House as a family	Managing MAT
Inclusivity	Life and Recovery Intertwine
MAT disclosure	
Voice is heard	
Free-feeling	
Layers of recovery	
Arturo's Themes	
Healthy clean	
Right v wrong reasons	
suboxone benefits	

MAT stigma	
Friends in OH	
Managing MAT	
MAT disclosure	
inclusiveness	
opinion counts	
giving back to community	
like taking a vitamin	
Mackenzie's Themes	
Healthy clean	
MAT taboo	
MAT is like vitamin	
strong recovery community	
involved in OH	
Life and recovery intertwine	
Long arrest hx	

Emergent Themes (P07)	Superordinate Themes
Mary Themes	Family Support
Development of thoughts and opinions	Reintegration
Family support/motivation	Networking
Purpose of MAT use	MAT Stigma
Networking	Every Decision Matters
Second chance at OH	Purpose of MAT use
Negative perceptions of MAT	Positive Peer Relations
Recover to live life again	Recovery Progression
Not influenced by others	Rules are Rules
Recovery Obstacles & Progression	
OH versus Typical Sober Living	
OH Structure and Boundaries	
Positive peer relations	

Reintegration	
Group Involvement	
Mackenzie Themes	
Family support	
Every decision matters	
Not wanting to use drugs	
Stopped caring other's perceptions MAT use	
Passive aggressive MAT	
Knew someone in OH	
Rules are rules	
Tried to integrate into house	
Good friend	
Involved in house	
Arturo Themes	
Fear of Substance use withdrawals	
self-detox	
Managing MAT	
MAT stigma	
Need for stability	
Financial obstacles	
Adapting and compromising	
Need for shared experiences	
Reintegrating into society	
Family Support	
Accountability	

Emergent Themes (P08)	Superordinate Themes
Mary's Themes	Familial Identity
MAT Bias/Beliefs	Financial Support
Interpersonal Struggles	MAT Bias/Beliefs

Character Development	Interpersonal Development
Financial Burden/Support	
Motherhood	
Arturo Themes	
Financial Strain	
Friends Influenced MAT	
Family Conflict	
Scared of autonomy/independence	
Skill building	
Methadone stigma	
Empowerment	
Children as priority	

Appendix C

	Theme 1	Theme 2	Theme 3	Theme 4	Theme 5	Theme 6	Theme 7	Theme 8	Theme 9
P01	Social Support	Perceived Risk of Substance Use	Navigating OH	Skill building					
P02	Chronic Pain	Recovery Process	Relationship Development	Perceptions of others matter	Safety	Pandemic Effects	Perceptions of MAT		
P03	Chronic Pain	MAT Perceptions	MAT Management	Leadership Involvement	Pandemic Effects	Social Support			
P04	Recovery Stages	Motherhood	OH Disconnect	MAT Purpose	Addict Identity	Stability			
P05	MAT logistics	Familial Values	12Step Involvement	Crossroads/last shot	OH Democracy	Spirituality	Roommates on a mission	No room for relapse	MAT Argument
P06	Healthy Clean	Suboxone use vs Methadone Use	MAT Disclosure	Inclusiveness	Sense of Community	Like a vitamin	Managing MAT	Life and recovery intertwine	
P07	Family Support	Reintegration	Networking	MAT Stigma	Every Decision Matters	Purpose of MAT Use	Positive Peer Relations	Recovery Progression	Rules are Rules
P08	Familial Identity	Financial Support	MAT bias/belief	Interpersonal Dev.					

Recovery Process: Participants factor prior attempts at recovery, adhering to 12-step programs, and their social support when evaluating where they are in recovery and their next steps.

MAT Perceptions: Participants perceptions of MAT (recovery) were shaped by their experiences both in and out of Oxford House.

Validation of Recovery Identity: Participants felt validated by roommates, family, and/or friends about how they are managing their recovery.

MAT Logistics: Participants grappled with managing their MAT prescription

Navigating Counterspaces: Participants discussed how they navigated recovery spaces and MAT

Implicit and Explicit Disclosure: Participants discussed how they managed disclosure of their MAT status.

Personal Development: Participants developed a variety of skills in OH which helped reintegrate into the community.

Familial Values: Family is important to participants as it affects how they reside in OH as well as contributes to their commitment to manage their MAT effectively.