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The Perception of Official Housing Policies for Women with Medically Assisted by Treatment

by

Vickie Roberson

MA, Kaplan University, 2014

BS, University of Phoenix, 2011

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Human Services - Disaster Crisis and Intervention

Walden University

May 2024

Abstract

Opioid overdose is the leading cause of death among the homeless, with limited access to housing, food, security, and medically assisted treatment (MAT). The women on MAT are affected because they may not be readily accepted into the housing community if considered non-abstinent, unlike other substance users who would not have those problems. There previously had not been research on how housing for women was affected when on MAT or any housing facilities that have established MAT protocol. In this generic qualitative design, 10 female participants on MAT who needed housing were interviewed using semi-structured interviews. Bandura's social learning theory was used to understand the perception of official policies on MAT in securing sober housing. Social learning theory was used to illuminate the findings of states, public health officials, and providers working together to understand better what is needed to facilitate MAT for opioid users through virtual interviews conducted in this generic qualitative design study. Purposeful and snowball sampling was used in this study to gain participants. Thematic analysis was used to analyze the participants' data. Four themes were found: that MAT is keeping them sober but stigmatized as a person with an addiction. The second theme was educating people on MAT. Theme 3 was about the importance of understanding that using drugs will kill them. Theme 4 was the experience of being turned away from different housing entities. Official housing policies could lead to positive social change and actions that would open doors for women on MAT to secure housing without discrimination and implement official housing policies locally and globally.

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Dedication

I dedicate this dissertation to my twin sister, who has always supported, encouraged, and helped me get through my Ph.D. Also, I thank my dad for loving and believing in me during college. I am who I am because of the greatness you and mom instilled in me. Lastly, my Pastor taught me the value of operating in excellence or not operating at all. I now say, as Jesus did, “It is finished!”

Acknowledgments

I want to express my most profound appreciation to my committee chair, Doctor Greg Hickman, who has the attitude and grit of a genius; you continually encouraged, pushed, and were patient with me during my short yellow bus syndrome. Without your advice and relentless help, this dissertation would not have been possible.

I want to thank my committee members, Dr. Virginia Smith and Dr. Kimberly Farris, for their untiring work in reviewing my dissertation. Thank you for the encouragement, insightful comments, and believing in me.

I want to thank the "Diss Family," who was supportive, always on the spot, encouraging, and continually offering to help if needed. My mentor, Dr. P. Springer, thank you for checking on me weekly at 2:00 a.m. You never failed to provide your support and help during the crucial time of chapter four and form and style.

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Chapter 1: Introduction to the Study

This generic qualitative design study aims to understand the perception of housing policies concerning sober housing for women in Medically Assisted Treatment (MAT) who are homeless, previously incarcerated, or in residential treatment. MAT is defined as numerous pharmacological and behavioral treatments combined with substance use disorder counseling (Estreet et al., 2022). MAT is the recommended treatment for opioid use disorders (OUD), particularly for craving tolerance and withdrawal symptoms (Estreet et al., 2022). MAT has developed since the 1970s with current medications, injectable and extended-release buprenorphine and naltrexone (Estreet et al., 2022). Opioid rates have progressively increased in women to be standard with addiction rates in men (Cangiano & Jacobs, 2018). Heroin use increased by 100% in women, while men increased by 50% from 1999 to 2010 (Centers for Disease Control (CDC), 2018).

The rate of women dying from prescription opioid overdose increased faster than men from 1999 to 2016 (National Institute on Drug Abuse (NIDA), 2018). Overdose deaths commonly include morphine, heroin, hydrocodone, oxycodone, fentanyl, and methadone (Bersamira et al., 2018). Hydrocodone, oxycodone, morphine, and fentanyl are legally prescribed to treat severe or prolonged pain (Bersamira et al., 2018). Women's opioid use increased substantially due to more excellent rates of protracted pain, health-seeking behaviors, and social norms, which are acceptable for women to request more help when having pain, thus growing misuse of opioids (Campbell et al., 2020). Women's non-medical use of prescription opioids has declined recently; however, their heroin use has increased (Jones, 2017).

The study found that between 2002- and 2013-women’s heroin use increased by 100% compared to men's by 50% (Jones, 2017). MAT is the recommended treatment for pregnant mothers with OUD due to the adverse effects that can be detrimental to the baby and mother (States New Service, 2017). Without MAT, opioid-addicted mothers give birth to newborns who experience Neonatal Abstinence Syndrome (NAS), which is painful and costly due to increased health issues (O’Connor, 2019). MAT has been shown to lessen the possibility of complicated pregnancies, improve adherence to prenatal care, and build loyalty to addiction treatment programs (States New Service, 2017). In addition, when a mother delivers a baby, the postpartum period of caring for a newborn, sleep deprivation, and possibly postpartum depression is a vulnerable and challenging time. Without MAT and support, the mother can relapse (States New Service, 2017).

Women on MAT have significantly more difficulty finding housing and often experience unsatisfactory living conditions (Alessi et al., 2017). Furthermore, recovery housing must be a last option instead of supportive housing, which may be non-abstinent based on consumer choice (Alessi et al., 2017). Finally, the system and principles of care guiding MAT need to be understood by policymakers when developing evidence-based policies that reflect best practices (AATOD, 2019). The knowledge obtained from this study may give local communities and state legislation the tools they need to create official policies, examine MAT regimens, and help secure housing. Given all these factors, this study can potentially promote change for women on MAT by facilitating official housing policies consistent across all housing entities.

In Chapter 1, the background research explains the existing literature gap and supports the need for the present study. Emphasis is placed on the purpose of the research and the specific research questions. Furthermore, the theoretical framework, the nature of the research design, definitions, assumptions, scope, limitations, and significance are expounded upon. Finally, a summary of what to expect in Chapter 2 is provided.

Background

This generic qualitative design aims to understand the perception of official housing policies concerning sober housing for women in MAT who are homeless, previously incarcerated, or in residential treatment. More than 2 million adults in the US have opioid use disorder, and about 90,000 adults die yearly from opioid overdose (Johnson et al., 2022). Behavioral therapy, pharmacotherapy, broadened access to naloxone, and safer syringe resources are treatment and harm reduction modalities for treating opioid use disorder and diminishing damage from opioid dependence (Johnson et al., 2022). Evidence suggests that in the US, 31% of patients in need of treatment receive or seek it despite being insured and having access to medication for opioid use disorder (Johnson et al., 2022). Furthermore, affordability, OUD stigma, and not having access to OUD treatment programs are barriers. In the National Survey on Drug Use and Health, 32 million individuals reported lifetime abuse of prescription opioids. More than 1.9 million people, ages 12 or older, abused prescription opioids in the past year (Agus et al., 2018). In the United States alone, opioid addiction is a significant public health problem (Agus et al., 2018).

Nonmedical prescription opioids show that women are more prone to enter treatment with psychiatric and social issues related to family, employment, stability, and homelessness (Bersamira et al., 2018). The Substance Abuse and Mental Health Services Administration's (SAMHSA) National Survey on Drug Use and Health (NSDUH) shows over prevalence rates of opioid use change in men and women, with women increasing their use at a rate of 15 per 1000 and men 8 per 1000 persons (SAMHSA, 2014a,b). Data on heroin use and treatment show that women users of nonmedical prescription opioids encounter more obstacles than men in accessing treatment (Office on Women's Health, 2017; SAMHSA, 2014a, b). Women are marginalized from mainstream society due to using drugs and their drug behavior; furthermore, mothers face greater stigmatization (Boeri & Lee, 2017). Stigmatization of women drug users in society is often referred to as junkies; within treatment services, they are still labeled junkies by health professionals and the staff that works with them (Boeri & Lee, 2017). Women who are tagged, stereotyped, and discriminated against are usually used to stigmatize; however, discouraging drug use with these strategies associates women with complex emotional and social results by causing social division (Rivera et al., 2015). Therefore, health professionals, staff, and law enforcement must reduce drug use stigma, eradicate prejudiced mindsets, and encourage women drug users to seek help and needed care since women drug users are at risk of losing family, friends, housing, employment, school loans, and numerous social and economic benefits (Rivera et al., 2015).

According to current concepts, OUD is a disorder with a chronic course; therefore, abstinence treatment has limited success (Bohmer et al., 2020). Bohmer et al.

(2020) further expressed that the focus of MAT is to decrease heroin use; however, it also reduces infectious diseases such as hepatitis C and HIV. In addition, MAT has been shown to reduce criminality, reduce mortality, reduce illicit opioid use, and improve mental and physical health (Abel et al., 2020). However, co-occurring disorders are prevalent in men and women, but mental health problems are more severe in women than in men entering treatment (Bersamira et al., 2018). The World Health Organization (WHO) has listed methadone as an essential medication for MAT since 2005 for opioid users (Fairburn et al., 2018). The three main types of medication treatment for OUD are Methadone, a full opioid agonist; Buprenorphine, a partial opioid agonist; and Naltrexone, an opioid antagonist (Akerman et al., 2018). Also, Methadone was used for OUD dating back to the early 1970s. Thus, MAT was coined as the gold standard in treating opioid addiction with Methadone and Buprenorphine in an individual's recovery from OUD (Mund & Stith, 2018).

Since 2015, the Department of Health and Human Services (HHS) has prioritized and expanded access to MAT for OUD to reduce opioid misuse prevalence and the fatalities accompanying it (Bewley-Taylor, 2017). As a result, researchers suggest that Buprenorphine utilization in MAT programs for opioid dependence is significantly decreasing; retention rates have increased, and Buprenorphine is more attainable and poses less risk than Methadone (Agus et al., 2017). In addition, Snodgrass (2016) discussed the NAOMI study, showing that MAT is 88% effective in stabilizing opioid addiction in the opioid epidemic and thus saves lives. Over the last 20 years, women of reproductive age have had an exponential increase in overdose deaths from opioids;

however, medications for opioid use disorder (MOUD) are significantly effective in improving quality of life and reducing overdose deaths (Bonnet et al., 2021).

Despite these benefits, women on MAT find housing challenging due to the limited accommodation available for the MAT population (Komaroff et al., 2016). Housing Firsts (HF), a non-abstinence-based program, has case managers employed to assist in housing, employment, and financial training for those experiencing barriers to affordable housing access (Greenwald et al., 2018). Transitional housing managed by peers is believed to reduce harm and has a maximum length of stay of 3 years (Komaroff et al., 2016). Unlike the Oxford House, it is self-run, enforces total abstinence, and operates on an 80% democratic vote (Beasley et al., 2018). The official housing policies ensure everyone is treated the same, whether applying for housing that enforces harm reduction, total abstinence, or non-abstinence. Different housing entities make their own house rules, often leaving women on MAT homeless (Greenwald et al., 2018; Komaroff et al., 2016). I have found no official housing policies for women in MAT concerning sober housing.

Problem Statement

Opioid users lack organizational skills, usually suffer from mental or physical health issues, live in unstable conditions, and find maintaining schedules and responsibilities complex (Komaroff et al., 2016). Higher medical costs and increased substance use occur among homeless substance abusers and those with unstable housing (Alessi et al., 2017). Researchers explored women with opioid use disorder's socio-structural context of substance use disorder treatment (deRoon-Cassini et al., 2021).

Women with opioid use disorder face numerous negative issues of social stigma, limited SUD treatment availability, poverty, and a punitive societal approach to drug use (deRoon-Cassini et al., 2021). The findings suggest the need for expanding interventions addressing women's housing insecurity, childcare needs, and economic insecurity (deRoon-Cassini et al., 2021). According to Komaroff et al. (2016), opioid-dependent people often have significant housing problems and substandard living conditions. There are three different stipulations for housing available to opioid users on MAT: total abstinence, MAT, or harm reduction (Beasley et al., 2018; Greenwald et al., 2018; Komaroff et al., 2016).

Therefore, housing entities differ regarding whether they allow MAT women admittance or the ability to continue in the program (Alessi et al., 2017). More specifically, housing entities disagree regarding sobriety, with no set rules for dispensing MAT and no official housing policies for people on MAT (Alessi et al., 2017).

In this generic qualitative study, I addressed the perception of official housing policies concerning sober housing for women with MAT who are homeless, previously incarcerated, or in residential treatment. The need for housing accessible to women on MAT leads to the need to address the implementation of housing policies. Although the aforementioned studies regarding sober housing barriers for women on MAT illuminate significant findings, I have found no research examining the perception of official housing policies on MAT concerning sober housing. I explored the perception of official housing policies concerning sober housing for women in MAT to address the documented problem of securing housing while on MAT.

Purpose of the Study

My goal for this study was to understand the perception of official housing policies concerning sober housing for women in medically assisted treatment who are homeless, previously incarcerated, or in residential treatment. My goal was to address the barriers women face on MAT when attempting to obtain housing. Women on MAT often have difficulty finding substandard live-in housing (Komaroff et al., 2015). While MAT is the gold standard for opioid use disorder treatment, many MAT residents do not qualify due to abstinence-based recovery homes (Rinker, 2019). One of the arguments against the admittance of women to MAT is that a woman's recreational use or sale of MAT to other residents may occur because it is an opioid.

Research Questions and Hypotheses

The research question for this study was: What is the perception of official housing policies concerning sober housing for women with medically assisted treatment for those who are homeless, previously incarcerated, or in residential treatment?

Theoretical/Conceptual Framework

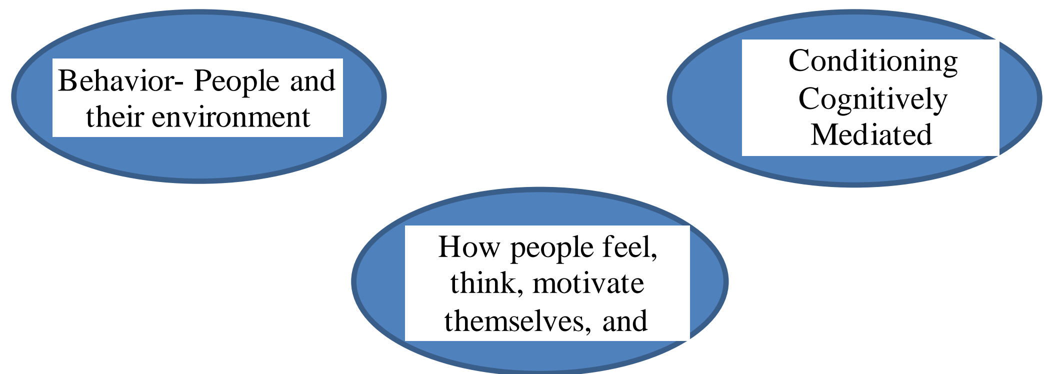
The theory most fitting for this study is Social Learning Theory. Albert Bandura (1974). a Canadian-born American psychologist is known for his social learning theory, in which he addressed how people and the environment operate simultaneously. Bandura (1974) postulated that behaviorism is linked with conditioning, such as salivating dogs, puppetry, and animalistic manipulation. However, Bandura (1974) believes learning through paired experiences is conditioning without explaining change and how it happened; therefore, conditioning was viewed as an automatic response and found to be

cognitively mediated upon further examination (Bandura, 1974). How people feel, think, motivate, and behave influences self-efficacy, as seen in Figure 1 (Bandura, 1993). People develop self-efficacy through significant processes, which are cognitive, motivational, affective, and selection processes, in which women must believe they can maintain abstinence (Bandura, 1993). The system shares organizing principles that grow, develop, and weaken, creating new systems and impacting individuals and the design.

In the present study, Bandura's social learning theory is based on narratives, which I used to conceptualize the perception of official housing policies concerning sober housing for women in medically assisted treatment who are homeless, previously incarcerated, or in residential treatment. In this research, I used social learning theory to advance understanding of what is needed to facilitate MAT.

Figure 1

Self-Efficacy



Self-Efficacy:

Collaboration is created through significant processes. (p. 8, para. 1)

Nature of the Study

This generic qualitative design study addresses the perception of official housing policies concerning sober housing for women with MAT who are homeless, previously incarcerated, or in residential treatment needing housing. I used social learning theory as a lens, while conducting interviews to understand women's perceptions, feelings, behaviors, and lived experiences on MAT regarding official housing policies.

All participants in this study were women ages 18 – 60 who live in Houston, Texas, but from different cities and states within the United States, guaranteeing some study diversity. I requested permission from The House of Extra Measures: Ralphs House, Houston, Texas transitional housing, to post a recruitment flyer on the women's information board and their assigned house chores board with the participant's criteria informing women about the study, access to research, and their interest in participating in the study. The participants met with me virtually or by telephone, whichever participants requested, before receiving oral information about the research and the risks involved (Bernard et al., 2018).

I explained my intent, study participation, participant privacy, and their right to withdraw without questions (Bernard et al., 2018). Participant vetting of potential MAT women occurred virtually or by telephone before the study began and the consent form was signed. Interested participants received a consent form approved by the Institutional Review Board (IRB) and my contact information for future inquiries (Weller, 2017). The women in this study were seeking housing after a residential program, incarceration, or homelessness. To assess this situation, I accessed the interview guide. I conducted virtual

interviews using a laptop media file or cell phone consisting of open-ended and probing questions to acquire data for participant analysis (Bernard et al., 2018). I performed the study virtually and recorded it with a laptop media file using semi-structured interviews and personal data sheets as tools for data collection until data saturation was achieved (Chang et al., 2020).

I will begin with nine interviews or until saturation is achieved. Virtual interviews will include women on MAT, homeless, previously incarcerated, or in residential treatment, and seeking housing. Participants were free to schedule the consultation based on their preference and discontinue it at any point. After completing the interviewing phase, I will start data collection analysis. To process the data, a thematic analysis will be used by organizing data into phrases, paragraphs, or statements. Next, I will categorize the words and phrases to find commonalities between the data to determine the ideas relevant to the purpose of the study (see Comunello et al., 2020). I will recruit participants using purposeful snowball sampling. Purposive sampling achieves a manageable amount of data by the primary researcher, including combining ideas to form a theory or system (Ames et al., 2019). Using this approach, I recruited only participants who met the specific criteria. Purposive sampling enables researchers to use detailed criteria in participation selection, which helps achieve transparency and increases transferability (Ames et al., 2019). I will use snowball sampling to find the specific population through Ralph's House participants, spreading the word to the general population.

The first criterion for eligibility is that participants must be women between 18 and 60. The second criterion is that participants must be on MAT. The third criterion was that the participants must be homeless, previously incarcerated, or in residential treatment. Finally, the fourth criterion is that the participant must need housing. I vetted potential MAT women virtually and by telephone before the study began and the consent form was signed. Each participant needed to meet all four criteria to be eligible for the study and was purposely selected from Ralph House, social media, or via Ralph's House participants' word of mouth to the general population.

Qualitative methodologists do not usually agree on the sample size needed for qualitative studies; however, they agree that some factors affect how many interviews are required before saturation is achieved (Cardon et al., 2015). Numerous factors influence the sample size needed to reach saturation, such as my nature and scope, interview quality, sampling procedures, researcher experience, and the number of interviews per participant. Furthermore, when no additional concerns or insights are detected and data is repeated, the adequate sample size is reached, and saturation is met (Cardon et al., 2015). I found two studies, one with a minimum of seven participants and another with a maximum of fourteen participants (Chatterjee et al., 2018; Granerud & Toft, 2015). The participant size depends on interview length and counts, purpose, probing questions, and detailed data guarantee maximum theme development; data saturation occurs when no new themes are developed (Bernard et al., 2018). I will categorize the data from the group of participants according to the outline's concepts, ensuring no new themes were developed. However, if the opposite occurs, creating new themes that align with the

outline concept will add more participants until saturation occurs. Given such, the sample size for this generic qualitative design study is nine participants or until saturation occurs.

The qualitative semi-structured interviews provided the primary data for the study. The discussion has questions focusing on a single concept and inductive and exploratory components, which are concisely stated (Rubin & Rubin, 2012). I will use interview questions to probe participants to discuss their perceptions and experiences securing housing for detailed data collection (see Bernard et al., 2018). Bernard (2018) postulated that the interviews will allow prompting, probing, and asking additional questions, enabling participants to express experiences and perceptions of the developed concept during the interview; the notation of verbal and nonverbal cues and interview notes were analyzed with the transcribed recorded interview documentation. I will examine the transcribed data, note the different ideas, and then conduct content analysis with open coding, line by line. Content analysis is conducted to interpret the data by studying the documented interviews for coding and categorizing themes, phrases, or words (Arsel, 2017).

Once the coding is complete, codes are reorganized into categories, and categories are examined to find critical themes. To determine essential attributes in any conceptual analysis by identifying concept elements performed by content analysis (Chaves et al., 2016). Therefore, questions to the author about the concept are essential. Several steps are involved in conceptual analysis (Amann et al., 2020), including data analysis of all commonalities in the data and then deciding how to develop the study's number of concepts. Next, the process existence or frequency of ideas is established, and then the

concepts for coding words, root words, and same-meaning phrases for the development concept categories are distinguished. Next, the rules developed for data coding are defined, the handling of irrelevant codes and actual data coding is established, and data analysis is conducted (D'Agostino et al., 2016).

I will use the concept of coding words and phrases with a maximum of 11 concepts, with code categorization within the set concepts. Inductive data analysis is used in qualitative research to learn about the study's problem by identifying themes or patterns (Lewis, 2015). I will use Dedoose software to code data from transcribed interviews and process field notes (see Liu, 2016). Interviews and observations are triangulated to validate the empirical findings and patterns further validate the empirical findings and patterns (Amann et al., 2020). I will search for critical concepts, topics, text, themes, data categories for coding purposes, and mode theme development. All knowledge of predetermined ideas regarding MAT and housing was achieved through researching MAT, housing, policies, official policies, and heroin addicts. Furthermore, participants could freely speak about their preconceived thoughts and perceptions of the phenomenon, achieved through essential questioning.

It is good practice for researchers to know their position regarding their research. Buckley and Doyle (2017) recommend starting in the early stages of research and using an identity/positionality memo to provide structure. I will maintain an identity/positionality memo in the present study. The note will assist in a focused written reflection of the research, including social, positional, and biased perspectives, and how internal and external facets of their identity and experience affect, form, and influence

their meaning-making processes and research (Comunello et al., 2020). I will use the memo to understand myself and identify and simplify the design process and topic. I will review the transcribed data, codes, and analysis to guarantee that coding and analysis are not diluted by ontology and positionality (Buckley & Doyle, 2017).

I am establishing credibility by structuring the study to find and work through a complex, repetitive research design process (Comunello et al., 2020). All virtual interviews increase credibility and enable me to gather rich details. Dedoose software is used to collect and analyze participants' data virtually. Dedoose software is used for virtual interviews to collect and analyze data until the data have themes or overall themes. For accuracy, participants can review the interviews after transcription, which helps validity and credibility (Buckley & Doyle, 2017). To further validate the study, each participant is screened to ensure that each participant met the participation criteria. I will provide the research findings from the correct perspective to ensure the study's conclusion's credibility and that the results are appropriate (Bibler-Zaidi & Ross, 2019). I will ensure credibility by applying triangulation, validation of participants, extended field engagement, negative case discussion, thick description presented, peer debriefing, reflexivity processes, and external audits to achieve confirmability (Comunello et al., 2020).

My responsibility is to supply every participant with information regarding the purpose and benefit of the study and obtain informed consent before any data is collected and before the IRB approves the study (Bibler-Zaidi & Ross, 2019). In addition, I will ensure no harm to the participants and communicate that participation is voluntary; it is

acceptable if participants do not answer any offensive, stigmatizing, or traumatizing questions presented during the interview process (Buckley & Doyle, 2017).

Transparency provides transferability, method reproducibility, and proper interpretation, supporting the validity of the findings (Bibler-Zaidi & Ross, 2019). Transferability allows qualitative research to be applied to other contexts instead of generating results directly applicable to different settings and contexts (Comunello et al., 2020). I will ensure transferability by providing a detailed description so readers can compare other contexts with all the available information and then transfer findings and aspects of the study design to different contextual factors being considered (Comunello et al., 2020).

Comunello et al. (2020) expressed that solid research design is the key to dependability. The research study is dependable if it proves consistent and stable over time (Comunello et al., 2020). Comunello et al., 2020 noted that the researcher would achieve reliability by using appropriate methods to indicate why the technique applies to the study's core constructs and concepts. Triangulation, sequencing methods, and having a well-formulated justification for the method choice confirm that the appropriate data collection plan was created for the research question. Comunello et al., 2020 noted that the researcher would fully resolve biases and prejudices through reflexivity, triangulation strategies, and external audits to attain confirmability (Comunello et al., 2020).

Definitions

A-CHESS: an acronym for Addiction-Comprehensive Health Enhancement Support System, is a tool to help reduce alcohol use (Chassler et al., 2019).

BUP/NX: buprenorphine-naloxone, a take-home treatment (Hay et al., 2020).

Buprenorphine: classified as a controlled substance schedule III drug approved by the FDA for opioid treatment. Buprenorphine is a partial μ-opioid receptor agonist like heroin and methadone; it will produce a euphoric high and cause respiratory depression (Adinoff & Robinson, 2018; Danilewitz & McLean, 2020; Edwards et al., 2019; Moore, 2019).

CSE: is an acronym for coping self-efficacy, which helps people manage strategies (Brink et al., 2021).

Dual diagnosis: is also known as co-occurring. The participant must have both a substance use issue and a mental health diagnosis (Chen et al., 2019).

FASH: acronym for Fentanyl-adulterated and fentanyl-substituted heroin. An illegal form of fentanyl in powder or pill form (Carroll et al., 2017; Ciccarone et al., 2017; El-Haddad & Suzuki, 2017; Gladden et al., 2016).

FYSB: Family and Youth Services Bureau administers a Transitional Living housing program for homeless youth ages 16 – 22 (Brown et al., 2017).

HIV: human immunodeficiency virus, a common disease among substance users (Abel et al., 2020; Cacciola et al., 2015; Galang et al., 2016; Ministry of Justice, 2020; US Centers for Disease Control & Prevention, 2018).

HUD: Housing and Urban Development are among the three housing options for homeless people (Bishop et al., 2017).

MAT: acronym for medically assisted treatment for opioid users who must have been on opiates for a year to be eligible, utilizing Methadone, Buprenorphine, or Naltrexone.

MBSR: acronym for mindfulness-based stress reduction. It is an eight-week session taught in MORE treatment (Garland et al., 2016).

Methadone: opioid receptor agonist. All physicians prescribing methadone must register with the DEA each year since 1974. Most clinics patients visit daily for methadone dosing; however, unregulated take-home methadone doses are allowed, but restrictions on the maximum take-home quantity are enforced depending on when a patient has been in treatment (Adinoff & Robinson, 2018; Aimee et al., 2021; Corkey et al., 2004; Elmusharaf et al., 2018; Idzik et al., 2019)

MMT: is an acronym for Methadone Maintenance Treatment (Hay et al., 2020).

MORE: Mindfulness-oriented recovery enhancement treatment. It is a non-pharmacological treatment for SUD (Chen et al., 2019).

Narcotics Anonymous: is a 12-step support group for people addicted to drugs who want to stay clean (Beasley, 2018).

NAOMI: acronym for North American Opiate Medication Initiative, a study testing whether methadone or heroin-assisted therapy improved life-long quality of life. The NAOMI studies show about 88% retention rates (Snodgrass, 2016).

OUD: opioid use disorder. The participant must have an addiction to opioids, whether prescription or non-prescription painkillers, heroin, or Xanax (Bohmer et al., 2020; Moore, 2019).

*Pharmacotherapeutic***:** aspect of OUD treatment that defines MAT as an opioid treatment for addiction in a certified, licensed program or a physician's office to provide pharmacotherapy maintenance. An opioid agonist is a partial agonist or antagonist medication combined with medical and psychosocial services or other treatment services (Adinoff & Robinson, 2018).

*POMC***:** acronym for proopiomelanocortin. Its cells activate MC4R-expressing neurons in the paraventricular nucleus of the hypothalamus and other brain regions (Daimon et al., 2021).

*QALY***:** stands for quality-adjusted life years (Hay et al., 2020).

*Recovery Housing***:** refers to a self-sufficient, completely peer-run home that is abstinence-based (i.e., Oxford House) (Cacciola et al., 2015).

*SUD***:** refers to substance use disorders. The participant can be addicted to any controlled substance, including alcohol (Moore, 2019; Snodgrass, 2016).

*Supportive Housing***:** refers to homeless people with substance use disorder and one or more disabling conditions (Pannella-Winn & Paquette, 2016).

TCO **is a Colombian transnational criminal organization that produced illegal opioids and brought them** into the US (Ciccarone, 2019).

*TH***:** Transitional Housing is one of the three housing options for homeless people (Bishop et al., 2017).

*TLP***:** refers to the Transitional Living Program, housing for homeless youth aged 16 – 22 (Brown et al., 2017).

*XR/BUP***:** stands for long-lasting Buprenorphine injection (Hay et al., 2020).

*XR-NTX***:** is extended-release Naltrexone is used for alcohol and opioid use disorders; it is time-released (Fishman et al., 2020; Hays et al., 2020).

Assumptions

I assume potential participants would talk to her at length, give detailed, rich data, offer constructive feedback, and honestly answer qualifying and interview questions. This generic qualitative design study consists of in-depth interviews that address the perception of official housing policies concerning sober housing for women in MAT. Another assumption is that the participants would receive "Medically Assisted Treatment," which is the pervasive stigma of OUD through pharmacologic treatment; Methadone and Buprenorphine, opioid receptor agonists, could be why medication is cast as the "assisted" part of OUD therapy (Adinoff & Robinson, 2018). Furthermore, they noted that the stigma of people with an addiction replacing one drug with another has been evident in programs and patients for over a decade. Additionally, the stigma remains present in peer-support settings using pharmacotherapeutic therapy approaches.

Finally, the stigma is so prevalent, locally and worldwide, that Narcotics Anonymous faces questions regarding member participation of those on MAT and whether they meet the criteria for participation (Adinoff & Robinson, 2018). Acquiring housing and attending NA meetings has been perceived as a concept with an implied basis with MAT. AATOD (2019) discussed the term "assisted treatment," which denotes that medication alone is insufficient to treat complex OUD and asserts that meetings are required. However, researchers have not proven how official housing policies could determine standard rules for all housing types to ensure equal housing opportunities for

MAT women. Therefore, the previous concept provides the basis of this study, which explores the perception of MAT in acquiring housing. The thematic analysis will yield results based on perceptions and lived experiences of women on MAT shared that will be used to address the research question.

Scope and Delimitations

Rinker (2019) suggested that many MAT residents do not qualify for recovery homes because they are abstinence-based. Further, MAT has been coined as the gold standard for OUD treatment and as an opioid; therefore, chances for women's recreational use and selling to other women are too dangerous. Thus, the one treatment available to help heroin addicts is being rejected in many recovery homes. Opioid addiction is a "disorder of brain structure and function" (Snodgrass, 2016, para. 1). Any condition should be treated with the best medication proven effective for the disease. However, some argue that limits should be put on the medication for the opioid epidemic, addiction, and death (Snodgrass, 2016). The lack of administering MAT, securing housing, and fighting the opioid epidemic results in increased substance use, higher medical costs, unstable housing, substandard living, homelessness, mental and physical health issues, and a lack of organizational skills and maintaining schedules or responsibilities (Alessi et al., 2017; Komaroff et al., 2016). All the approaches, qualitative research, MAT participants, stakeholders, housing staff, and legislative staff may represent competing beliefs and understandings to get things done, which may cause MAT participants, stakeholders, housing staff, and legislative to retreat to strengthen its power base (Boaz & Locock, 2019). They argued that the territorial defense adds to the

confusion of the stakeholders, the legislative and housing staff required to work with and draw clear boundaries amidst blurred lines (Boaz & Locock, 2019).

Limitations

One of the study's limitations is that the selected population is women from one transitional house, Ralph's House participants word of mouth to the general population, and social media (FB). They may not respond openly or truthfully, but how they feel, I expect them to. Bibler-Zaidi and Ross (2019) posit social bias as a limitation to data collection as participants may respond based on how they believe I wanted them to. Their behavior would be altered because they are being observed, known as the Hawthorne effect (Bibler-Zaidi & Ross, 2019). I will address limitations by conducting dialogic engagement. There may be limitations in purposive sampling because of selection bias and errors due to a lack of random sampling (Ngozwana, 2017). Cui et al. (2022). The small sample size is a limitation because it can be viewed as insufficient and limits the ability to stratify the sample by age and length of time in searching for housing. An example that better exemplifies the populace of women on MAT could enhance transferability to other samples or contexts by the readers of this study. Transferability is likely increased by providing rich and detailed data (Cui et al., 2022). This research challenge may not have been possible if I did not have adequate participants for my study. Not having the correct number of participants in my research will make my research not adequately addressed because of the lack of data. Another challenge for me is to remain unbiased and impartial due to familiarity with this population. The study should not compromise the participants' privacy; therefore, having a secure location that

protects the participants' identity and privacy while interviewing and divulging information is critical (Ngozwana, 2017).

Significance

This generic qualitative design study aims to address the perception of official housing policies concerning sober housing for women in MAT who are homeless, previously incarcerated, or in residential treatment. This study aims to improve the process of securing housing for MAT women, ensure equal opportunities for all women in addiction, and implement official MAT policies in all housing facilities, thus emphasizing its significance. Pannella-Winn and Paquette (2016) expressed local, state, and national policies to help homelessness or housing instability. The American Rescue plan passed by Congress in March 2021 for housing and homelessness issues included $5 billion specifically for assistance funding for housing and homelessness assistance (Yang, 2021). Yang states that local governments are issuing funds to focus on finding new solutions to homelessness. Yang noted that the federal and provincial levels often do not link together. Therefore, a state program, Project Homekey, receives $1.2 billion and is set to accept another $2.75 billion in September to provide additional access to affordable housing by turning hotel rooms into permanent housing (Yang, 2021). A federal plan was implemented to ensure the state and local communities have the needed guidance and resources to build a system that will end homelessness ("United States Interagency Council on Homelessness," 2022). Although it is a federal plan, the local communities are urged to collaborate to develop local and system-level intents to prevent and end homelessness. The goal to reduce homelessness by 25% by 2025 is an initial framework

to end homelessness in the United States ("United States Interagency Council on Homelessness," 2022). The results of this study may give information to Congress, the federal government, local governments, and communities who need support in interpreting and applying the policies in all housing entities.

The results of this study may also serve as a resource for understanding how housing policies could assist women on MAT and the potential benefits of securing housing. Knowing how official housing policies for women on MAT can bring positive social change with new insight for implementing housing policies. Housing policies can reduce adverse effects such as homelessness, unstable housing, bias, and relapse. In addition to creating official housing policies for MAT in all housing entities, the present study may give hope to numerous women affected by homelessness and housing instability due to being on MAT. This study may be the information needed for the state legislature to implement official housing policies.

Understanding the implications of implementing official housing policies for women on MAT may give new information on the benefits of official housing policies for women on MAT or any consequences affiliated with official policies for women on MAT. Knowing how official housing policies affect women on MAT could cause positive change in giving insight to all housing entities on stipulations, if any, on MAT and assisting those women who need housing. In addition, official housing policies can decrease homelessness, relapse, and lack of housing. Finally, official housing policies for women on MAT can aid in transitional housing, stable housing, abstinence, and possible employment opportunities to help stabilize women's lives.

Summary

This chapter introduces the research study, which seeks to consider official housing policies for women with MAT. People on MAT experiencing homelessness and unstable housing must overcome housing barriers presented by stakeholders, local, state, and national implementing, adapting, interpreting, and applying official housing policies. Unfortunately, very little research has been conducted on official housing policies for MAT, although Medicaid policies for opioid agonist therapy have been studied and have no impact on housing policies (Bauhoff et al., 2016). Chapter 1 describes the problem statement and purpose of this study. First, the research question is outlined, providing a theoretical lens and description of the nature of the study. Next, the definitions of constructs, assumptions, scope, delimitations, limitations, and significance are provided. This study aims to contribute to research regarding women's perceptions and experiences concerning sober living on MAT. The information seeks to assist housing entities, local communities, state legislation, and women concerning the perception of official housing policies.

Chapter 2 provides information on the theoretical foundation of the study. It expounds on the social learning theory, how it relates to this study, and why it is appropriate for this study. In addition, it includes a literature review and historical content on opioids, MAT, and housing entities. This study aims to understand how experiences and perceptions of official housing policies concerning sober living affect women on MAT.

Chapter 2: Literature Review

Many previous opioid users on MAT seek housing after residential treatment to maintain sobriety, alleviate homelessness, find structure, and continue having a sober support network (Beasley et al., 2018; Greenwald et al., 2018; Komaroff et al., 2016). However, they face discriminatory housing barriers because no official housing policies are standardized, leaving each house to decide whether to accept or deny housing to the women (Alessi et al., 2017). In addition, women in treatment programs face challenges different from men regarding demographic and treatment progress (Berkeljon & Mondragon,2010). For example, women reported substantial differences regarding women being employed less, having lower incomes, and having less healthcare access than men (Berkeljon & Mondragon, 2010).

In chapter 2, I give an overview of the literature review strategy for finding research articles supporting the study. The literature review has six sections. The first section provides a history of opioid users. The second section is a discussion on Methadone treatment for opioid users. The third section includes a discussion of Buprenorphine treatment. The fourth section includes information about Naltrexone treatment. The fifth section includes review of different housing types. The sixth section includes literature on self-efficacy. Finally, the seventh and concluding section provides a summary of the chapter.

Historical Context

The media and public health gave warning regarding heroin addiction among lower socioeconomic groups in large metropolitan cities in the late 1960s and early 1970s

(AATOD, 2019). This caused towns nationwide to immediately open methadone treatment facilities in the late 1960s (AATOD, 2019). In addition, McConnell (2020) noted that the U.S. Department of Housing and Urban Development (HUD) launched the CAREER ACT, a program supporting the Patients and Communities Act, in October 2018. The CAREER ACT revealed that transitional housing, steady employment, and sobriety are necessary for substance users. Therefore, the federal government allocated over $275 million to Kentucky, DC, and 23 other states for the Commonwealth's prevention treatment to tackle the opioid and substance abuse crisis (McConnell, 2020). In addition, having official housing policies implemented guarantees that the procedure for abstinence in both housing types is the same and ensures fair and equal treatment to all women on MAT requiring housing (Pannella-Winn & Paquette, 2016).

Although SAMSA and NIDA have implemented some guidelines and policies, and many lessons have been learned over 50 years of using medication to treat OUD stigma and discrimination over any effective public policy, our nation still has significant problems (AATOD, 2019).

This generic qualitative design study may increase the knowledge in addressing the tools needed to create official housing policies for women on MAT and secure housing. Given all these factors and their implications, this study is essential. This study can potentially promote change for women on MAT by implementing official housing policy standards that are universal in all types of housing.

Literature Search Strategy

Attempting to exhaust all areas for articles about official policies on housing, opioid users, and MAT, the following databases were searched: PsycARTICLES, ERIC, GreenFILE, PsycINFO, Academic Search Complete, CINAHL Plus with Full Text, EBSCOhost, Gale Academic, Primary Search, Education, Human Services, and SocINDEX with Full Text. Only peer-reviewed articles within the last 5 years were included in the search results. The following keywords are used to find pertinent articles for the study: *opioid, opioid users, the opioid crisis, opioid epidemic, substance users, medically assisted treatment (MAT), opioid medically assisted treatment (OMT), drug policies, policies, and procedures, official policies, laws, housing, transitional housing, harm reduction, Oxford House, housing policies, housing programs, housing options, homeless, the commission, narcotic drugs, Buprenorphine, Methadone, Naltrexone, recovery options, long-term recovery, Global Partnership, drug policy development (GPDPD), and World Health Organization (WHO).*

The initial search using the terms *opioid, opioid users, the opioid epidemic, opioid crisis, and substance users* yielded important information for that category. After the initial inquiry, keywords added to successive lines narrowed the search to the theories within the study, including *MAT, maintenance treatment, policies, housing, homelessness, which, globally, self-efficacy, and long-term recovery*—in addition, narrowing the search to add medically assisted treatment helped obtain current articles on the subject that were otherwise unavailable. For example, Bohmer et al. (2020) discussed that the Federal Cabinet in Germany adopted the National Strategy on Drug Addiction

Policy in 2012 to help substance users avoid or reduce their use through harm reduction repression, prevention, and treatment.

Theoretical Foundation

I used social learning theory as the theoretical foundation for this study. This theory states tha people and the environment operate simultaneously. People are influenced by what they see (Bandura, 1974). The social learning theory states that people are affected by written words, observation, and personal experiences. Bandura (2001), the founder of the social learning theory, believed that people respond to behavior or perceived constraints in explaining human learning (Bandura, 2001). As seen in Figure 1, Bandura further expressed that behavior is cognitively mediated. That is, how people think, feel, and motivate themselves, and that behavior influences efficacy (Bandura, 2001). Social learning theory includes behavior and cognitive learning theories, including a process with four components: attention, retention, motivation, and reproduction (Bandura, 1986; Bandura, 2001). First, people must pay attention and accurately perceive the modeled behavior being observed. Secondly, the observing people must retain what they observed. Third, people must maintain the image of the demonstration and replicate the movement. Fourth, people must be motivated to learn a behavior because people do not duplicate every behavior they have learned, but only those that inspire them (Bandura, 1986; Bandura, 2001). Bandura (1986) asserted that other people's behavior is used to model their behavior in unidentified circumstances. This theory shows that people emulate negative or positive substance abuse behaviors from their significant other,

peers, friends, or parents. They often learn what they do not want to experience from observation.

Social learning comprises two opposing learning theories (Omrod, 1990). Human learning is a function of the environment and mental processes. In the 1950s and 1960s, social learning theory blended behaviorism, the dominant learning theory, and cognitive learning theories, which gained eminence in the 1970s and are still prominent in the 21st century (Omrod, 1990). In 1977, Pierce (1977) expressed that Bandura argued that no practice or reinforcement is needed but only observation for learning to happen. Pierce (1977) also believed that emphasizing the environment and cognition to exclude others led to “a truncated image of human potential” (p. 1). Bandura (2001) postulated that behavior imitation and consequent reinforcement are often delayed and further noted that learning happens during stimuli while the person observes the model without support. Locke (1987) expressed that people learn by watching or modeling others’ behaviors; thus, the characteristics of the model and learner impact the modeling process.

The environment and cognition are both reinforcements, and the environment can reinforce modeling (Locke, 1987). Just as the environment could influence people’s behavior, people can change the setting through their behavior because it is possible for each factor to control the other two facets and be affected (Locke, 1987). Bandura (1977) further expressed that modeling has substantially impacted behavior therapy because it can encourage positive behavior and eradicate undesirable behaviors.

A person's sense of self-efficacy is their belief in their abilities to perform the tasks to achieve their jobs (Ben-Yuda, 2016). Bandura’s (1977) earlier theories

emphasized modeling; however, his later theories emphasize people's self-efficacy and the impact of motivation, which makes people work diligently at a task when they believe they are good at that task and work less when they think they are not capable (Bandura, 1977). First, according to Bandura (1977), people must possess the skill taught and have confidence in their abilities to attain the objective. Second, people must maintain confidence and positive thinking in their abilities, which produces faith (Bandura, 1977). Finally, it is essential to understand that self-efficacy is part of a network, not a one-factor theory (Lent, 2016). It comprises cognitive, behavioral, trait contextual, and gender input variables, and some characteristics would be confident, ambitious, hopeful, outcome expectations, supportive, and kind (Lent, 2016).

Social learning theory's overall premise is that deviant behavior, such as substance use, is a learned behavior, like any other behavior (Higgins et al., 2019). People with friends or family who approve of substance use have an increased likelihood of substance abuse (Higgins et al., 2019). People model what they see around them, known as imitation; friends, family, acquaintances, and their social environment are forms of negative approval if that is portrayed. People committing criminal behavior, i.e., substance abuse, expect differential reinforcement, the anticipated punishment or reward (Locke,1987).

According to Locke (1987), part of social learning theory is non-social reinforcement because of the unconditioned physical and physiological stimuli derived from intrinsic rewards after performing the behavior. The individual has four principal bonds: attachment, commitment, involvement, and belief (Higgins et al., 2019; Loughran

et al., 2017). Higgins et al. (2019) postulated that the first attachment to those who approve of substance use is likely to result in committing deviant behavior due to close friendships. Second, it is the individual's stake in compliance with the law; for example, someone on a football team would choose not to indulge in substance use due to the risk of dismissal from the group. Third, Higgins et al. (2019) noted that the more people are involved in meaningful and social activities, the less likely they are to indulge in substance use but rather spend time in prosocial activities. Fourth, if people do not believe in society's laws and values, there is a greater likelihood of substance use and criminal behavior (Higgins et al., 2019; Loughran et al., 2017).

Bandura (2007) asserted that for an alcoholic, there is no difference in asking the bartender for cognac or ginger ale. An alcoholic has choices, the skill to put down the cognac, pour it out, or leave the bar. Bandura (2007) postulated that a substance user has the capability of self-management and self-regulation rather than a matter of will. Substance users cannot typically regulate their self-will regardless of how badly they want to stop using opioids (Chatterjee et al., 2018). Furthermore, they may abstain for a couple of months, but then emotional states catch them off guard and relapse (Carlsen et al., 2019).

Self-regulation is related to several problematic substance abuse conditions: the ability to manage stressful situations, depression, boredom, loneliness, social pressures, restlessness, and interpersonal conflicts (Bandura, 2007). Bandura (2007) expressed that reward is motivation, and reinforcement is a factor in observational learning. For example, the substance user can have reinforcements from their environment and

cognition by getting high with a peer and being told how good the heroin is (Bandura, 1974). The second aspect Bandura (1997) discussed is self-efficacy and collective efficacy, which is critical to understanding what motivates people to tackle significant societal problems. Bandura (1997) believed groups and individuals do not readily solve a problem unless they have a perceived sense of efficacy to rectify the situation individually or collectively. Therefore, economic stakeholders, housing providers, treatment providers, mental health providers, MAT facilities, and government officials must collectively unite to make official housing policies on MAT to ensure fair treatment for all substance users (Alessi et al., 2017; Paquette & Pannella-Winn, 2016). Finally, perception is everything. Bandura (1997) stated that if people perceive an issue, they can positively address an issue individually and collectively.

In this study, I interviewed people modeling behaviors from parents, significant others, friends, or peers who have learned from one or several influences. Social learning theory was relevant to this study, and I used it to clarify how women have observed substance abuse by loved ones or peers, influencing their attitude toward substances. The women in this study were influenced by observation, actions, and philosophy, which impacted how they feel and approach their situations in adulthood. I will explore if substance use observed as a child or as an adult is more prevalent in their attitude toward substance use.

Another theory relevant to the topic of study is the strain theory by Robert Agnew. Agnew (2001) believed that a justification for substance users' behavior is negative affective states produced by indirect deviance. Brady et al. (2018) expressed that

there are three types of sources believed to cause strain: failure to attain positive goals, which may happen when successful barriers are visible (e.g., prejudice or racial discrimination), loss of positive stimuli (e.g., death or illness of a loved one, the breakup with a girlfriend or boyfriend), and individuals not being able to avoid negative triggers when young (e.g., negative stimuli) child abuse, hostile parent and peer relationships, criminal abuse, and unstable employment.

Brady et al. (2018) stated that Agnew believed minorities, particularly African Americans, are more likely to confront strain than Whites living in poverty, disrupted families, and academic problems leading to delinquency and criminality. In addition to the Strain Theory mentioned above, Agnew believed that negative affective states were indirectly produced through strain deviance (Agnew, 2001; Brady et al., 2018). Agnew (2001) thought anger is the primary negative affective state connecting strain to coping with criminality because it lowers inhibitions, increases feelings of entitlement and revenge, and leads to other aggressive traits. According to Agnew (2001), the General Strain Theory (GST) and substance use have been investigated in the existing literature; it was determined that experiencing strain and coping through substance use has a consistently positive relationship with substance use being the coping mechanism when experiencing negative stimuli (e.g., stressful life events, personal problems, depression, and suicidal behaviors of family and friends) in abusers (Agnew, 1992; Brady et al., 2018). GST explains strain and its relationship with the substance user, although this study's foundational theories are behavior and self-efficacy.

Literature Review

Opiates such as heroin and morphine (medicinal) originated from the opium poppy. They were first recognized in the 1800s and advertised to doctors and patients as an approach to relieve pain and treat ailments such as coughs, diarrhea, anxiety, and minor pains safely and effectively (Binswanger & Lyden, 2019). Ciccarone (2019) stated that a German pharmacist, Friedrich Serturner, discovered in 1805 that morphine was given to women and was primarily distributed by American physicians, making the ensuing opioid misuse problem medically induced and worsened using hypodermic syringes. Substantial cultural and societal aspects of heroin use in the 1940s and 1970s often signified an outsider status. This suggests the refusal of typical values and solid supply-side forces after World War II development of the Italian and French connection (Ciccarone, 2019). Madras (2017) stated that the US was provided with heroin in the 1970s from a new source of heroin, which was imported from Southeast and Southwest Asia (Ciccarone, 2019). According to Madras (2017), in the 1990s, Colombian transnational criminal organizations (TCOs) produced a new form of heroin, which was brought into the United States, causing an escalation in heroin use and, thus, harmful outcomes.

The supply of opioid pills, refined heroin, and fentanyl had emerged, and the demand for societal and cultural opioid use led to opioid dependency (Ciccarone et al., 2017; Madras, 2017). Fentanyl-substituted heroin and fentanyl-adulterated (FASH) have the most significant increase in overdose in the Northeast and Midwest regions (Ciccarone et al., 2017). El Haddad and Suzuki (2017) noted in a flourishing unit of

chemical similarities, fentanyl is the main chemical; the similarities are in a variety of Morphine-equivalent strengths, with some being less effective by weight than fentanyl and others having greater effectiveness (El Haddad & Suzuki, 2017). There is great concern regarding potent opioids in the fentanyl family, which include carfentanil, sufentanil, and remifentanil, and whether they will become well-known in the opioid arena (El Haddad & Suzuki, 2017). The DEA reports that China is the primary source of illegally produced fentanyl, which is transferred in powder and pill form to the US through Internet sales, Canada, and Mexico (US Drug Enforcement Administration, 2016).

The illegally manufactured FASH is incorporated into the illegal drug distribution in powder form, counterfeit opioid pills, and counterfeit benzodiazepines sold as heroin (Gladden et al., 2016). Carroll et al. (2017) noted that FASH did not have a demand in the market, yet there is a gamut of desire for FASH ranging from aversion and refrainment from accepting FASH to being an enthusiast; therefore, heroin users substantiate it has been unexpected and unsettling. Heroin users who support fentanyl are hindered from buying it due to the identity being concealed as heroin or counterfeit brand name pills (Ciccarone et al., 2018). Ethnographic observations indicate a greater danger of fentanyl due to the swift changes in its purity and effectiveness, fentanyl similarities, and different heroin combinations (Ciccarone et al., 2018). Effectiveness, purity, and mixture variations in the fentanyl arena may affect the overdose ratio (Ciccarone et al., 2018). There is growing concern regarding the misuse of the opioid pill and moving to heroin because it changed from oral administration to intravenous injection; in the US,

injection is favorable, which brings concerns regarding the spread of hepatitis C and HIV (Galang et al., 2016; US Centers for Disease Control & Prevention, 2018).

Pardo (2018) indicated that interventions for fentanyl drug supply include controlling the source and prohibition; therefore, a mutual stance is required between the US and China to improve monitoring, regulation, and pharmaceutical and chemical manufacturing to prevent illegal sales. Knierim (2018) noted that the US and Chinese governments had made an increasing list of controlled psychoactive drugs, including opioids and originators, and discussed classifying fentanyl as a class drug. However, banning it will be challenging due to the available amount of illegal fentanyl (Alexander et al., 2021). Alexander (2021) noted that fentanyl and other similar opioids rose tenfold between 2013 and 2018, resulting in deaths—Furthermore, 40% of fentanyl deaths in 2018 involved cocaine and 11% of methamphetamine. In the US in 2016, an importation ratio of 1:4 totaling 2.6 metric tons was possibly distributed; this amount would fit into ten industrial drum barrels (US Drug Enforcement Administration, 2017a). The Iron Law of Prohibition recommends that drugs like fentanyl, which are highly potent, be expected because of perfecting the effects of prohibition (Beletsky & Davis, 2017). Another concern is tight limits on the original fentanyl, which quickly promotes the supply of substances similar to fentanyl, currently up to 60 but can surpass 600 (Beletsky & Davis, 2017).

The DEA has enforced a first-ever class restriction on the fentanyl family to discourage the resourcefulness and creativity of illegal drug producers (Beletsky & Davis, 2017). Interventions such as monitoring drugs, collecting identification and data,

and increasing local drug surveillance by data sharing are implemented to prevent the drug supply (Pacula & Powell, 2018). Improved administration would benefit first responders, emergency and hospital staff, public safety, and community-based programs (Ciccarone, 2017). An informal form of leadership in the US that is evolving is drug checking due to the FASH crisis (Ciccarone et al., 2018). Drug surveillance, increasing the Naloxone distribution, raising the awareness level of Naloxone in the community, supplying clean syringes, creating consumption places that are supervised to prevent overdose, and decreasing blood transmission risks are medical treatment, supply interventions, and harm-reduction approaches provide a safety net for at-risk people (Coffin et al., 2017).

Southeast Asia, Southwest Asia, Mexico, and Colombia were importing heroin before 2000; in the 2000s, heroin was mostly transshipped by TCOs from Colombia and Mexico (Coffin et al., 2017). As a result, the distribution of heroin was split, with the eastern US supplying Colombian heroin and the western US supplying black tar heroin (US Drug Enforcement Administration, 2015). The Mexican TCOs progressively controlled the heroin market in the US, from small competition to increasingly regulating their market share in 2005, from 50% to 90% in 2016 (US Drug Enforcement Administration, 2015a). The Drug Enforcement Administration (DEA) reports that from 2005 to 2012, the DEA obtained heroin samples from eastern US cities from unknown sources and of unknown quality, suggesting that Mexican-sourced heroin is more refined (U.S. Drug Enforcement Administration, 2016). The USDA noted that the more refined heroin from Mexican authorities is called “Mexican White,” mirroring the Colombian-

sourced powder heroin replaced in the Northeast and Midwest retail outlets (U.S. Drug Enforcement Administration, 2015). Opioid addiction dates to the Civil War, and ailing veterans experienced the first opiate addiction epidemic (Courtwright, 2015). From the 1910s to the 1920s, records of morphine maintenance clinics in the United States indicate that the southern White population experienced the highest rate of opiate addiction (Courtwright, 2015).

Few Black Southerners were in the clinics' records due to racist beliefs about Black bodies and inadequate medical care provided to Black Civil War troops in the 19th century (Courtwright, 2015). In the 19th century, psychiatry believed opiate addiction came from being mentally overstimulated, leading to substance use and insanity (Courtwright, 2015). Furthermore, psychiatrists thought Black Americans were too simple-minded for mental overstimulation; therefore, they could not suffer from insanity and opiate addiction, which only occurred in White Americans (Courtwright, 2015; Roberts, 2020). J. D. Roberts, a North Carolina doctor, postulated that Black bodies did not have the same delicate nervous organization as White bodies; therefore, Black bodies did not require the opium stimulant (Roberts, 2020). Roberts (2020) further expressed that Black people were ignorant of medical care and did not know how to care for themselves while medicating with opiates like White Americans.

The United States experienced an unforeseen rise in the opioid epidemic in the 1990s, resulting in an estimated 350,000 opioid overdose deaths between 1999 and 2016 (Bowen & Irish, 2019; Chekol et al., 2020). James Adams noted in 1889 that there were three disadvantages of opium: "In an overdose, it is an active poison; in ordinary doses,

various functional derangements largely offset its benefits, and its use involves the danger of the opium habit," which caused Adams and colleagues to want change (Binswanger & Lynden, 2019, p. 1). As a result, the Harrison Anti-Narcotic Act was implemented. It regulated the dispensing, importing, producing, or selling of opioids, registering and paying a nominal tax, and keeping detailed records, which is believed to have decreased opioid consumption (Courtwright, 2015). Courtwright. (2015) further states that the Harrison Narcotics Act bill increased revenue from opium and coca leaves traffic and discouraged opioids. Drug addicts and smokers use coca leaves. In 1970, inhibitory opioids were discovered; however, in the late 1990s, they changed opioid prescription patterns (Brow et al., 2021). Charlesworth et al. (2019) argued that these changes were due to pain recognition as a debilitating health issue instead of an adverse health event causing frequent opioid use by healthcare providers (HCPs). Treating acute pain or injury with opioids is usually the catalyst for long-term opioid use.

Furthermore, each day opioid medication is supplied, it is likely that after the third day, persistent opioid use increases. The Centers for Disease Control and Prevention (CDC) reported that between 2002 and 2010, prescription opioid abuse increased; between 2011 and 2013, it peaked (Baldwin et al., 2017). Charlesworth et al. (2019) reported that about 8% of opioid-naïve patients being given opioids after surgery for seven days were still on opioids a year later. In the United States, since 2000, over 750,000 lives have been lost to opioid overdose, of which 70,630 occurred in 2019, indicating an acceleration of drug overuse throughout COVID-19 (Borquez et al., 2020). Overdose deaths in the early 2000s were primarily due to prescription opioids; however,

heroin-related overdoses have increased since 2010 (Bohnert et al., 2020). An individual's pathway to heroin use can vary by age and cohort (Cheslack-Postava et al., 2018). In the 1960s, opioid users reported being introduced to heroin as teenagers, while opioid users in 2010 reported that their introduction to opioid use was as an adult through prescription opioids (Cheslack-Postava et al., 2018). According to Gaul (2020), the rates of heroin-related overdoses were significant in individuals aged 18–25 and 26–34 as of 2017 (Hair et al., 2019).

Over 11.5 million people aged 12 and up misused prescription opioids in 2016 (Hair et al., 2019). Additionally, in 2016, drug overdose deaths from prescription or illegal opioids (66.4.5%) soared by 27.7% since 2015. Since 2010, the prescribing of moine milligram equivalents (MME) has declined, but opioids are still the usual pain reliever for many (Hair et al., 2019). The Gaul (2020) surveillance data revealed that in 2017, over 56.8 million people had an opioid prescription filled, with 13% between 20 and 24 years old and 17% between 25 and 34 years old. People misusing opioids, overdosing, and OUD frequently pave the way for the legitimate use of prescription opioids, and progressing to illegal drugs was identified as the unintentional consequence of prescriptions (Hair et al., 2019). In 2018, opioid use was a significant issue for high school students and young adults in the United States; 6% of 12th graders reported illicit prescription opioids, and 0.8% reported heroin use (Fishman, 2021). In 2018, the National Household Survey proposed that 0.4% of teenagers under 18 and 0.9% of adults aged 18–25 had OUD (Bachman et al., 2019).

Prescribed Opioids in Emergency Departments

People with acute or chronic pain-related conditions seek treatment in the emergency room as a significant source of prescription opioids (Idzik et al., 2019). Of 18.8 million prescriptions annually, about 19% are emergency discharges with opioid medications. Chronic pain refers to non-cancerous, not life-threatening pain lasting three months or more than the duration of normal healing tissue (Brow et al., 2021). Between 2004 and 2011, misuse or abuse of prescription opioids in the emergency department (ED) increased by 153 %. People with opioid prescriptions in substance-abuse treatment programs more than quadrupled between 2002 and 2012 (Baldwin et al., 2017). Chronic pain includes low back pain, migraines, severe headaches, and arthritis. Acute pain usually has constant tissue damage, reflects the nociceptors and sensitized central neurons, and does not last longer than six weeks, generally the time required for healing injury or disease (Brow et al., 2021). Additionally, acute pain includes dental, fractured bones, appendicitis, postoperative pain, and myocardial infarction. Prescription opioid misuse is a vulnerable issue in ED due to rapid patient turnover, pharmacy data, centralized medical record limitations, and the provider's lack of continuity of care.

There are significant providers in the ED who can prescribe opioids, which are physicians, nurse practitioners (NPS), and physician assistants (PAs) (Idzik et al., 2019). Also, NPs and PAs treat, diagnose, and prescribe medication for pain; however, opioid prescriptions vary by state because some states do not allow NPs and PAs to prescribe schedule III-V controlled substances without physician supervision. Prescription drugs and combinations of other medications given during ED visits include codeine,

hydrocodone, hydromorphone, morphine, oxycodone, fentanyl, methadone, meperidine, and propoxyphene. Charlesworth et al. (2019) argue that some current guidelines and policies limit opioid prescription quantities, mandating providers' use or enrollment with monitoring of prescription drugs to identify all overlapping, previous, or high-risk prescription fills. However, no policies exist for new or low-dose opioid prescriptions, leading to long-term or high-risk opioid use for some people (Charlesworth et al., 2019). On October 24, 2018, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act was signed into law, giving nurse practitioners (NPs) the ability to prescribe buprenorphine as part of the medically assisted treatment for OUD (Moore, 2019). It was a chance for NPs to play a pivotal role, given by legislation, in reversing the rising opioid rates of addiction and overdose in the United States (Moore, 2019).

Methadone Treatment

According to Corkey et al. (2004), methadone hydrochloride is a synthetic agonist opioid that affects the same brain receptor, producing similar effects as heroin and other opioids. Methadone reduces cravings and prevents withdrawals by stopping the opioid receptors, making it helpful in treating addiction (Ghavami et al., 2019). Methadone clinics follow the criteria for treatment that are the same as the U.S. Federal Regulations, which are based on the DSM-IV-TR criteria of dependence with multiple self administration of heroin per day for at least one year (Adelson et al., 2018). Methadone was developed in Germany in the 1930s; it is known as dolophine, methadone, and schedule II medication, which reduces opioid withdrawal and dependence (Corkey et al.,

2004). In the 1950s, the Public Health Service used methadone to treat opioid abstinence syndrome (Fairbairn, 2018). Methadone has been listed as an essential medication on the World Health Organization list since 2005. It is vital for treating OUD, reducing IV use and overdose death, and improving social functioning and quality of life (Fairbairn, 2018). Methadone is a gradual opioid agonist taper used as a clinical approach for opioid detoxification (Aimee et al., 2021). A washout period of a week or more is required for Methadone before XR-NTX can be administered, which causes a delay in the completion of tapering. XR-NTX initiation may result in the resumption of illicit opioids due to failed induction caused by dropout (Aimee et al., 2021).

Methadone Impact

In the United States, from 2000 to 2013, the number of people with OUD increased from approximately 600,000 to over 2 million, of which 586,000 were heroin users and 980,000 prescriptions (Barry et al., 2018). The authors further informed the readers that only 15 – 20% of substance users receive MAT, and opioids were the cause of 33,091 deaths in the United States in 2015. People who experience withdrawals from heroin and do not take Methadone can experience anxiety, agitation, flu-like symptoms, sweating, dehydration, and possibly face hospitalization or death (Corkey et al., 2004). With medication, people may experience common and severe side effects like sedation, dizziness, constipation, nausea, vomiting, headache, high blood pressure, possible itching, respiratory depression, and pulmonary and cardiac problems (Corkey et al., 2004). Methadone is slowly absorbed through the GI tract when administered orally. A single dose will combat withdrawals for 24 – 36 hours. However, it reduces cravings and

will not give a person euphoria, sedation, or analgesia (Elmusharaf et al., 2018). Methadone is an opioid agonist that can be administered in a 40 mg tablet or liquid form, typically daily, at opioid treatment centers (Moore, 2019). Moore (2019) further expresses that for some people, Methadone clinics are burdensome, having to dose daily at clinics while holding a job, and others find Methadone clinics a lifesaver to their sobriety.

Buprenorphine Treatment

Buprenorphine, created in the 1960s as a pain medication, is a partial agonist that strongly binds to receptors in the brain, limiting the opioid effects to block the high heroin high; it has been available since the 1980s as an injection or a strip, which is administered underneath the tongue and is a safer alternative to opioid detoxification than methadone, with or without naloxone (Agus, 2017). The MAT programs have increased their use of Buprenorphine due to decreased opioid dependence, high retention rates, fewer risks than methadone, and greater convenience (Agus, 2017). Buprenorphine has been known to produce mild euphoric sensations in adequate quantities in a small percentage of patients, especially when taken with benzodiazepines, and can cause respiratory depression (Danilewitz & McLean, 2020). Buprenorphine was six times safer than Methadone, rarely overdosing, and most people report no euphoria but normal feelings since starting opioid use.

According to Stancliff and Zucker (2019), Buprenorphine and Methadone have the same protective advantages in that Buprenorphine can be initiated soon after opioid withdrawal begins, unlike Naltrexone. Danilewitz and McLean (2020) stated that the U.S.

Department of Health and Human Services and Health Canada state that the clinical guidelines for the maximum daily doses of Buprenorphine to treat OUD are 24 mg and 32 mg. However, its effective ceiling is 24 mg; therefore, taking more medication will not affect an individual due to the safety feature of the patient not being driven to take higher doses to chase a heightened euphoria. The U.S. Food and Drug Administration approved Buprenorphine, Naltrexone, and Methadone to treat OUD. A systematic review of Buprenorphine found it helpful in managing opioid withdrawal (Rhee & Rosenheck, 2019). The authors further informed that a meta-analysis of nineteen real-world observational studies determined that Buprenorphine caused substantial reductions in overdose mortality and risk of both causes.

Naltrexone Treatment

Naltrexone is used to treat opiate abuse and alcoholism; it is an antagonist that binds to the mu-opioid receptors, although it does not stimulate the brain (Ciraldo et al., 2022). Naltrexone at a higher or regular dose of ≥ 50 mg is used for impulse control disorders, cocaine addiction, amphetamine addiction, eating disorders, and autism spectrum disorders, which are off-label (Boda, 2019). Naltrexone will block the effects of preventing relapse with a daily dose of 50 mg, and naltrexone dependence and tolerance do not develop (Bjorndal et al., 2010). The known side effects are nausea, headaches, vomiting, decreased appetite, abdominal pain, dizziness, sleep disorders, and lethargy (Boda, 2019). Naltrexone is an opioid antagonist customarily administered monthly by injection (Moore, 2019). Naltrexone is rarely used for OUD; however, people must withdraw entirely from opioids to begin naltrexone treatment (Moore, 2019).

Naltrexone is administered at 50 -150 mg for opioid and alcohol use disorder and 3 – 6 mg for pain and inflammation (Daimon et al., 2021). Some patients reported that the low dose of naltrexone improved their happiness and frame of mind, which proopiomelanocortin (POMC) neurons would denote as changes in mood and pain; however, no evidence was found when using electrophysiologic imaging and peptide measurement approaches.

Teenagers and young adults need effective treatment for OUD and rarely are given medication approved by the FDA (Feder et al., 2017). Adolescents and young adults have personal problems, health issues such as HIV and STDs, criminal conduct, overdose, death, social issues, and opioid misuse (Adams et al., 2019). This population is not given medication for OUD; instead, they must go to detoxification and afterward counseling, whether inpatient or outpatient, for OUD (Bagley et al., 2018). The retention rate for teenagers and young adults leaving treatment against medical advice is high in detox and residential care, and inadequate attendance in counseling when OUD medication is not given (Fishman et al., 2021). Three randomized pharmacotherapy trials were conducted for teenagers and youth in outpatient tapered-off buprenorphine in varying lengths (Badger et al., 2016). Badger noted that the first 28-day study for teenagers ages 16 – 18 with illicit opioid use found buprenorphine was better than clonidine in controlling cravings. The second study with teenagers and young adults ages 15–21 who were administered buprenorphine for eight weeks, then tapered for four weeks, found it more effective, and retention in treatment was better than two weeks of buprenorphine detoxification. The last 28 – 56 days of study with teenagers and young

adults ages 16 –24 found that more extended buprenorphine treatment was superior to shorter treatment (Badger et al., 2016). Extended-release naltrexone (XR-NTX), buprenorphine, and RCT buprenorphine studies showed that in young adults ages 18 –25, MOUD is usually lower in adults; however, many benefit considerably from MOUD (Fishman et al., 2020).

Treatment Approach and Crisis

Prescription opioids and illicit opioids are not the same. Prescription opioids are legally manufactured by pharmaceutical companies and obtained through medical prescriptions. On the other hand, illegal opioids are manufactured just as legal opioids; however, they can be distributed illegally and used for recreational use by those addicted to opioids (Atsma et al., 2022). In the US, there was a 900% increase in people seeking opioid addiction treatment between 1997 and 2011(Akerman et al., 2018). Between 2013 and 2015, opioid overdose deaths increased significantly from 7.9 per 100,000 to 12.3 per 100,000, and a 72% death rate increase related to prescription opioid pain relievers between 2014 and 2105 was noted (David et al., 2016). The American Psychiatric Association for OUD recommends taking opioid agonist or antagonist medications such as Methadone, Buprenorphine, and Naltrexone (Swartz et al., 2016). The purpose of the treatment is relapse prevention and decreased use, symptoms, and cravings (Swartz et al., 2016). The National Surveys on Drug Use and Health showed a 37% 2000 to 28% 2010 decrease in heroin admissions with treatment plans including MAT (Akerman et al., 2018). Even though the evidence is consistent regarding medication being a positive treatment outcome, clinical staff can boost their knowledge by promoting an

understanding of clinical treatment approaches and real-world outcomes (Benth et al., 2017).

To prevent relapse to opioid dependence following opioid withdrawal, an individual can take a monthly injection of XR-NTX, a μ-opioid receptor (Ackerman et al., 2018). A phase 3, 24-week, randomized, double-masked, placebo-controlled trial on XR-NTX confirmed sobriety, reduced cravings, and treatment retention. In addition, roughly 51% of individuals who continued XR-NTX treatment for a year remained sober (Ackerman et al., 2018).

Due to the significant number of drug overdose deaths in 2017 from heroin or a prescription pain reliever, SAMSA initiated the State Targeted Response by implementing the Opioid Crisis Grant Opioid (STR) program (Clarke et al., 2020). The grant funded 57 states and territories in May 2017 to provide better treatment access, increase needed treatment, and provide opioid prevention treatment and recovery activities to address the opioid crisis (Clarke et al., 2020). SAMSHA provided grants to the 57 states and territories over two years, dispensing almost $500 million yearly (SAMSHA, 2017). Missouri implemented the MedFirst model, a SUD treatment, and partnered with a Harm Reduction and Recovery Community Outreach Center to receive harm-reduction supplies (Pew Charitable Trust, 2016). OUD individuals actively using went to the Outreach Center and were given a clean needle, naloxone, and an invitation to addiction services. If they accepted, they were transported to a nearby SUD agency to be seen by the doctor that same day. Usually, the women return to the Outreach Center and

relate to recovery housing providers and sleeping quarters for the night (Pew Charitable Trust, 2016).

Galanter (2018) noted that the Twelve-Step program appeared in the 1930s because no medication was available to rehabilitate people with alcohol dependency. Soon, the Twelve-Step approach was part of recovery from alcoholism in the treatment community. Over time, medication was a part of treatment and was frowned upon in the culture of Twelve-Step recovery (Gryczynski et al., 2015). Long-term members who were frequent attendees were familiar with evidence-based medicine and opposed the medically assisted treatment approach to addiction. Therefore, new attendees on MAT, Buprenorphine, Methadone, or prescribed Naltrexone could be looked down upon and discouraged from speaking at the meetings (Gryczynski et al., 2015). Substance users who actively participate in 12-step meetings have better sobriety outcomes; however, attending 12-step meetings without engagement will eventually result in declining returns (Galanter, 2018). Gryczynski et al. (2015) argued that people on MAT have difficulty with the compatibility of the 12-step belief system and utilizing MAT for their opioid dependence. Although both approaches view addiction as a chronic disease, 12-step programs require total abstinence from all psychoactive substances, including MAT. Therefore, changing the language from 12-step meetings to recovery for MAT users created cohesiveness within the addicted and abstinent population, giving them a sense of belonging (Gryczynski et al., 2015).

Another treatment for SUD is mindfulness-oriented recovery enhancement (MORE), a technique that includes mindfulness, reevaluation, and appreciating positive

events (Chen et al., 2019; Garland et al., 2016). MORE is an eight-week combined therapy with cognitive-behavioral therapy for people with dual diagnoses, used for opioid and alcohol relapse, addressing SUD challenges in their recovery (Chen et al., 2019). The eight-week course includes mindfulness-based stress reduction (MBSR), MORE, and positive psychology techniques that promote the importance of living and learning to appreciate the good times and feelings (Garland et al., 2016). MORE is an intervention for reducing addictive behaviors and a non-pharmacological treatment for people at risk for opioid use to manage chronic pain (Chen et al., 2019; Garland et al., 2016).

Cost of Treatment

It is estimated that the financial and societal cost of opioid addiction is $80 billion per year (Simmons, 2017). Over the next five years, it is estimated to range from $60 billion to $100 billion for community treatment, prevention, and resilience efforts (Katz, 2018). Opioid use disorder (OUD) is a SUD regarded as obsessive opioid use that builds tolerance and withdrawal after substance use has stopped (Reimer et al., 2019). OUD inflicts economic hardship on society in the United States, costing between 55 billion dollars and 78.5 billion dollars from 2007 to 2013, respectively (Reimer et al., 2019). The 2007 costs are mainly ascribed to lost work production at 46%, healthcare at 60%, and criminality at 9% (Reimer et al., 2019). Additionally, the 2013 costs are mainly ascribed to the treatment of substance disorder (4 %), healthcare costs (33%), nonfatal work lost production (26%), fatal outcome lost production (27%), and price of criminality (10%). Birnbaum et al. (2015) A U.S. study from 1998 to 2002 on pharmacy and medical claims of 16 health plans of self-insured employers comparing opioid users to non-opioid users

showed that opioid users' medical claims were higher (Birnbaum et al., 2015). Medical claims, pharmacy utilization, hepatitis, pancreatitis, and psychiatric disorders healthcare costs for opioid users were eight times higher than non-users' costs (Birnbaum et al., 2015).

There are possible benefits to society in treating OUD, significantly reducing overdose deaths, infectious disease control, improved quality of life, and less criminal conduct (Evans et al., 2015). In the past 20 years, illegal substance use has been treated as a public health issue instead of a social problem requiring intervention by the criminal justice system (Evans et al., 2015). However, overdose is the leading cause of injury deaths in the US, and opioid-related deaths are higher than drug-related deaths combined (Cai et al., 2015). Furthermore, deaths from substance use disorders have been projected to inflict an annual cost to society in the U.S. in 2014 of $220 billion compared to $69.9 billion for obesity or diabetes. The most significant portion of the direct cost is accredited to the criminal justice system (Office of the National Drug Policy (ONDCP), 2015).

Furthermore, the U.S. Federal government funding for the National Drug Control Policy treatment estimated that the average cost is $1583, including $11,487 societal benefit, a 7.1 benefit-cost ratio. Additionally, when accounting for local and state expenses, the funds allotted for prohibition and execution are perhaps much higher. Furthermore, 65% of the total benefit was attributed to crime reduction costs, which include incarceration. Additionally, increased employment earnings were 9 %, and the remaining 6% was attributed to lower medical and behavioral health healthcare costs.

Evans et al. (2017) emphasized that an unfunded mandate in California entitled Substance Abuse and Crime Prevention Act was voter-initiated. The ruling allows those convicted of drug offenses, non-violent offenses, probation, or parole violations to bypass incarceration and instead go to drug treatment, which saves taxpayer funds (Evans et al., 2017). The U.S. Department of Health and Human Services (USDHHS) (2015) noted that California has one of the nation's highest rates of needed drug use treatment and is among the highest per-capita spenders on corrections. Furthermore, in California in 2014, 89.5% of individuals needing SUD treatment did not have access to it (USDHHS, 2015). Crime prevention, direct or indirect, can lessen the problem inflicted on victims, the criminal justice system, and communities, creating significant economic benefits (Weil, 2016). Unfortunately, health and criminal justice policymakers have a substantial stigma for OUD treatment (Fiellin & Samet, 2016).

Americans use 80% of the world's opioids and 99% of the world's hydrocodone supply, yet the U.S. is only 5% of the world's populace (Bride & Morse, 2017). In the US, the CDC reported in 2010 that four times more prescription opioids were sold to pharmacies, hospitals, and doctors' offices than in 1999 (Egbuchua et al., 2023). In the U.S., between 1997 and 2007, the average sales of prescription opioids increased by over 400% (Davis et al., 2017). Furthermore, heroin is no longer the most commonly abused form of opioid and prescription pain relievers; instead, the non-medical use of prescription opioid pain relievers is the largest single category of illegal drug use besides marijuana (Bride & Morse, 2017). Reduced quality of life and a greater risk of death are linked to chronic opioid use (Davis et al., 2017). The CDC reports that since 1999,

consumption and overdose deaths have dramatically affected people's lives and healthcare services (Egbuchua et al., 2023).

Compared to the general population, chronic drug users use thirty percent of emergency healthcare services because opioid users are at high risk for hospitalization (Egbuchua et al., 2023). In the U.S., between 1993 and 2012, inpatient admission for opioid overuse in adults ages 18 and older increased by over 150%, and by 2012, admissions rose to 296 per 100,000 people in comparison to 1993, which was 117 per 100,000 people (Healthcare Cost and Utilization Prevention (HCUP), 2017). One of the most expensive places to receive care is the emergency room, where opioid users seek care (Aweh et al., 2015). Emergency room medications most given were oxycodone pain relievers with 56.2 visits per 100,000 visits, hydrocodone with 31.2 per 100,000, methadone with 24.3 per 100,000, and morphine with 12.3 per 100,000 (Aweh et al., 2015).

Opioid Agonist Therapy (OAT) includes Buprenorphine, Naloxone, and Methadone care for people with opioid addiction (Aweh et al., 2015). Also, policymakers' inconsistency regarding OAT is the benefits confirmed through clinical trials. It is an opioid substitution that is over-consumption and cost-effective for large populations, as opposed to a controlled environment of clinical trials (Aweh et al., 2015). Another cost concern is that Medicaid programs fund over one-third of all substance abuse treatment in the United States, and those who qualify as low-income have diseases, illnesses, and disabilities at higher rates, which may cause the medicine to be less effective (Burns et al., 2018). Opioid addiction is not viewed universally as a persistent

relapse; however, healthcare and public opinion often treat opioid addiction as a short-term illness (Katz, 2018). The concern of Medicaid is long-term, allowing patients to go in and out of treatment several times, knowing the longer a patient is in treatment, the better the outcome is encouraging (Burns et al., 2018). There are federal regulations that each state must abide by, but each state constructs its own set of Medicaid benefits (Burns et al., 2018). Opioid addiction is not universally viewed as a persistent relapse; however, healthcare and public opinion often treat opioid addiction as a short-term illness (Katz, 2018). Medicaid is long-term, allowing patients to go in and out of treatment several times, knowing that the longer a patient is in treatment, the better the outcome is (Burns et al., 2018).

Only 20% of the 2.1 million people in the U.S. diagnosed with OUD receive medically assisted treatment (Hay et al., 2020). A Markov model simulation was used to conduct a cost-utility analysis of a mean age of 41 OUD individuals, with 50% having abused prescription opioids and 50% having used heroin (Hay et al., 2020). Take-home treatments provided to the individuals were Buprenorphine-Naloxone (BUP/NX), extended-release Naltrexone inoculation (XR-NTX), and Buprenorphine long-lasting inoculation (XR-BUP; Hay et al., 2020). The primary treatment approach is BUP/NX compared to MMT, and the most cost-effective are XR-NTX and XR-BUP, paying at a limit of $175,000 per quality-adjusted life-year (QALY). The QALY gains were similar for all four treatments; however, the cost per individual varied substantially ($1.7- $1.85 million). In 5,000 simulations of probabilistic sensitivity analyses (PSA), 23% of BUP/NX is cost-effective, and 66% of XR-BUP is cost-effective and controls the other

three treatments. Although MAT is the most commonly used treatment, it is less cost-effective than Buprenorphine injectable take-home form (Hay et al., 2020).

Barriers and Risk

The opioid crisis worsens in rural areas, and prescription opioid overdose rates are twice as high as in urban areas (Cox et al., 2020). The opioid problem has increased in rural countries such as northern New Mexico since the latter part of the 1990s; it is still a national hot spot for opioids (Cox et al., 2020). According to Cox et al. (2020), in the Civil War era, Black Americans did not have access to prescription painkillers or opioids; however, prescription painkillers and opioids have always been prevalent among White Americans. (The treatment of chronic pain by overprescribing opioids in rural America is primarily found in labor-based occupations and at high risk for work-related injuries and disability (Cox et al., 2020). In rural communities, to manage chronic pain, prescribing opioids is perceived as harmless compared to heroin and is needed to continue employment (Brady et al., 2015). In addition, prescription opioids are less intoxicating, hard to access due to pharmacy regulations, and costly when bought on the streets (Back et al., 2016). Therefore, rural prescription opioid abusers will start injecting heroin.) They state that the prescription opioid and heroin crisis in rural areas is worsened by limited healthcare services, including mental health and substance use (Back et al., 2016). \

A national priority is still substance abuse prevention, increased treatment provider access, and substance use services, but there remain significant disparities nationally in rural areas (Ellis et al., 2020). People in rural areas seeking OUD treatment face environmental, economic, MH providers, income-related issues, gaps in health care

insurance, SU treatment facilities, and logistical issues in rural communities (Ellis et al., 2020). MAT is an evidence-based treatment that includes medication and behavior therapy counseling (World Health Organization, 2017). MAT is a cost-effective treatment known to lessen opioid dependence, opioid deaths, rates of infectious diseases by injection, and criminal behavior, as evidence suggests prosocial behaviors after treatment (Baldwin et al., 2017). However, there are known barriers to staff knowledge or ability to prescribe medications, insufficient funding, knowledge of treating patients with drugs, and negative attitudes regarding MAT treatment (Ackerman et al., 2018).

There is a shortage of providers and treatment facilities in most rural areas; therefore, substance users cannot access traditional psychosocial treatments, which would reduce opioid use, treatment retention, and overdose and improve social functioning (Agus et al., 2018). OUD individuals are left relying on 12-step and self-help meetings; however, 12-step meetings such as Narcotics Anonymous (NA) and Alcohol Anonymous (AA) require total clean time (Gryczynski et al., 2015). Also, people on MAT are not considered to have clean time because they use buprenorphine. Abstinence is free from all opioids; therefore, MAT individuals are not abstinent and are replacing one opioid with another. According to the community 12-step meetings, some people consider discontinuing buprenorphine treatment because it creates a barrier for those who benefit from buprenorphine treatment and 12-step meetings (Gryczynski et al., 2015). This type of MAT stigma could be detrimental to treatment outcomes, needing the preservation of NA with psychosocial interventions while recognizing MAT pharmacotherapy's importance (Agus et al., 2018).

An individual's OUD status as a person with an addiction forms their social identity; therefore, a recovery identity change is critical for success—prosocial relationships prompt behaviors to seek treatment and maintain recovery (Cruwys et al., 2015). Individuals on MAT expressed the importance of the patient-counselor relationship in sustaining MAT treatment with respect and empathy to feel safe and control their recovery (Colbert et al., 2018). Furthermore, MAT individuals wanted their MAT counselors and providers to know all medical subspecialties required, be up to date on medication changes, and not be subjected to bias (Colbert et al., 2018). A barrier among state treatment facilities is that state and territorial treatment facilities are separately housed from recovery and prevention, making it hard to collaborate on the continuum of care for OUD women (Byrd et al., 2019). While some programs offer transportation, other Medicaid programs do not provide transportation to opioid treatment centers. Factors affecting treatment and prevention, such as employment and childcare in recovery, are not addressed (Byrd et al., 2019). (Bachman et al. (2019) implied that young people have become aware that heroin is one of the most dangerous drugs, which accounts for its low-frequency use and personal disapproval of use.

Young people looked at heroin as a risk when cocaine considerably spiked in 1987 for four years. The findings of availability to heroin in12th graders made it easy to attain, with about 20% use throughout the 1980s, increasing to 35% from 1986 to 1998, while the use of other narcotics included Oxycontin, Codeine, Vicodin, Percocet, and Hydrocodone from 1978 through 1989 (Bachman et al., 2019). Addiction and illicit drug use are global crises causing physical and mental harm to the person with an addiction,

increased unemployment, diminished social function, and increased violence and crime rates (Chang et al., 2020). A meta-analysis in 2015 found that women experience unemployment, use illegal amphetamines, and indulge in criminal behavior during OUD treatment (Hudson et al., 2020). The effects of BMT and MMT in females addicted to opiates are similar in sexual activity regarding sexual satisfaction; however, the more positive impact is BMT on sexual desire and arousal (Ammozegar et al., 2021). According to the 2020 World Drug Report 2018, 269 million people between the ages of 15 and 64 used at least one illicit drug, with marijuana, opiates, and opioids being the most popular substances (United Nations Office on Drugs and Crime, 2020).

According to Taiwan's first national household survey, the frequency of drug use was approximately 1.2%, and the most widely used were methamphetamine, ecstasy, cannabis, ketamine, and heroin (Chang et al., 2020). In 2002, of all substance users who received treatment, 80.9% were heroin users; in 2007, it increased to 93.8%, and in 2011, it decreased to 83.3%; yet among the substance users who received treatment, the percentages were more than 80% of illicit drug use, according to the Taiwan Surveillance System of Drug Use and Addiction Treatment. Previous studies have shown that treatment for substance use reduces criminality, increases employment and physical and mental health, and decreases relapse in the ex-substance user (Chang et al., 2020). Taiwan started a deferred sentencing model, a treatment alternative to prison that helps substance users get treatment (Ministry of Justice, 2020). As a result, the substance users who received deferred sentencing for re-arrest and reconvictions were substantially lower than those who were processed regularly into the criminal justice system.

A pilot project to address the human immunodeficiency virus (HIV) was initiated in Taiwan, a deferred prosecution and methadone maintenance treatment (MMT; Ministry of Justice, 2020). Taiwan had a strategic approach "from criminal to a patient," corresponding with "from punishment to treatment" (Ministry of Justice, 2020). All substance users in Taiwan before 1998 were penalized as criminals; however, the Against Narcotics Act in 1998 changed the classification of substance users to patients, which allowed them access to treatment and other interventions without sentencing (Ministry of Justice, 2020). Also, Taiwan did not instantly incarcerate the substance user because they had a deferred prosecution policy that would provide treatment with an option of four types of penalizations. According to Chang et al. (2020) and the Ministry of Justice (2020), the four types of penalization are: (1) complete MMT treatment with the deferred trial, (2) observation and treatment, (3) required treatment, and (4) jail sentence. This type of sentencing aims to help the heroin user integrate back into society, continue or gain employment, and live everyday life without substance use. Further, heroin users obtain medical treatment, MMT, better social function, and reintegrate back into society instead of facing jail time (Chang et al., 2020; Ministry of Justice, 2020)

When the police arrest a heroin user for heroin and reveal to the prosecutor that they are trying to quit heroin, and the prosecutor believes that they are an appropriate candidate to stop addiction while living in the community, they will receive deferred prosecution and MMT (Chang et al., 2020). On the other hand, if heroin users do not state that they are trying to quit heroin, they will be observed and have rehabilitation for less than two months, and if they remain heroin free in the two months, they will not be

prosecuted. However, if they test positive for heroin use after a professional evaluation, they will be required to attend treatment for a minimum of 6 months to one year. Further, heroin users who recidivate within five years can apply for summary judgment or be prosecuted, complete MMT, and have deferred prosecution if they advise the prosecutor that they do not intend to relapse and want to maintain sobriety (Chang et al., 2020).

There is a severe problem of prison overpopulation in Taiwan (Ministry of Justice, 2020). The prison space should be 24.9 ft. per prisoner as specified by the International Human Rights Regulations; however, in 2014, Taiwan's prison space per prisoner was 15.3 ft. (Ministry of Justice, 2020). Therefore, giving heroin users a chance for treatment instead of incarceration helps reduce overcrowding and leaves room for prisoners (Cheng, 2017). Recidivism factors are economic conditions, employment, social functioning, and integration into society, with work necessary for healthy social development (Cheng, 2017). Heroin users' employment problems could result from drug use and social discrimination (Edwards et al., 2020). A previous study showed that the high rate of heroin and cocaine use is a factor of association in a low-employment trajectory group through middle adulthood (Edwards et al., 2020). Reentry into the community requires the heroin user to have employment to help them improve economically, social control, structure and discipline of a daily routine, and expectations of their performance and productivity (Buttner, 2011). Cheng et al. (2017) noted that problematic heroin use reduces the chance of finding and holding down a job and increases the likelihood of unemployment. Additionally, being employed and treatment

retention is highly correlated, as heroin users maintain their treatment and recover better (Cheng et al., 2017).

Housing

One of the primary reasons for homelessness is substance use, particularly among opioid abusers who experience substandard living and extensive housing placement difficulties (Cacciola et al., 2015). Access to affordable and safe housing is a significant challenge for people after incarceration on parole or probation (DeGuzman et al., 2019). Ex-criminals who are homeless or have unstable living conditions present challenges in gaining employment, maintaining sobriety, completing parole and probation stipulations, building a sober support network, and accessing needed medical, substance abuse, and mental health services (DeGuzman et al., 2019). It is vitally important to have safe and stable housing in recovery; however, 32% of people expressed being slightly housed 30 days before entering substance abuse treatment (Delucchi et al., 2019). Several questions have been raised about where people being released from incarceration into the community will live (DeGuzman et al., 2019). This presents the question of whether those with SUD can maintain sobriety without stable drug-free housing and sober support networks that support recovery; SLH is an encouraging choice for a drug and alcohol-free atmosphere (DeGuzman et al., 2019).

Several housing types are available to substance users: recovery homes, sober living, supported housing, and transitional housing. Recovery homes are based on abstinence, a social model, peer support, and a safe, healthy environment supporting recovery from SUD (Panella-Winn & Paquette, 2016). Recovery homes promote alcohol

and drug use healing and their associated problems and are generally supportive living environments (Delucchi et al., 2019). In 2018, The National Council noted that The National Council for Behavioral Health and National Alliance for Recovery Residences (NARR) implemented the toolkit to help states increase the safety and effectiveness of recovery housing: Building Recovery: State Policy Guide for Supporting Recovery Housing (National Council, 2018). The National Council (2018) expressed that the toolkit assists policymakers and advocates in “Protecting Recovery Housing: Standards: Incentives and Investment, Supporting Recovery Housing in Practice: Additional Quality and Access Considerations, and Resource Appendices." Recovery housing positively affects recovery from substance use, alcoholism, employment, and criminal conduct (Delucchi et al., 2019).

Sober Living

Sober Living Homes (SLH) is based on the social model philosophy; no treatment or formal programming is available (Gupta et al., 2016). Little is known about SLHs because they are derived from a grassroots movement that formed outside the range of skilled treatment and scholarly research (Gupta et al., 2016). An SLH can be a small single-house or multi-house organization (DeGuzman et al., 2019). SLHs are not required to be licensed or certified by any federal, state, or local agency; therefore, a reliable member count of the house is unknown, and a comprehensive listing does not exist (Callahan et al., 2016). Some SLHs are part of associations that offer their members safety, health, operational standards, and technical support (Callahan et al., 2016). According to DeGuzman et al. (2019), “SLHs represent one type of recovery residence e

within a broader range of residences that vary by level of structure, staffing, licensing, professional services offered, operations, and philosophy of recovery" (p. 3).

The 12-step meetings have no case management, treatment planning, counseling, or structured daily activities (Delucchi et al., 2019). Also, the 12-step meetings model philosophy does not have treatment or programming; however, they must attend 12-step meetings and maintain sobriety (Gupta et al., 2016). Residents give back by putting into the house operations and management, peer support, practical knowledge, keeping the home, and can stay if they want if they pay their rent, utilities, and other fees (Delucchi et al., 2019; Gupta et al., 2016). Some residents work, some get help from family members, and some get assistance from programs through criminal justice, paying one to one-to-six months' rent (DeGuzman et al., 2019). Recovery residences improve outcomes for substance users through recovery capital, which is the process of helping substance users with social, human, and cultural resources and finances (Hemberg et al., 2017). Unlike other types of recovery that offer group or individual treatment or recovery support services, recovery capital helps people make conscious decisions about whom they serve and how and where they operate (Green et al., 2018; Jason et al., 2016). For example, residents can accrue financial capital by providing low-cost housing, social support is given to fellow residents by living among their peers and encouraging a sense of community, and human capital is enhanced through different aspects such as accountability with household members, house rules being enforced and outlined, inspired mutual aid groups involvement, and promoting community learning through shared practical information (Green et al., 2018; Jason et al., 2016). Therefore,

operational attributes such as housing location, amenities, fees, house rules, philosophy, program adjustment, and residents are vital to the service provided in SLHs (Green et al., 2018; Jason et al., 2016).

Supported Housing

Supported housing was established in the early movement when mental hospitals were downsizing or closing (Avanzo et al., 2020). The separation between accommodation and treatment services is the core aspect of supported housing (Avanzo et al., 2020). The supported housing theory was based on a linear continuum; people gradually evolved from hospitals to halfway houses and group homes, less supervised, to attain independent housing (Killaspy et al., 2018). However, in most cases, this model did not work in people evolving to independence; instead, people were left confused about their accommodations and care and were stuck in small, isolated residential settings (Killaspy et al., 2018). The core of recovery-oriented rehabilitation is providing adequate long-term housing (Aamodt et al., 2020). Supported housing that can help residents develop their homes and improve their quality of life are the availability of staff, emotional support, and daily task assistance (Andvig & Gonzalez, 2015b). .

The availability of staff, emotional support, and daily task assistance in supported housing help residents improve their quality of life and give them a home. (Andvig & Gonzalez, 2015b). In Norway, the social housing policy states that the local government should assist people who need access to suitable housing, stable accommodations, and staff support for individuals to meet their needs and goals (Marquardt, 2016). The Norwegian Tenancy Act is based on rental agreements for supportive housing requiring

collaboration agreements between the housing service and the resident (Aamodt et al., 2020). Supported housing gives residents access to staff, on and off-site, help with substance use and mental health, and has rules they must abide by regarding the regulation of their housing and common living areas (Padgett et al., 2018).

Supported housing caters to people with serious mental illness, housed in boarding home models and highly structured group living, for-profit entity, non professionally managed, with full tenancy rights and eviction protection (Padgett et al., 2018). Supported housing may be scattered-site units in regular apartments with support as needed. No designated program or clustered apartment buildings with programs, support from staff, and tenant recovery are strongly encouraged (Piat & Sieda, 2018).

The UK has two housing sectors: public housing and supported and sheltered housing (Hobson et al., 2020). General housing refers to management and supply, and supported private housing refers to providing accommodations and support for people at risk, meaning those with mental health issues, learning impairments, ex-criminals, drug and alcohol use, young people, previously homeless, and women escaping domestic violence (Hobson et al., 2020). The National Housing Federation (NHF) explains "provision as supporting some of the most vulnerable people in society who face barriers that go far beyond housing, women of which can be isolated, have physical and mental health problems, histories of offending or substance dependency issues" (NHF, 2015, p. 3). In the UK, there is welfare support to help households with low-income housing meet their rental payment, which has been implemented since the 1970s (Hardie, 2021). The Housing Benefit (HB) was implemented in 1983, and the Local Housing Allowance nce

(LHA) was implemented in 2008 for private tenants. Furthermore, the goal of HB and LHA is that the cost of their housing should not reduce their income below the set 'Income Support Levels' (Harde, 2021).

Transitional Housing

Transitional housing is needed when permanent housing is unavailable; therefore, indirect or interim placement is required (Cross et al., 2019). The United States Social Services embarked on a new and growing area of transitional housing facilities, which provides long-term housing accommodation to previous women human traffickers (Brown et al., 2017). Furthermore, the facilities are patterned after the anti-domestic violence movement, are available for several months to two years, and can house four to thirty women at a time. The facilities provide confidentiality, a safe house, basic needs, food, clothing, restorative counseling, and peer mentoring (Brown et al., 2017). People seeking transitional housing have faced substance and alcohol use, addiction, physical health concerns, mental health issues, homelessness, criminality, sex trafficking, and the need for social services for women and children (Brayton, 2018). More than 1 million American children and youth experience homelessness each year, facing challenges of crime, mental health issues, physical health issues, drugs, and adult homelessness (Grady et al., 2018). There are three primary types of housing interventions offered for homeless people by the U.S. Department of Housing and Urban Development (HUD), which are Rapid Re-housing (RRH), Transitional Housing (TH), and permanent housing subsidies (Alexander et al., 2021).

RRH has three significant components: finding appropriate housing, recruiting landlords, providing rental and moving expenses, and having access to case management and other supportive services while at home. Some researchers suggest This is less cost effective than RRH interventions, and homelessness is experienced for shorter times (Alexander et al., 2021). From 2007 to 2017, the TH beds dropped by 43%, representing a shift in federal policy towards the Housing First model and RRH programs (Mosley, 2022; Hobson et al., 2020). A study of 2282 families randomly assigned to one of the three housing interventions found that families participating in the TH experienced housing and good outcomes equal to families receiving regular care three years later (Brown et al., 2017). Brown et al. (2017) suggest that restrictive TH requirements may block families needing intervention because families registered in the Family Options Study did not qualify for TH. The Health and Human Services, through The Family and Youth Services Bureau (FYSB), administers The Transitional Living Program (TLP), which provides housing for approximately 18 to 21 months to homeless youth ages 16 to 22 years old (Brown et al., 2017).

Self-Efficacy

In self-efficacy, known as the exercise of control, it is noted that people must be coerced externally to work on environmental issues that they perceive to exceed their coping abilities (Heald, 2017). Albert Bandura postulated that motivation is impacted by self-efficacy. People who believe they are good at something will work hard to accomplish the task regardless of the barriers(s) (Bandura, 1977). Research suggests that cognitive abilities and self-efficacy are two components that produce positive outcomes

(Behrend & Howardson, 2015). Different people on different professional levels bring talents and skills. They are working together for one common purpose: to create policies and implement laws to make changes in implementing official procedures on housing for MAT users. Bandura believed people's perceived capability affects their performance (Heald, 2017). Heald further expresses that "believe" is the operative word in that people must think that addressing the issue is within their capabilities, individually and collectively. People in a group must believe in collective efficacy.

Substance use disorders are a severe problem affecting individuals, families, and society (Moore, 2019). The primary treatment for SUD is pharmacological, supported by psychosocial methods where they learn coping strategies and their insight into the disease concept is formed or enlightened (Sutcu & Yildirim, 2016). The psychotherapy methods used in addiction treatment are cognitive and behavioral therapy, which change how an individual thinks, change the areas of attention and enjoyment, capitalize on one's abilities, and decrease the desire for substance use (Kucuksen & Sener, 2017). A physical and mental practice involving the awareness of internal events and focusing attention on the here and now is a cognitive and behavioral treatment called mindfulness (Tamam, 2016). Mindfulness is derived from Eastern meditation practices; however, it has been used in the West for nearly 30 years as a method of psychotherapy (Tamam, 2016). Mindfulness' goal is to lessen individuals' thoughts of distrust and judgments to prevent the immediate situation from past and future effects (Atalay, 2018). Self-efficacy sufficiency is believed to be increased if achieved (Atalay, 2018).

Self-efficacy sufficiency's definition is a person's self-belief that they possess the necessary skills to finish a project so they can deal with life's difficult situations (Aylaz & Bayir, 2021). One factor that affects behavior change is efficacy sufficiency; therefore, the goal is to increase self-efficacy sufficiency (Aylaz & Bayir, 2021). Bandura proposed that self-efficacy is a critical component in the social cognitive theory, which affects student learning due to its effect on motivation (Ben-Yehuda, 2015). Having higher success, being healthier, being integrated socially, having good mental and physical health, being emotionally stable, successful in school, career-oriented, and socio-political life are attributes of having a stronger sense of individual competence (Bandura, 1977). Further, if people believe positively in self-efficacy, they will be more active in controlling their lives.

The concepts of self-efficacy are self-respect, self-perception, and self-regulation; however, self-efficacy is not concerned with people's skills but with yielding good results using those skills (Aylaz & Bayir, 2021). Bandura (1993) indicated self-regulation is how a person directs, controls, and affects their behaviors. The different techniques, methods, tactics, and strategies a person uses to learn about themselves are called self-organizing learning, a process whereby they are cognitively motivated by their goals and values (Bandura, 1993). Self-perception, self-awareness, and self-worth are a sense of self feelings, and our cognitive ability denotes our level of self-perception (Aylaz & Bayir, 2021).

There are four primary sources of self-efficacy perception: 1) the individuals' events directly experienced, 2) what the individual learned from others, which is indirect

experiences, 3) being persuaded by people convincing them they have the skills to be successful at the task, and 4) the individual's psychological state – how the person feels mentally and physically affects the self-efficacy perception (Bandura, 1997). Further, it is crucial in the impact of thinking, motivated beliefs, behaviors, and decision-making skills in substance use. For example, Abramson et al. (2004) found in a study to protect against drug use disorder that people with low self-efficacy are more likely to start addictive drugs, and people with low self-efficacy are more likely to be addicted.

Many factors have been found to influence adolescent substance use; self-efficacy has played a significant role in adolescent substance use behaviors (Brink et al., 2021). An adolescent would possess self-efficacy if the individual had control over social functions, specific activities, and psychological functions (Bandura, 1977). Self-efficacy is a personal factor that helps with coping strategies, which is called coping self-efficacy (CSE) in the addiction literature (Brink et al., 2021). Bandura (1997) determined that coping self-efficacy is learning to manage high-risk situations with the proper coping mechanisms; if a person cannot adequately cope, it can lead to lessened self-efficacy and a higher chance of relapse (Bandura, 1997). Coping efficacy beliefs determine whether people will struggle, for how long, or persevere in adversity (Bandura, 1977).

Furthermore, those with a higher grade of CSE approach life's challenging situations in a "go-getter" way. In comparison, the lower grade CSE takes their energy and focus on managing the significant emotional difficulty. Self-efficacy considerably affects conflict resolution, stress coping, and physical and psychological problems and is an essential personality and situation-specific behavior (Bandura, 1977).

Substance use disorder is a chronic and complex disease affecting millions in health complications, injury, low productivity, conflict, and premature death (Baler et al., 2016). People in recovery would benefit from emotional support to help them when they are lonely, frustrated, stressed, and need coping skills (Ashford et al., 2021). Various online and mobile interventions can reinforce coping skills, prevent relapse, respond to deterioration, and connect people to peer support to accelerate online recovery (Ashford et al., 2021). One study suggested that a minimum of 10% of SUD American adults used peer support services online; however, there have been little to no assessments completed for online clinical efficacy (Crane et al., 2018), except for one online recovery tool, a smartphone-based intervention, Addiction-Comprehensive Health Enhancement Support System (A-CHESS) (Chassler et al., 2019). In a randomized clinical trial, A-CHESS was instrumental in reducing alcohol use by half for people with alcohol use disorder by giving them recovery tools, peer support, and information content through asynchronous text-based discussion (Chassler et al., 2019). Substance use disorders can cause lonesomeness and isolation and will intensify as substance use increases; however, this cycle can be broken as positive peer support is established (Ashford et al., 2021).

Optimistic peer support and relationships are already in place at AA, NA, Recovery Centers, Behavioral Health Centers, and Social Service Agencies that build rapport through sharing their experiences and information (Ashford et al., 2021). Self efficacy for SUD means they believe they can perform the necessary behaviors to achieve the desired outcome (Bandura, 1997). Self-efficacy is one of the most significant predictors of health behavior change because it affects how a person thinks, feels, and

behaves and is versatile and domain-specific (Bandura, 1997). Self-efficacy for a person with SUD means they successfully avoid relapse, maintain sobriety, and obtain positive recovery outcomes (Gorgulu, 2020). Conversely, when given peer support, people with low self-efficacy successfully avoided relapse and maintained sobriety (Bandura, 1997).

Prescription opioids, fentanyl, illicit opioids, and opiates have been a severe problem for the economy, healthcare, social arena, and substance users (Komaroff et al., 2016). The individual on MAT continues to struggle with finding housing because they are not accepted as sober. AA does not take MAT individuals in meetings as straight; most Oxford Homes do not allow them in their homes, and other homes do not accept them in their living quarters (Beasley et al., 2018). No set rules or policies define sobriety; therefore, each house can decide whether to take women (Beasley et al., 2018; Greenwald et al., 2018; Komaroff et al., 2016).

Summary

Chapter 2 discussed the study's theoretical foundation and the social learning theory and how it relates to Chapter 2. Included in Chapter 2 is the literature review and historical content on opioids, housing entities, and MAT. Chapter 3 discusses the research design and rationale for this study. The role of the researcher and methodology is discussed in detail. Who will be in the study, step-by-step details of the method, and how it answers the research question. Also, Chapter 3 will discuss participants' prequalification, participant engagement, debriefing, and how the data is collected and analyzed. The conclusion of Chapter 3 discusses the credibility, trustworthiness, and ethical considerations of the researcher and participants.

Chapter 3: Research Method

In this generic qualitative study, I examined the perception of official housing policies concerning sober housing for women in medically assisted treatment who are homeless, previously incarcerated, or in residential treatment. My goal was to better understand and address the MAT users' barriers to obtaining housing. MAT is an opioid; therefore, MAT is risky because it can be sold to other women and used recreationally (Rinker, 2019). Furthermore, many MAT users do not qualify for recovery homes due to their abstinence requirement. The Drug and Alcohol Programs Department licenses group homes, halfway houses, and residential facilities to treat substance users (Cacciola et al., 2015). However, licensing is unnecessary for recovery homes to treat boarding or rooming houses (Cacciola et al., 2015). The NAOMI study showed MAT was 88% effective in stabilizing opioid addiction and saving lives (Snodgrass, 2016). I explored the perceptions of women on MAT who were not readily accepted into housing compared to SUC women not on MAT. The findings from this study can be used by future stakeholders and those who work in recovery homes and sober living facilities to implement standard housing policies to help MAT women attain housing.

Research Design and Rationale

I chose a qualitative methodology to understand women's perception of securing housing while on MAT. Qualitative researchers seek the rich discovery of specific populations' experiences and issues (McGrath et al., 2019). Furthermore, qualitative researchers seek to understand phenomena and events through experiences, behaviors, and social issues.

The development of the research question came after an extensive literature review that revealed a gap regarding different definitions of sobriety, a lack of standard housing rules for women on MAT, and other regulations for MAT women's nonacceptance or acceptance into housing. Qualitative methodologies are used to study experiences and concerns that affect populations (Liljedahl et al., 2019). I used qualitative research to understand a specific event or occasion. I chose the qualitative method because I could create specific open-ended questions for participants to express extensive details on their encounters when applying for housing (see Barrett & Twycross, 2018). I used the generic qualitative design study to explore a setting, phenomenon, or experience to understand the why instead of the what (see Stake, 2010). My goal was to understand the perception of official housing policies concerning sober housing for women on MAT who are homeless, previously incarcerated, or in residential treatment.

Although a plethora of information exists on housing for substance users, there is little information on understanding their perception of official housing policies for women on MAT. The design of this study was appropriate because I examined a set of women's perceptions and experiences (see Gustafason, 2020; Liu, 2016). I used a protocol interview guide for an organized and smooth interview.

Research Question

What is the perception of official housing policies concerning sober housing for women with medically assisted treatment who are homeless, previously incarcerated, or in residential treatment?

Role of the Researcher

My role as the researcher was to protect the participants and be objective, fair, and professional while collecting, analyzing, and gathering the study population (see Dos Santos et al., 2020). As a researcher, I first recognized that my subjectivity shaped the methodology, informed the research, analysis, and treatment of gathered data, and influenced interactions with the study participants (Chang et al., 2020). Therefore, I need to be respectful, trustworthy, and sensitive to the participants' rights and not be judgmental, which tends to be a significant issue when obtaining information (see Caine et al., 2016). The participants reflected and shared life experiences, allowing me to enter their world. I communicated my needs, thoughts, desires, and inner self by being candid while being sensitive and respectful of the participants (see Caine et al., 2016). As the researcher, I enrolled and interviewed all potential participants. Building rapport with the participants was vital so they felt comfortable sharing their feelings, beliefs, and truth. h.

My goal was to be nonjudgmental and unbiased; therefore, I posed straightforward, concise, and fair questions. I gave the participants an outline of the study, asked open-ended questions, allowed them to share whatever was on their mind, and reminded them they could decline to answer any questions if they were uncomfortable. The study participants were recruited from the general population through Ralph's House, social media, Facebook (FB), and Ralph's House participants' word of mouth. I relied strictly on individuals who wanted to participate in the study; no incentive will be offered. I went through Ralph's House, Ralph's House participant's word of mouth to the general population, and social media to ensure I do not know any

participants. However, if a participant knew me, I did not ask them to participate in the study to reduce my bias risk. I reminded participants that they could withdraw from the study without repercussions.

Methodology

I chose a generic qualitative design study to understand the perceptions of women on MAT regarding housing policies. I used this method to understand the participants' perceptions and attitudes toward housing policies or lack thereof, why they believe what they do.

Participant Selection

I used purposive and snowball sampling to recruit participants who met a specific criterion. Snowball sampling, known as referral sampling, is when existing participants provide referrals to recruit participants required for the research (see Arieli & Cohen, 2011). The participants for this study were recruited from Ralph's House, Ralph's House participants' word of mouth to the general population, and social media. The use of social media as a recruitment tool was chosen because it has a large base to find participants willing to give candid feedback on their experiences and less risk of bias than blogs..

Individuals from this specific population spreading the word in the general population increased the probability of having adequate participants for the study. Galdas (2017) stated that social media is a proficient way to recruit a broad population of research participants as a networking platform. Participation from Ralph's House participation pool was chosen because it allowed a specific population of women on MAT, yet diverse in age range and coming from different parts of the United States.

Social media (FB) was chosen because it has a large base for finding participants and less risk of bias. Finally, word of mouth (snowballing) was selected because this is a specific and intricate population; therefore, individuals spreading the word to the general population increase the probability of having adequate participants for the study.

I began by obtaining participants for my study by posting a recruitment flyer at Ralph's House to announce the research and get volunteers. The recruitment flyer included a brief study summary and my contact information for interested parties. The same notification will be posted on social media. Additionally, I will ask Ralph's House women participants to spread the word to the general population to increase the study population. When contacted by interested female participants, I will ask the following qualifying questions: Are you a woman between 18 and 60? Are you currently on MAT? Are you homeless, previously incarcerated, or in residential treatment? Are you in need of housing? This generic qualitative design study will begin with nine participant interviews. After that, further interviews will be conducted if saturation does not occur (Bernard et al., 2018). My research found two studies, one with seven participants and the other with fourteen participants. Suppose I cannot obtain nine participants from the beginning. In that case, I will repost the recruitment flyer on another social media platform, Instagram, which was not used the first time. On the other hand, if I do not reach saturation or nine participants, I would review the data already obtained and look for meaning in what was provided (Cardon et al., (2015).

Instrumentation

I will use an interview protocol for this study. The interview protocol will began with the participant asking to participate in the study. Next, I will follow up via email, phone, or text to guarantee their qualification. Finally, a consent form will be emailed to the participant advising that the consent form must be signed and returned by email. The interview will be scheduled upon receipt of the consent form. Next, I will schedule interviews with the participants on the telephone.

The interviews were 60 minutes long; however, I was flexible in scheduling. The interviews will be virtual and performed in my private office. I will create the interview questions and conduct the interviews with each participant. The interview questions will provide the primary data for the study, focusing on a single concept (see Rubin & Rubin, 2012). The interview will consist of six open-ended questions, prompting, probing, and asking additional questions to allow female participants to convey their perceptions of and experiences with the developed concept. Finally, the interview will end by asking the participants if they have any more information they want to share and thanking them for participating in the study.

To reduce researcher bias, my committee members reviewed the interview questions. The 60-minute virtual interviews will be performed in my private office and recorded via laptop media files. I am an instrument in my study because I created interview questions, conducted the interviews, interpreted the data, and transcribed the data for clarity. The interviews will be scheduled in 60-minute increments per participant; however, flexibility will be given if less or more time is required. The recording and

prescriptions will be completed via laptop media files. I will review the transcripts twice to ensure accuracy.

Recruitment, Participant, and Data Collection

When the IRB approves, I will promote my study through word of mouth and recruitment flyers at Ralph's House. All interested parties will be advised to contact me by email or phone. In addition, all parties interested will be contacted within 72 hours by phone to pre-qualify by asking the qualifying questions to ensure they meet the study criteria. When the participant qualifies and verbally consents to participate in the study, I will email the consent form to obtain a signature and proceed further. I will advise the participant when the consent is completed and returned to me; I will call them to schedule an interview suitable for both parties. I will inform the participants to have a quiet place without interruptions where they are comfortable sharing openly and schedule ample time to discuss their perceptions, experiences, and feelings about the official housing policies with women in MAT. The interviews will be virtual and conducted as quickly as possible.

All interviews will be performed virtually in my private office and recorded via laptop media files. The discussions will be double-checked for accuracy and data collection purposes. A copy of the transcripts will be kept for data collection, and a copy will be available to the participants if requested. In addition, every communication (email, recording, etc.) between the participant and myself will be logged and saved for data and information. This process will be repeated until all participants are interviewed. .

The interview questions will be emailed to the participants before the interview to allow time for them to review and think about the queries (Korstjens & Moser, 2018).

I hope sending the interview questions beforehand would give the participants time to give deep thought and feelings about the study. In addition, I will schedule interviews with the participants on the telephone. The interviews will be scheduled for 60 minutes; however, I will be flexible in scheduling to give each participant adequate time in case the interview lasts more than 60 minutes. I will begin the discussion by sharing information about the study, using icebreakers to make the participant feel comfortable, and asking simple open-ended questions to build rapport with the participant (Rubin & Rubin, 2012). I will inform the participants that the interview will start. I will perform the 60-minute virtual interviews via Zoom.

As I ask each interview question, I will probe the participants to elaborate for clarity, flexibility, and exploration (Barrett & Twycross, 2018). After asking all six questions, I will ask the participants if they have any comments to improve the study. After completing all virtual interviews, the participants will be asked if they would like a copy of the transcript. If they say yes, I will inform them it will be emailed by the end of the week. In addition, I will advise the participants to email me if they need to make any changes. Finally, I will thank the participants and inform them they have completed the study. The participants will be advised that they will receive a study summary within seven days of completion.

Data Analysis Plan

I will begin analyzing the collected data when the interviews are completed, and saturation is reached. Each interview will end with me summarizing the participants' discussions. Participants names are removed and replaced with an alias (W1, W2, W3, …) to protect the participant's identities. The summary transcript will be sent to the participants if they request a copy. At the interview, the participants will be informed that a transcript summary will be emailed if they ask for one. Also, contact me if any errors are found in the transcription. Finally, I will email to thank the participants for participating in the study and advise them that they have completed it. After conducting all the interviews, I will interpret the data by examining the recorded interviews and journal entries for coding and categorizing words, phrases, or themes (Comunello et al., 2020).

I will use categorical aggregation, a form of thematic analysis, to process the collected data by organizing them into phrases, statements, or paragraphs with a word or phrase representing the collected data. I will use DeDoose data analysis software to assist in coding and organizing each interview. The DeDoose software will code the data with coding strips, perform participant response comparisons, establish word frequencies, search the text for key concepts, themes, and topics, and categorize the data for coding development (Liu, 2016). DeDoose takes an inductive approach to dissecting and organizing data to provide a summary of the outcome while at the same time connecting the findings to the study objective and assisting in coding, storage, and sectioning of the data (Liu, 2016). The central theme was obtained as the data analysis progressed. If

requested, a results summary will be emailed to the participants when the analysis is completed.

Issues of Trustworthiness

I will ensure quality research by confirming credibility, transferability, dependability, and confirmability (Korstjens & Moser, 2018). The qualitative researcher asks for the findings to be trusted when they discuss trustworthiness. There are many criteria and definitions for reliability; however, the best-known criteria are credibility, transferability, dependability, and conformability, which were implemented in this study (Korstjens & Moser, 2018).

Credibility (Internal Validity)

Creditability is the internal validity of qualitative research (Korstjens & Moser, 2018). Interactions with the participants will be documented to ensure the study remains transparent by establishing open communication. All communication with the participants will be honest and upfront, including reading and coding data. Each participant will receive an interview summary to confirm that the conversation was what the participant conveyed in the interview if requested. If changes are needed, I will correct the outline according to information from the interview. Having the participants check the interview summary for accuracy ensures that I communicate the meaning to provide an accurate analysis process (Kahlke, 2017).

I will keep analytic notes (journal) and reflexivity during the study by logging fieldwork activities, which adds to the study's credibility (Dodgson, 2019). I will journal all events, ideas, accomplishments, inspirations, and frustrations to reflect and share

thoughts and assumptions (Hemphill & Richards, 2018). I will be transparent throughout the study of any biases, beliefs, feelings, and ideas that could influence me. I will respect each participant and convey the message they communicated in the study. I reframed interview questions by questioning from an individualistic perspective instead of a group to check for inconsistency. Establishing my authority will provide further opportunities to prove credibility (Korstjens & Moser, 2018). I will debrief the participants after the interview, which is part of the interview process, and establish credibility (Nyamathi et al., 2016).

Transferability

According to Ferrando et al. (2019), transferability is the level of qualitative research results that can be transferred with other women to other contexts or settings; I facilitate transferability judgment through a thick description of a potential user. This study is specific to women on MAT; therefore, transferability is limited. However, transference can occur with other women on MAT who need housing at Ralph’s House, Facebook, or Ralph’s House participant’s word of mouth to the general population. The data within this study applies to those women, medically assisted treatment programs, those needing housing, all housing entities, and legislation to make housing policies. The data collected can be used to understand how women are affected by being on medically assisted treatment when applying for housing, how there are no rigid housing rules so a housing entity can decide for or against the women on MAT, and how some group’s view women on MAT as not being sober and are not welcomed in group meetings. These

findings could be helpful in the housing entities statewide, legislative system, substance abuse arena, family, and human service areas.

Dependability

Dependability refers to finding stability over time, evaluating findings, and the interpretations and recommendations that are supported and received (Korstjens & Moser, 2018). For example, I will journal throughout the data collection and analysis stage, keeping an audit trail of my communications, thoughts, actions, and biases. Guest et al. (2014) state that an audit trail and reflexivity establish dependability when used.

Conformability

The study's conformability entails knowing the areas of neutrality and securing the data's inter-subjectivity (Korstjens & Moser, 2018). The interpretation should be grounded in data rather than a person's preference and viewpoints; the focus is on the interpretation process and is rooted in the analysis process. (Guest et al., 2014). I implemented the strategy to achieve conformability and dependability in the audit trail. I will provide thorough notes on research decisions, meetings, materials, reflective thoughts, sampling, findings, and data management information.

Intra-Coder Reliability

Intra-coder reliability is within-coder reliability (Berg et al., 2019). I will use the same coding, data collection, transcription, and analysis process for all participants, increasing the study's reliability (Morse, 2015). In addition, the study will be structured the same way an outsider can repeat the research and get the same results, ensuring reliability.

Ethical Considerations

Ethical consideration in qualitative research is critical in procedural, transactional, relational and sociopolitical contexts (Comunello et al., 2020). I will treat all participants with respect and equality. To ensure participant confidentiality, information gathering, storing, and privacy issues will be discussed with the participants before the interviewing process begins (Ngozwana, 2017). I will consider these issues carefully, collaboratively, and relationally with understanding, consideration, and an ethical approach to their role (Comunello et al., 2020). To further ensure confidentiality, information will be stored on a jump drive not connected to the internet, providing anonymity, eliminating data identity, and disclosing all sponsors and funding agencies (Buckley & Doyle, 2017). The participant will collect all data confidently and be given pseudonyms instead of their names (W1, W2…). After completing the study, the participants are debriefed to ensure no harm when returning to their pre-study state (Buckley & Doyle, 2017). Researchers must submit their research proposals to review boards and committees to ensure participants' beneficence (Ngozwana, 2017). Checking the study and the debriefing process must not harm the participants.

Summary

This generic qualitative design study began with nine female participants between 18 and 60 years old who needed housing and were on MAT. The interviews were performed virtually. The data is collected and recorded via laptop in media files and transcribed, coded, and analyzed with DeDoose. Categorical aggregation or thematic analysis is used to determine the over-arching themes in the data. Credibility and

reliability were assured through the study's organization and structure. Ethical considerations are made to guarantee the participants' privacy and comfort. All documentation (i.e., emails, consents, notes, journals, interviews) is on an external drive

Chapter 4 will discuss the data collection process, information from each interview, participant demographics, how, when, and where the data will be collected, and the collection instrument. It will present any variation in data collection from the Chapter 3 plan. Chapter 4 will discuss discrepant and non-confirming data and the study's credibility, transferability, dependability, and conforability.

Chapter 4: Results

In this study I examined the experiences and thoughts of women on MAT regarding their perceptions official housing policies. Participants were asked about their experiences attaining housing while on MAT and their perception of official housing policies to address this generic qualitative design. I asked the participants what experiences they had observed and faced while being on MAT trying to attain housing.

Chapter 4 includes the participants' demographics, the number of participants used, the data collection process, the interview settings, the apparatus used to record the data, and any variations made from Chapter 3. I discuss any abnormal circumstances in the collection process. Also, I discuss the data analysis process of how data was coded, interpreted, and how it was analyzed. I address creditability, transferability, dependability, and confirmability within the study. In conclusion, I present the study results and supporting materials and discuss any inconsistent cases within the case.

Data Collection

I recruited nine participants for this generic qualitative design case study. The participants were recruited via The House of Extra Measures Ralphs House, the Truscon, and Hoskins locations. I met with the two house managers on May 23, 2023, via Zoom (Truscon and Hoskins locations) to discuss my study, answer any questions, and advise them that I would send an email with an attachment to the Recruitment Flyer. The IRB approved me to research on April 11, 2023.

However, I had surgery scheduled for April 23 and wanted to recover before starting the interviewing process. The recruitment flyer requested that interested women

contact the researcher via my Walden email, text message, or phone call. I received phone calls and text messages from interested parties and one email. I did a 24-hour turnaround on contacting the prospective participants, attaining the participants' email addresses, and reviewing the qualifying questions again to ensure the prospective participant was equipped for the study. The prospective participants who did not qualify for the study were thanked for being willing participants and advised that they did not qualify to participate.

The participants who qualified for the study were congratulated and I announced that they would receive the consent form, interview questions, Zoom information for the interview, and information about the interview process in their email. The participant and I scheduled the interview. I reminded the participant to check her email for necessary information before the interview. I reiterated the importance and urgency of the consent being read and an email stating "I Consent" to move forward in the interview process. I double-checked my email to ensure the participant's "I Consent" email was delivered. If I did not receive the email, the participant was advised to check her email and email me so we could conduct the interview. All interviews were completed virtually on Zoom and recorded in the media files on the laptop.

All participants had emailed me with the "I Consent" before the day of their interview. I followed the interview guide. I restated that the interview was being recorded, the interview process, their participation was strictly voluntary, and they could withdraw from the study at any point if they felt uncomfortable or could not answer a question if they felt uncomfortable answering. I asked the six formerly emailed questions.

All interviews were completed on time and without any delays or technological issues. No adjustments were made to the method design discussed in Chapter 3.

I thanked the participants for volunteering to be part of the study and reviewed the process after the completion of the interview. The participants were advised that I should email a summary of the interview within seven days, and the participant should review it, make any changes, or approve the summary and email me back. I advised the participant that her part of the study was completed after reviewing the interview summary. I told the participant that an overview of the study results would be sent to her after the study. All data collected from the interviews were stored via laptop media files. All nine interviews were virtual via Zoom, with times ranging from 45 to 60 minutes from start to finish. However, the majority of the interviews were between 50 to 60 minutes.

As shown in Table 1, demographic characteristics

1.1 Table 1

Interview Demographics

Age	Recruited from House of Extra Measures	Recruited from social media	Virtual interview	Turned down for Housing	Another Program referral
44-54	2	0	2	2	1
28	3	0	3	2	1
24-27	4	0	4	2	1
Totals	9	0	9	6	3

Data Analysis

After completing all the interviews, the recordings were converted to transcript documents via laptop media files. I reviewed the transcription line by line for accuracy against the media files and made corrections as needed. One transcription for W2 converted one word wrong, which I corrected. I read over the transcripts twice to ensure accuracy. Once completed, I reviewed the questions and answers for each participant twice. This started the participants' summary process. After putting the questions and answers in paragraph form, I completed the summary, reviewed it twice, and emailed it to the participant for review. All summaries sent to the participants came back with no disputes or corrections.

I commented on the margin of the transcribed Word document for the first coding round. Words and phrases were typed in the comment section of the transcribed Word document. The wording and phrases were "uneducated, need to be educated, turned down numerous times, it is unfair, relapse, and because of MAT." I continued commenting on the margin of the transcribed data until all nine interviews and questions were commented on. The first round of codes was similar to ideas from the participant, which I noted; however, it was not the exact phrasing from the participant.

Round 2 of coding consisted of another Word document highlighting the exact verbiage by two or more participants. This was necessary for me to see the similarities between the participants. Also, I could take the comments from the first round and use them in the second round of coding the participants' exact verbiage to gather distinct similarities. The participants established a trend and expressed that they had been turned

down three to five times or numerous times when applying for transitional, supportive, or sober living housing. The first question is if the participant had used and been turned down when looking to secure housing. In round two, I gathered insight from the participant's statements and repeated views gathered insight from the participant's statements and repeated views in round two.

Round 3 coding was another Word document organized with each participant's interview answers color-coded to each person. I made an Excel worksheet with specific headings to address the six questions with thirteen columns/codes. For example, question five was a three-part question. Therefore, part A questions: Do you have peers not on MAT who easily secured housing? Part B question was, if so, what is their drug of choice? Moreover, part C was, why do you feel housing was not an issue for them? Thirteen column headings addressed the six questions. Two questions had two parts; therefore, it was a column for parts A and B and a part C for two questions with three parts. I was able to assign the appropriate codes to the correct columns.

The fourth round of coding involved transferring the transcripts and Excel spreadsheet with the ten columns with codes into DeDoose. I used Stages 1 and 2 to mark and code the document. All documents were coded with the original code. I checked the coding to ensure there was no overlap, similar codes meaning the same thing, missing items, and misappropriation.

Round 5 coding consists of looking for similar codes to move them to distinct codes. I discovered that the participants expressed their feelings with Questions 3 and 4. Question 3 was: Did your attitude become tainted against the housing entity, and do you

understand their reasoning? Question 4 was: How did it feel when you were turned down? Was your sobriety in question, and do you think it is fair? At this point, I generated the code Feelings. I grouped reasoning from Questions 2 and 3 and Feelings from questions three and four. Similar and supporting ideas were the main categories produced from the group of codes. The types grouped from codes allowed me to see emerging themes and the unassigned code that addressed one participant's comments. All of the codes were similar and relevant to the study.

The final coding round merged the codes that related feelings of not being accepted into housing, needing to be educated on MAT, and fairness. To create a theme, I combined categories such as reasoning, feelings, sobriety, and what next. The first theme was MAT is keeping them sober but stigmatized as a person with an addiction. The second theme created expressed educating people on MAT so they will understand and not treat them as people with an addiction. The research continued with Theme 3, noting the importance of understanding that using drugs will kill them; still, MAT saves their lives, and Theme 4 was the need for justice and fairness. Research of the four themes was the study's final theme recognition. The four themes I developed were significant to the research question discussed in the results.

Evidence of Trustworthiness

Credibility

I ensured the study was transparent by documenting every interaction and communication with the participants. All documentation, such as the consent forms, notes, and media interviews, is secure in a folder on my laptop. My laptop is accessed by

a password known to me and my index finger. The journal I kept on the participants is locked and in a file cabinet; only I have the key. I was honest with the participants when communicating their opinions and coding the data. After interviewing each participant, I sent a summary of the interview to ensure that what I wrote was what was conveyed to me. Every participant told me there were no changes to the summary; therefore, no corrections were needed.

I intentionally used every word and phrase in coding the participants' meanings. I noted every comment, unspoken interaction of movement, occurrences, any bias I encountered, and accomplishments in a journal designated for research. Also, I noted her viewpoint and emotions in the journal to ensure transparency throughout the study. The participants were handled respectfully when communicating and documenting what was conveyed so as not to lose the study's intended value.

Transferability

In this study, I explored women on MAT who needed housing. No adjustments for transferability were needed from Chapter 3. I examined the experiences of nine women specifically; however, there are lessons to be learned from their experiences, and these lessons can benefit other women. In addition, it can move to women on MAT who have attained housing, women in transitional homes, women in sober living, and family members of women on MAT. However, this study is not about transferability to other populations; the study's goal is to better understand and address the MAT users' barriers to obtaining housing.

Dependability

I maintained dependability throughout the study by keeping a journal with every comment, unspoken interaction of movement, occurrences, any bias I encountered, and accomplishments. I kept a journal and made journal entries of everything concerning the study. I would read over the journal entries to reflect on and examine my views on the study to ensure I am not using my ideas or beliefs but only the participants to interpret the study. I transcribed a summary of each interview and sent it to each participant for review and corrections to verify that what was in the summary was correct. The participants approved all the summaries, ensuring the meaning and context were maintained during the analysis.

Confirmability

In the methods section in Chapter 3, I thoroughly explained how I executed the study, and its original design was not compromised. Documentation was noted on all comments, occurrences, biases, communications, interview dates and times, transcriptions, and the justification of the study's final results. I stayed on track by logging each participant's progress and status of the study to guarantee that time frames were met. Therefore, this study can be replicated.

Data Analysis

This study's research question was: What is the perception of official housing policies concerning sober housing for women with medically assisted treatment who are homeless, previously incarcerated, or in residential treatment? I discovered four themes. Interview questions, participant responses, codes, and themes are exemplified in Table 2.

The four themes in this study were: MAT is keeping them sober but stigmatized as a person with an addiction; educate people on MAT so they will understand and not treat them as people with an addiction; understanding that using drugs will kill them, still, MAT saves their lives, and being turned away from different housing entities and feeling there is a need for justice and fairness.

MAT is Keeping Them Sober but Stigmatized as an Addict

Six participants expressed that they had applied for transitional and sober living housing and were turned down because of being on MAT. The counselor referred to two participants, one by her counselor and one by the recovery coach, presented in Table 1. When asked if they had applied for housing, the eight participants were in one accord and had been turned down. The other two participants said they knew they would attend The House of Extra Measures: Ralph's House because that was their only option being on MAT. Also, her peers told her about two houses that did not take people on MAT. One participant stated, "This is my first time in treatment, and the HEROES program recommended Ralph's House so I could stay on MAT.

All nine participants acknowledged that no houses opened doors to people on MAT because they were not sober, which responses are presented in Table 2. W1 reported, "I was told I still take an opioid, Suboxone, so I am not sober, but that is so one sided. W2 expressed, "Five houses were against MAT medication because they said the participant was still on drugs." W3 expressed that she was told, "I was still taking drugs being on MAT. W3 stated, "We all have different pathways to recovery, and MAT {Suboxone} is part of my pathway that helps keep me sober." W4 said, "A couple of

houses told me they did not consider people on MAT sober." W5 & W7 stated, "We do not accept people on MAT because you are not considered sober." W6 expressed, "One home that was good in setting people up for success and helping them get on their feet, find work, and find permanent housing said we do not accept people on MAT." W8 said, "One home I desperately wanted to go to did not accept MAT because I was still taking an opioid. So, I started figuring out how to stay on MAT and be under the radar to avoid homelessness." W9 expressed, "I am not an addict; I am taking what I need to maintain sobriety.

Educate People on MAT So They Will Understand and Not Treat Us as Addicts

Participant responses are presented in Table 2. Eight participants stated that people need to understand MAT and how it can help people addicted to opioids. This was the consensus of the participants when asking them what they would like to see regarding housing. W1 stated, "Housing is one-sided." W2 said, "If more houses gave us more opportunity, more people would be sober. Mr. Ralph is saving people's lives. W3 said, "I just think people need to learn about MAT so they will not be so negative." W4 stated, "I think not enough people are educated on MAT, and when they know better, maybe people on MAT will have better. W5 said, "People need to be educated on MAT. When I first got on MAT, I knew nothing about it, so I had to do my research to learn about it."

W6 stated, "They probably do not understand it and need to be educated on MAT." W7 said she wants to be treated fairly because addiction is an addiction, and no one should get special treatment because they are not on MAT. After all, I was still working to stay sober. W8 stated, "I just think there is a lack of education, and people

must be educated on MAT. W9 said, “So I do not understand why they are so narrow-minded about MAT because they are uninformed people, and there are many uneducated people regarding MAT.

Using Drugs Will Kill You, still, MAT Saves Our Lives

All nine participants voiced their feelings when asked how they felt when they were told why they were turned down, and the responses are presented in Table 2. W1 stated, “Angry, you know some people abuse it, but people abuse Xanax, Narcos, Advil Tylenol, and Adderall and die, but MAT keeps me alive.” W2 expressed, “Very disrespectful; I would have relapsed without MAT. It is not fair. I am just like any other person in that sober living house. You could not tell the difference between me and someone not on MAT. W3 said, “Oh, that made me feel stressed out and overwhelmed because I wanted the same opportunity that everybody else had, and it was not like that. My sobriety would have been questionable. W4 expressed, “Yeah, a little disheartening because it is so limited for people like me and us to find somewhere to live because of the MAT medication.” W5 said, “I felt angry and had every right to feel angry. Why am I being singled out because I do not take crystal meth, crack cocaine, or drink alcohol. A person with an addiction has an addiction, and if they want to use, they will regardless of their drug of choice.”

W6 stated, “Oh, it is annoying, frustrating, and unpleasant. If I did not have Ralph’s House, it would jeopardize my sobriety.” W7 expressed, “Hopeless like, what am I going to do? Like not knowing, fearing the unknown, knowing that home was not an option. It is unfair because addiction is an addiction, and no one should get special

treatment because they are not on MAT. After all, I was still working to stay sober." W8 said, "That is disappointing. I feel like they should accept other people on MAT as well and have a choice of two, three, or four places they could go." W9 stated, "I feel like it is very closed-minded; I do not understand. They will often have people in these sober living houses, and they will still be on drugs and things. However, they do not take people on MAT when MAT people have a higher success rate, so I do not understand why they are so narrow-minded about it." It is upsetting because I am no different from the next person on other drugs."

There is a Need for Justice, Fairness, and Equity for Persons on MAT

When asked if they felt housing policies governing all types of housing would help people on MAT attain housing, all nine participants agreed it would, as presented in Table 2. W1 said, "Yes because more people would be sober. I knew somebody who overdosed and died. He was attending court with me and told me he hoped he had a sober living house to go to instead of going back to his old stomping ground." W2 stated, "Yeah, that would open many more opportunities for people on MAT." W3 expressed that housing policies governing all housing would help people on MAT obtain housing. Yes, ma'am, it would be more accessible and beneficial for us because it is limited. Yes, we are almost complete because this house only houses 14 people. So, what is going to happen when we are full? It is scary to think about other people who did not get a chance all because MAT housing is not available." W4 said, "Yes. I think it is all about equality, and everyone should be treated the same and given the same opportunity if we are trying to better ourselves and work on our program. Because housing is a huge part of it, if you

get placed somewhere, MAT is accepted, but if not, that could jeopardize a person's sobriety. In early recovery, your surroundings are significant, and you are very sensitive to everything. So yes, I think everyone should have a choice to live wherever they think is best for their recovery. Everybody should have the same selection of places to choose from."

W5 stated, "Yes, without a doubt, all rules are the same for everyone to enhance a successful recovery." W6 expressed, "Yes, what is good for you for housing is good for me in housing. Once people learn about MAT and do not think we are substituting one drug for another, maybe more houses would be open to people on MAT." W7 said, "Yes, it would. People on MAT would have an option instead of only option A but have B, C, D, and E as options. W8 stated, "Oh yes if every house had to follow the same rules, that would be great. They should be obligated to accept people on MAT and not discriminate against somebody just because they are on MAT. It is not like we use it to get high but to maintain our recovery." W9 said, "Absolutely because everyone would have an equal chance. Some people with criminal backgrounds can get houses, whereas others on MAT cannot." "I believe official policies should govern all housing so everyone can have fair treatment. Our Pledge of Allegiance states, "For Liberty and Justice for All."

Table 2

Interview Questions, Responses, Themes

Questions	Responses	Code Words & Phrases	Themes
Have you ever applied and been turned down for housing? If so, how many and why? Why do you feel housing was not a issue for your peers on other drugs Interview Questions 1 & 5	I still take an opioid Suboxone. Five houses did not take people on MAT I am still taking drugs being on MAT People on MAT are not sober. People on MAT are not accepted, I am still taking an opioid. I a not considered sober.	Not sober, on Opioids, still on drugs, do not take people on MAT	MAT is Keeping them sober but stigmatized as a addict
What would you like to see regarding housing? Interview question #3	For it not to be one-sided, get more houses so we can have more opportunities, learn about MAT so they will not be harmful, do research and learn about MAT, be will not be harmful, do research and learn about MAT, be treated fairly because addiction is an addiction, they probably do not understand, for people not to be so narrow-minded because they are uninformed so we cannot access housing.	People need to understand MAT, more housing, more sobriety, learn about MAT, educate and inform people, and be treated fairly.	Educate people on MAT so they will understand and not treat us as addicts.
How did you feel When you were told the reason for being turned down for housing?	I am angry because people abuse Xanax, Advil, Tylenol, and Adderall and die, but MAT keeps me alive	Angry, very disrespectful, unfair, stressed out, over-whelmed because	Using Drugs will Kill You still, MAT saves our Lives.

Questions	Responses	Code Words & Phrases	Themes
Interview questions 2 & 4	It was disprectful because I would relapse without MAT; It is unfair. I am like anyone else in sober living; stressed out and overwhelmed because I want the same opportunity as everyone else, a little disheartened, angry and singled out; it is annoying, frustrating, unpleasant, hopeless not knowing what am I going to do, it is disappointing, I feel like they are very close-minded, and it is upsetting.	because I am different from the next addict, disheartening because housing is limited to us, disappointing because addiction is an addiction.	
Do you feel housing policies governing all housing types would help people on MAT attain housing? Interview question #6	Yes, because more people would be sober. It would open many more opportunities for people on MAT; it would be more accessible and beneficial for us because we are limited. I think it is about equality and everyone should be treated the same and given the same opportunities; everyone should have the same selection of places to choose from, and all rules all the same foe everyone to enhance a	More people will be sober, there will be more housing opportunities and equal chances, everyone will be treated the same, all rules will be the same for everyone, there will not be discrimination, and the same policies should govern all houses.	There is a need for Justice, Fairness, and Equity for Persons on MAT.

successful recovery. which is good for you for housing is good for me, people would have more options instead of just option A, the house would be obligated to accept people on MAT, everyone would have an equal chance, and that would be “for liberty and justice for all.”

Summary

Chapter 4 discussed the study's setting, demographics, data collection, analysis, themes, and reliability. The main themes in the study were revealed. The five themes revealed were connected to the research question. The first theme that materialized was that the participant’s believed MAT was keeping them sober; however, they encountered the stigma of being an addict. The second theme developed was that the MAT participants desired to see people educated on MAT so they could understand it and not be treated as addicts. The third theme emerged that using drugs will kill you, but MAT saves our lives. The MAT participants were adamant that MAT had been the key to their success in recovery. In contrast, the participants believe using drugs will kill them, but MAT stops them from overdosing. The fourth theme is that there is a need for justice, fairness, and equity for people on MAT.

Nine participants were turned down for housing because they were still labeled addicts, not sober, and taking drugs because they were on MAT. The last theme developed, asking for justice and fairness regarding housing. The participants believed that if other people with a different drug choice could easily attain housing, have three or more options, and are not discriminated against, all housing entities should be that way across the board. People on MAT, crack cocaine, methamphetamine, or alcohol should be treated equally. Fair treatment in all housing entities should not be an option but a standard for everyone. This can be accomplished by governing all housing entities with the same policies and standards. In addition, everyone should be educated on MAT to understand better and not label people on MAT as people with an addiction or not sober. .

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Chapter 5 will review the study's results and compare them with what has been found in previous research to verify if the results confirm, disconfirm, or extend knowledge of the impact and feelings of women in MAT needing housing. The results will analyze and interpret the findings according to the theoretical and conceptual framework to ensure the interpretations do not exceed the scope of the study. The study's limitations, recommendations, implications, and opportunities for positive change are due to the data found within the study. Chapter 5 will discuss the opportunity for positive change and advances due to the data found within this study.

Chapter 5: Discussion, Conclusions, and Recommendations

In this study, I examined the official housing policies concerning sober housing for women on MAT who are homeless, previously incarcerated, or in residential treatment. I constructed the study to understand the participants' attitudes and feelings about housing policies, or lack thereof, and why they believe what they do. I used in-depth interviews to understand the women's MAT population.

..........During data analysis, I found four themes to answer the research question. The first theme involved the perception that MAT is keeping them sober but stigmatized as a person with an addiction. The second theme included educating people on MAT so they will understand and not treat them as people with an addiction. Theme 3 was about the importance of understanding that using drugs will kill them; still, MAT saves their lives. Last, Theme 4 was about the experience of being turned away from different housing entities and feeling that there is a need for justice and fairness. The research question was: What is the perception of official housing policies concerning sober housing for women with medically assisted treatment for those who are homeless, previously incarcerated, or in residential treatment?

Interpretation of the Findings

Previous research confirmed the study’s results regarding women on MAT having difficulty securing housing. However, there is limited research regarding women’s feelings about MAT obtaining housing. The findings of this study supported four areas from previous results regarding people on MAT. First, women on MAT have significantly more difficulty finding housing and often experience unsatisfactory living

conditions. The stigma is so prevalent, locally, and worldwide, that Narcotics Anonymous (NA) faces questions regarding member participation of those on MAT and whether they meet the criteria for participation. MAT residents do not qualify for recovery homes because they are abstinence-based. The one treatment available to help heroin addicts is being rejected in many recovery homes. According to Gryczynski et al. (2015), people on MAT are not considered to have clean time because they use buprenorphine according to NA and AA. Abstinence is free from all opioids; therefore, MAT individuals are not abstinent and are replacing one opioid with another (Gryczynski et al., 2015).

Alessi (et al., 2017) suggested that women on MAT have significantly more difficulty finding housing and often experience unsatisfactory living conditions. These findings support the findings of the study. The eight participants were turned down for housing 16 times because the different housing entities did not accept people on MAT. They were told they still had an addiction, still used drugs, and MAT was still a drug. One participant stated they are against MAT in Kerrville, TX. A person on MAT was not considered sober, and people on MAT were not accepted in the housing entity. The individual on MAT continues to struggle with finding housing because they are not accepted as sober. AA does not consider MAT individuals in meetings as sober; most Oxford Homes do not allow them in their homes, and other homes do not accept them in their living facilities because they are not considered sober (Beasley et al., 2018). These findings support Alessi et al. (2017) findings that women on MAT have significantly more difficulty finding housing and often experience unsatisfactory living conditions.

The results of this study show a negative impact on MAT women securing housing, although additional research needs to be completed.

Third, the stigma is so prevalent locally and worldwide that AA faces questions regarding member participation of those on MAT and whether they meet the criteria for participation. MAT residents do not qualify for recovery homes because they are abstinence-based, and the one treatment available to help heroin addicts is being rejected in many recovery homes (Adinoff & Robinson, 2018). Only two participants out of nine were not turned down for housing. However, one participant was told Ralph's House was the only option for her, and the other was referred by the HEROES program, advising her that no one else accepted people on MAT. Although some guidelines and policies have been implemented, and many lessons have been learned over the years of using medication to treat OUD stigma and discrimination, our nation still has significant problems (AATOD, 2019).

Rinker (2019) suggested that many MAT residents do not qualify for recovery homes because they are abstinence-based. However, licensing is unnecessary for recovery homes to treat boarding or rooming houses (Cacciola et al., 2015). Two participants already knew they were going to Ralphs House. The other eight participants applied to different well-distinguished recovery homes, transitional homes, and supportive homes. The result to all the housing entities was "no," which centered around MAT being the reason for refusal. No set rules or policies define sobriety; therefore, each house can decide whether to take women (Beasley et al., 2018; Greenwald et al., 2018; Komaroff et al., 2016). Within the study, most participants could attain housing at one

house for people on MAT. Although, this house is a pilot study by the University of Houston, whose grant is due to expire in 2025. The women hope they can return home, the grant is extended, or they have found work and secured permanent housing, such as an apartment.

The results of this study were illuminated through the lens of the social learning theory. Albert Bandura stated that people and the environment operate simultaneously, and how people feel, think, motivate, and behave influences self-efficacy (Bandura, 1974). The study's results were based on participants' self-efficacy, believing they could maintain abstinence. The social learning theory states that people develop self-efficacy through significant processes, which are cognitive, motivational, affective, and selection processes (Bandura, 1993). In this study, all participants used self-efficacy through positive thinking, feelings, behavior, and motivation to maintain sobriety (Bandura, 1993). Participants shared their perceptions, thoughts, lived experiences, and the impact disclosure had on them and the system. Furthermore, through the social learning theory, the findings suggesting that state officials and legislatures work together will be used to advance understanding of what is needed to facilitate MAT.

Limitations of the Study

This generic qualitative design was limited to a specialized population. I observed nine women on MAT needing housing, which was not intended for generalized people. All the views are limited to a woman’s perspective because the study had only female participants. The women in the study were limited to an age parameter ranging from 18 to 60 years old. Therefore, women on MAT who are over 60 or under 18 may share a

different feeling regarding securing housing. All of the participants discussed the negativity displayed to them while trying to secure housing. The nationality of the nine participants was comparatively close in range, with three Afro-Americans, three Hispanics, and three Anglo-Americans. A qualitative study of men on MAT looking to secure housing may show different results from those within this study. Another limitation of the study is that I hope that state officials and legislation will work together to advance understanding of what is needed to facilitate people on MAT. However, the study may not reach state officials and legislation, meaning there would be no change in the disparities learned from the study.

I have been sending out a snippet of the research findings voiced by the women to recovery and supportive housing, Oxford homes, and transitional homes to educate them on MAT. Also, I hope they will be open to their facilities people on MAT. I hope the different facilities will join together to make a difference in the local communities and local officials to promote change in the legislation.

Recommendations

As the opioid epidemic continues to be a nationwide problem and there is a lack of standard housing policies for all housing entities, the issue of housing for the MAT population, women, and men will be affected. Further research is suggested to explore the perception of official housing policies for women and men to address the documented problem of securing housing while on MAT. Further research is warranted to determine how the lack of housing affects women in the age range over 60 years old and women research is needed nationwide to discover if standard housing policies are an answer for

under 18 years old. Further research is warranted for family members of people on MAT to detect their feelings and the impact on them witnessing the lack of housing. Further research is needed nationwide to discover if standard housing policies are an answer for people on MAT trying to secure housing. Further research is required to address the lack of knowledge on MAT and how it works for people with previous opioid addiction.

Implications

The results of this study could lead to positive social change and actions that would open doors for women on MAT to secure housing without discrimination and have official housing rules. It may make a difference by regulating MATs and all official housing policies locally and globally. It can bring about social change by acknowledging the negativity women on MAT face in securing housing and being a part of AA or NA. Social programs, such as support groups and housing for people on MAT, would be beneficial in being a part of a supportive community and having a place to call home. Counselors and Therapists can benefit from knowing about house placement and the supportive community to advise the participant upon release from residential, incarceration, or homelessness.

It can provide awareness to local, state, and national legislations of the need for standard housing for people on MAT. Eight participants in the study were affected by negative comments when securing housing. All housing entities could learn from being educated on MAT, understanding the need for MAT housing, and the bias that appears when people on MAT cannot secure housing. Still, someone on crack cocaine, amphetamine, or alcohol can choose three or four housing entities. The knowledge of the

housing entities and industry for people on MAT can profoundly impact legislation to promote equality. All housing entities know it is liberty and justice for all, regardless of their drug of choice.

My study regarding MAT women's perceptions of official policies on sober housing is affected by the social determinants of health (SDOH). SDOH is affected by who these ladies are, their age, their genetic factors, what they indulge in, alcoholism, substance use, physical activity, diet, their condition, working, growing, and their age. It also includes their social network, socio-economic status, environment, health systems, and culture. Resources, power, and money from these SDOHs, locally and nationally, influence health inequalities (Ayuku et al., 2020). In addition, secure and adequate housing itself is an SDOH.

Furthermore, two frameworks are aligned with my study, which WHO developed. They are structural and intermediate determinants that impact health and can promote health and equity in MAT women (Ayuku et al., 2020). The socio-economic and political context a MAT woman is born into, and lives in are how society makes and executes decisions, which is governance, social and economic policies, and social and cultural values the MAT women place on health. These factors can lead to unequal material and monetary resources, shaping MAT women's socio-economic position (Ayuku et al., 2020).

MAT women's place in society is shaped by their socio-economic position, which affects their experiences, vulnerabilities, and results that impact their health. Their education, income, gender, ethnicity, income, and social class are socioeconomic

positions that affect their intermediate health determinants, including housing quality, work environment, and finances to buy clothing, healthy food, or healthy living conditions, which are material circumstances. Psychosocial factors affecting MAT women are good or bad relationships, stressful living conditions, social support, and biological and behavioral influences (Ayuku et al., 2020).

Conclusion

The study results support previous research that has been completed regarding the lack of housing for people on MAT, the stigma people on MAT face, and the lack of set rules or policies for all housing entities causing inequality. The findings indicate that people on MAT are limited to minimal and no housing and are stigmatized because they take MAT maintenance medication to ensure their sobriety and recovery.

Women on MAT have witnessed bias when they are turned down for housing due to being on MAT. They have faced the stigma and endured being labeled as a person with an addiction. They have heard AA and NA meetings state that people on MAT are not considered sober. Additionally, every housing entity gets to decide its definition of sobriety in all housing entities. Decisions made by different housing entities impact the attitude of people of MAT and the homelessness rate, thus affecting society on a local and national scale of seen and unseen bias.

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Appendix A: Interview Protocol

Purpose	This generic qualitative design study aims to understand the perception of official housing policies concerning securing sober housing for women with medically assisted treatment who are homeless, previously incarcerated, or in residential treatment.
Target Population	Adult women on MAT between 18 and 60 years old who need to secure housing.
Volunteer Introduction	Thank you for volunteering to be part of my study. This study explores the perception of official housing policies concerning sober housing for women with MAT who are homeless, previously incarcerated, or in residential treatment. The following questions are necessary to determine if you qualify for my research. 1. Are you a woman between the ages of 18 and 60? 2. Are you currently on MAT? 3. Are you between the ages of 18 and 60, on medically assisted treatment, plus any of the following: homeless, turned down for housing, previously incarcerated, or had previous residential treatment? 4. Are you in need of housing? **Non-qualifying** I will inform the volunteers that they did not meet the criteria for the study and thank them for their time. I would ask them to spread the word to their friends, associates, and family.
Interview Questions	1. Have you applied for housing and been turned down? If so, how many turned you down, and how long have you been looking to secure housing? 2. Who was the housing entity (e.g., Oxford House, private house) that turned you down, and what was their reason?

	3. Did your attitude become tainted against that housing entity? Do you understand their reasoning, and what would you like to see regarding housing? 4. How did it feel when you were told why you were turned down? Was your sobriety questionable because you are on MAT, and do you think it is fair? 5. Do you have peers not on MAT who easily secured housing? If so, what is their drug of choice, and why do you feel housing was not an issue for them? 6. Do you feel housing policies governing all types of housing would help people on medically assisted treatment attain housing (if yes or no, why/how)?
Debriefing	I want to thank you for participating in my study. I want to ask if there were any questions about any part of the study they would like to ask now or get clarification. The purpose of conducting this study was to allow women in medically assisted treatment to share their experiences and perceptions of official housing policies concerning sober housing for women in medically assisted treatment who are homeless, previously incarcerated, or in residential treatment. The basis for this study stems from the findings of previous researchers who provided information and findings that support the need to have official housing policies for women on medically assisted treatment. The results of this study will inform the different housing entities and local communities of the need for having official housing policies. The finding will also tell lawmakers to influence legislation to enforce official housing policies and create equal housing opportunities for those on medically assisted treatment and everyone needing accommodation.

Appendix B Recruitment Flyer

I am seeking women on MAT in need of housing.

I am seeking women between 18 and 60 on medically assisted treatment for an interview in the next two weeks.

Volunteers must be:

- 18 to 60 years old
- On medically assisted treatment
- Plus, any of the following: homeless, turned down for housing, previously incarcerated, or had previous residential treatment

Contact: Vickie Roberson @ 832-540-8853 or vickie.roberson@waldenu.edu