Health & Justice

RESEARCH ARTICLE Open Access

A qualitative investigation into the effectiveness of a housing navigator program linking justice-involved clients with recovery housing

Jodie M. Dewey[1*], Patrick Hibbard[1], Dennis P. Watson[1], Juleigh Nowinski Konchak[2] and Keiki Hinami[2]

Abstract

Background Roughly 24–36% of people who are incarcerated in the U.S. are formally diagnosed with opioid use disorder (OUD). Once released, individuals involved with the criminal legal system (CLS) face increased risks of return to use and fatality and are 129 times more likely to die from an overdose within the first two weeks of release compared to those without CLS involvement. People who are CLS-involved and who are seeking a recovery living environment can access temporary stable housing through recovery homes. However, entering a recovery home can be difficult due to fragmentation among recovery housing organizations and their non-uniform application and screening procedures. A navigation pilot program was implemented to provide clients with recovery home placement advice, pre-screening, and referrals in Cook County, IL. Existing research on recovery homes has rarely examined the importance of recovery housing navigation for enhancing service engagement among CLS-involved individuals receiving medications for OUD.

Methods Semi-structured qualitative interviews were conducted with 22 clients and three recovery housing navigators as part of a program evaluation of the navigation program pilot. Qualitative software was used to organize and qualitatively analyze transcripts through several rounds of coding producing emergent themes, which were then triangulated, and expanded using navigator data.

Results Clients seeking recovery home services reported multiple prior challenges securing safe and supportive recovery living environments. Despite low initial expectations, clients described their interactions with housing navigators in favorable terms and felt navigators worked with them effectively to identify and meet their housing and substance use needs in a timely manner. Clients also commented on their partnerships with the navigator throughout the process. Interactions with navigators also calmed fears of rejection many clients had previously experienced and still harbored about the process, which bolstered client-navigator relationships and client motivation to engage with additional services.

*Correspondence:
Jodie M. Dewey
jmdewey@chestnut.org

Full list of author information is available at the end of the article

Conclusion Evidence from this study suggests recovery home navigation can improve the speed and efficiency with which clients are connected to appropriate services that are tailored to their specific needs as well as increase client motivation to engage with a myriad of recovery services.

Keywords Recovery housing, Patient navigation, Criminal legal system involvement, SUD

Background

Prior research focusing on individuals who have been incarcerated demonstrates considerable health-related inequities among them, including increased risks of mental and physical health issues, lower engagement with health services, and higher rates of substance misuse (Fazel, 2016; Ferguson et al., 2016). 85% of those housed in prisons and jails either meet DSM criteria for a substance use disorder (SUD) or were under the influence at the time of their crime (de Viggiani, 2007; Gutierrez, 2021; Han, 2020; Krawczyk et al., 2018; Pho et al., 2021), with roughly 24–36% of this population diagnosed with an opioid use disorder (OUD; Bronson et al., 2020). Research has shown providing medication-based opioid use disorder treatment (MOUD; e.g., methadone, buprenorphine, or naltrexone) during incarceration reduces reincarceration rates (Knight et al., 2012; McCollister & French, 1998; Wexler, 1995) and, when continued after release, reduces active drug use (Polcin et al., 2010; Wexler, 1995). However, carceral settings inconsistently provide MOUDs (Krawczyk et al., 2018; Pho et al., 2021; Williams et al., 2019), resulting in less than 33% of the incarcerated population receiving MOUDs (Kirk & Wakefield, 2018; Martin et al., 2021; Williams et al., 2019).

People returning from incarceration face an increased risk of use and overdose, with some studies showing them 129 times more likely to die from an overdose compared with those who have no CLS involvement, especially within the first two weeks of release (Binswanger et al., 2007; Hartung et al., 2023; Joudrey et al., 2019; Ranapurwala, 2018; Victor et al., 2021). Additional research has found the lack of stable post-release housing increases the risk of opioid-related emergency department visits and overdose and contributes to a dual public health crisis (Baggett, 2013; Yamamoto et al., 2019) as well as recidivism (Knight et al., 2012; Lo Sasso et al., 2012; Wexler, 1995). Recovery housing is evolving as a support service that may provide an answer for people at risk by interrupting the chains of risk and the revolving door of incarceration (Almquist & Walker, 2022).

Recovery Housing offers a solution for people in recovery with insecure housing

Recovery homes are an evidence-based solution for simultaneously addressing housing insecurity and substance use for people in recovery, and they can be an important source of reintegration support for residents who are CLS-involved (Mericle et al., 2017; Polcin, 2006, 2018a). In addition to improvement in traditionally measured outcomes like substance use (e.g., Jason et al., 2007; see Reif et al., 2014 for a review), recovery homes can drastically reduce opioid use and recidivism for CLS-involved individuals by linking them to recovery support systems (Polcin, 2018b), thus reducing reintegration barriers that undermine long-term treatment retention (Majer et al., 2020). For example, a 2022 study indicated a higher percentage of respondents serving probation and living in recovery housing reported improved health (Phelps et al., 2022), though this study included more housing options and study design limited rigor (e.g., cross-sectional, potential selection bias). Additionally, Polcin and colleagues (2010) found CLS-involved recovery-home residents had improved outcomes on arrests, employment, and substance use over 18 months. Recovery homes can also help CLS-involved individuals adhere to the conditions of probation or parole by providing drug- and alcohol-free housing compatible with court-ordered monitoring (DeGuzman et al., 2019; Jason et al., 2014; Lo Sasso et al., 2012; Zywiak et al., 2009).

While recovery homes can provide the stability needed for successful recovery and reintegration post-incarceration, securing a recovery home placement is challenging for many CLS-involved people receiving MOUD (Clayman et al., n.d.; Jason et al., 2022; Kepple et al., 2019; Wood et al., 2022). In addition to a broad set of barriers finding recovery home services (e.g., costs, availability; see, e.g., Duffy & Baldwin, 2013; Komaromy et al., 2023; Manuel et al., 2017), individuals with OUD seeking recovery home placement often face policies and practices that do not support the use of methadone or buprenorphine (Miles et al., 2020; Wood et al., 2022), including within the very recovery homes they hope to reside (Miles et al., 2020). Anti-medication stigma derives from the belief that people receiving methadone or buprenorphine treatment are not in proper recovery because these medications are themselves opioids (Szalavitz, 2018). For example, a 2019 study of providers ($n=360$) that included many recovery home workers found that 25% were unwilling to serve those receiving MOUD (Kepple et al., 2019). Add to this the complications of returning from incarceration, and the situation compounds (Cernasev et al., 2021). In addition to these barriers, those attempting to engage with recovery or treatment services often confront a confusing array of options. The sheer amount of information necessary to navigate such a system can be

daunting. Misinformation or, worse, prior negative experiences (e.g., MOUD stigma) may leave potential service recipients with the perception of a hostile environment, impacting their motivation to engage in treatment and recovery (Cernasev et al., 2021; DiClemente et al., 2016; Stanojlović & Davidson, 2021). Patient navigation models may offer an effective approach for successfully linking this population to services.

The evidence base for recovery housing is still growing and in need of rigorous study designs (e.g., RCT) to demonstrate overall effectiveness and evaluate specific elements (Reif et al., 2014).

Patient navigation and types of support

Patient navigation programs link individuals to services by serving as a bridge between service recipients and providers. To improve overall health outcomes (Bovaird et al., 2015), health and service navigators work directly with clients and providers to identify barriers to care, minimize access delays, and improve health-related outcomes and client satisfaction for those most vulnerable to illness and disconnected from formalized health care systems (Paskett et al., 2011; Wang et al., 2015). This co-production process reformulates traditional paternalistic welfare models by inviting clients to participate more fully throughout the healthcare continuum (Needham & Carr, 2009). Navigators often know more about the availability of services, allowing them to more efficiently broker vital information on behalf of clients with multiple and complex needs (Ashford et al., 2020) and ideally foster a positive relationship that will increase client motivation (Bovaird et al., 2015; Coote, 2022; Durose et al., 2017; Needham & Carr, 2009). Existing research demonstrates the effectiveness of navigators providing both instrumental (e.g., transportation and making appointments) and relational support (e.g., building client-provider relationships; Davis, 2008; Paskett et al., 2011) within general healthcare contexts and, over the past 30 years, patient navigation models have expanded to connect patients to a broader range of health and social supports including housing (Freeman, 2012).

The current study is a qualitative investigation of how implementing a housing navigation program might improve the recovery home engagement process for CLS-involved individuals receiving MOUD. Data were collected as part of an evaluation of a housing navigation pilot program for Cook County Health. While a few existing studies focus on the effectiveness of navigation programs that connect those with unstable housing to health resources, no data exists on navigators' role in connecting CLS-involved individuals who are seeking recovery housing.

Methods

The current study

The current study is a qualitative investigation to understand both clients' and recovery housing navigators' experiences with a housing navigation program. Understanding their perspective is essential to fully grasp the complexity of issues that undermine linkage to recovery housing, a significant issue for CLS-involved individuals. Data were collected as part of a larger evaluation of The Cook County Recovery Home Coordinated Capacity Pilot Program, a three-year collaborative effort to enhance treatment and recovery service engagement among CLS-involved individuals receiving MOUD. This pilot utilized the expertise of recovery housing navigators, employed by a local MOUD provider, to place individuals referred to the navigation program into one of eight Chicago-based recovery homes willing to accept CLS individuals receiving MOUD. One recovery navigator, who also served as the supervisor, shared their lived experience with substance use and recovery and indicated the purpose of the navigation process was to center clients' needs to ensure a collaborative process. Clients were often referred to the housing navigation program through various agencies, such as hospitals, in-patient treatment facilities, and in some cases were referred by court staff (e.g., probation, parole). While this program was specifically developed to meet the needs of CLS individuals receiving MOUD, housing navigators assisted anyone who contacted them.

Participants

Qualitative interview participants included both clients and recovery housing navigators. Recovery navigators invited all clients referred to housing navigation program to participate in the qualitative study. Of the 95 individuals who called for housing navigation and agreed to be contacted for a follow-up qualitative interview, 22 were successfully contacted, verbally consented, and completed a semi-structured interview. Only one client refused to participate. The remaining individuals could not be reached as many failed to return messages left by the researcher, or their phone had been disconnected. Without their own cell phone, many clients left agency numbers (e.g., hospitals, in-patient facilities) but were no longer at these sites once the researcher attempted to locate them. While not all participants were referred through a correctional site, the referral population does have an elevated risk of being CLS-involved (See Table 1).

Client participants discussed several challenges that impeded their interest or ability to seek out recovery housing. Lack of support, fear of homelessness while trying to recover from substances, prior CLS involvement, and MOUD stigmatization all contribute to clients' future help-seeking behavior. One client described the

Table 1 Demographic data

Gender (*n* = 22)	
Male	82% (18)
Female	18% (4)
Age (*n* = 22)	
Average: 42 Years	Range 24–59 Years
Race (*n* = 22)	
Black	50% (11)
White	36% (8)
Hispanic/Latino	14% (3)
CLS History *	
Any Past CLS involvement	82% (18)
Incarceration History	50% (11)
Released within last 30 days	36% (4)
Released 31 days-90 days	9% (1)
Released over 90 days	63% (7)
Community Supervision	9% (2)
MOUD Use (*n* = 14)	
Buprenorphine	50% (7)
Methadone	43% (6)
Injectable Naltrexone	7% (1)

*Numbers overlap

significant challenge for those with little to no support, especially when being released from incarceration:

The lead author also interviewed recovery housing navigators employed by a not-for-profit behavioral healthcare organization (*n* = 3). Two of the three navigators began at the start of the pilot, while one joined six months later. All three navigators identified as women and averaged 10 years' experience working at the healthcare organization; 1 held a master's in social work, 1 in counseling, and two of the three were Certified Alcohol and Drug Counselors (CADC). Of the three navigators, one came to work with direct lived experience with substance use and recovery.

Data collection

Various agencies referred clients to the navigation program (e.g., hospitals, detox centers, corrections-based facilities). Once connected, navigators asked if clients would be interested in sharing their experiences by participating in a 30-minute qualitative phone interview. If interested, navigators filled out a consent to contact form and provided it to the lead author, a PhD-level research scientist with over 20 years of qualitative interviewing experience. The lead author would then contact participants introducing herself and describing the goal of the project. She would then provide additional details regarding the project, answer questions, and, obtained verbal consent from those individuals interested in being interviewed. Interviews were audio-recorded and transcribed, removing all identifying information. Following the interview, clients were mailed a $25 debit card to compensate for their time. The lead author also conducted two dyad interviews with housing navigators. During the first year, the lead author interviewed one housing navigator and one supervisor while during the second year, the lead author interviewed the same housing navigator and a newly hired navigator. Following each interview, the lead author jotted summaries about key findings and shared them with the research team.

Individual client and navigator dyad interviews followed a semi-structured interview guide developed by the lead PI (third author) in collaboration with the housing navigation programs' project leader. Questions for clients focused on reasons for seeking housing, prior challenges accessing housing, current substance use/MOUD status, and past/current CLS involvement. Clients were also asked to share their perception and satisfaction with the housing navigation program and encouraged to offer suggestions for program improvements. Questions for recovery housing navigators sought to uncover the procedures and decision-making processes that linked clients to recovery housing. The client and navigator interview guides were initially pilot tested and iteratively modified to allow further exploration into topics and issues introduced during earlier interviews. Data collection will continue through the duration of this three-year project.

All study procedures were approved by the lead author organization's Institutional Review Board.

Analysis

The first author used MAXQDA qualitative analytic software, to identify, code, and cluster key themes found in the transcripts (VERBI Software, 2022). The lead author used both inductive and deductive approaches when coding the data. During the first round of coding, the lead author used the interview guide categories to reveal differences and similarities across client responses. Next, in alignment with grounded theory, the lead and third author engaged in line-by-line coding specifically designed to extract the cultural knowledge shared by clients to organize their behaviors and interpret their experiences. Grounded theory is an iterative method of data collection and analysis with the goal of inductively developing ideas through an illumination of variations across descriptive and process categories (Charmaz, 2014). By noting those factors that impede, accelerate, or change the process used to link clients to housing, the lead author utilized her existing knowledge of the recovery home literature to transform process codes to conceptual codes (Saldana, 2021). As a final step, findings were discussed with the other authors (who also have prior experience in recovery home research) to ensure data findings fit with the authors' understandings of the functioning of recovery homes. Data was presented to

the recovery navigators and the housing navigation program project leaders during monthly meetings. Through "member checking" authors were able to refine patterns used to establish the final analysis presented in this paper (Candela, 2019).

Results

Prior experiences shape willingness to seek help

Client participant demographic information appears in Table 1. As displayed in the table, over 80% of the sample experienced some type of CLS involvement (e.g., incarceration, detention, community supervision, open court cases). The table also shows that more than half of those interviewed were receiving MOUDs.

> *Oh man, one of my hardest challenges was when I, before I was arrested, I didn't have anything or, I left a bad situation, and as I begin to get closer and closer to being released from the penitentiary, I don't have anything that I can go back out there to. It's like, they just throwing me back out into society with nothing, no job, no financial support, no housing, or anything. We go back to what we had left out there. (Male, 56)*

Feeling as if society is 'just throwing' them back, clients perceive they will only be denied assistance due to stigmas around CLS involvement and substance use:

> *It makes it very hard on you because most people look at you like, "he's a convict and he's a drug addict and if we put him in an apartment, it's just gonna be a waste, because it's gonna be drugs being sold out of the apartment. It's gonna be people coming in here doing drugs and stuff like that." (Male, 56).*

The belief that past CLS involvement will harm their chances of being accepted into recovery housing prevented many from even attempting to access available services.

> *It is very difficult because every place I looked up, they say … you have to pass a background check and credit check. And my credit is not that good and I have a background. I haven't been in trouble in over 20 years … [but] every place I check, when I see that they do a background check, I just pass it up … (Male, 50).*

Finding housing that accepts clients receiving MOUD treatment added another layer of challenges for CLS-involved individuals attempting to secure housing. One client nearing the completion of an in-patient program and seeking housing stated: *"I called like 20 or 30 different places and only two of them said they took methadone, but they were filled up." (Male, 24)* Although this client's methadone treatment center provided him with a list of housing options, he was required to contact the sites independently, only to find a small percentage even accepted methadone patients. When he asked the two homes accepting methadone patients when beds would likely be available, the client was told to *"keep calling"*, something he described as *"frustrating"*. Study clients further wondered if a screening question to determine methadone dosage levels commonly utilized by the few homes that accept methadone clients was designed to deny entry, with one client sharing: *"A lot of recovery homes, you have to be on 40 milligrams or lower in order to even get through the door." (Female, 37)* When asked why she thought this was the case, the client indicated that homes might believe a higher dose was used just to get high, and the home would not want the liability of a potential overdose. Another client iterates this point, stating *"A lot of people don't want to take somebody who is on methadone. [They think] that we're not necessarily in recovery and we're still using." (Female, 41).*

Finally, for one client, mental health issues posed additional challenges to obtaining timely recovery support and housing.

> *There is such a high demand [for female housing] that there's a two-month waiting list. For somebody who is in a dire situation, [and if] you're not properly medicated, you know, clinical depression with PTSD and severe anxiety … I need help now. (Female, 41)*

Without recovery housing support, clients fear return to use and the potential to overdose:

> *I am in recovery and fell on hard times [he was evicted]. I had nothing to fall back on as far as family … I didn't want to be on the street in recovery and relapse and be in a situation where there won't be a return for me … I was clean and I knew I was gonna pick up the drink and the drugs and I was going to be back off to the races. (Male, 57)*
>
> *Prior experiences of being turned away from housing due to criminal legal system involvement, substance use, mental health conditions and MOUD usage can undermine how individuals seek out help, especially at time when their recovery and life depend on it.*

Navigators and types of support

Study participants initially contacted the navigation program because they were in search of housing, with some *"desperate for housing". (Male, 31)* Although not all

participants were successfully linked with recovery housing, all but one found the program helpful. Clients shared their experiences accessing recovery housing through the navigation program which can be divided into instrumental and relational support.

Instrumental support

Despite facing housing challenges for years, several individuals were unaware of available housing programs or how to navigate the process to secure a spot. One client stated:

> *Oh, well it [the navigator program] was great for me because I don't know how to do any of that kind of stuff. So, I mean, she was very diligent and, you know, right on task and on the ball. I couldn't believe that I got a phone call as soon as I did. (Female, 41)*

Another client shared:

> *I didn't know anything about it [housing]. But … she was very helpful … and she gave me a lot of directions to go. Gave me a couple of places to call, and actually, she helped me find sober living … and she even followed up on me. (Male, 53)*

Clients recognized and appreciated how efficiently the navigator found them timely placement.

> *I contacted her. She called me back that afternoon. Then she called me back after [the recovery home] called. Then I called [the recovery home]. They did my phone interview the next morning. They called me and told me I was accepted. So, it was a day, and I was in. (Male, 43)*
> *Navigators were helpful as several clients were unaware that recovery housing existed and felt supported to have someone help them get connected and follow-up to see their progress in reaching the homes.*

Some felt the navigators had such a firm understanding of the recovery housing landscape, they helped them chart a successful pathway. One client participant stated, "*It's very helpful in directing me in the right place to go versus me just going out there blind … I have somebody already there to do that for me to save me time.*" (*Female, 37).*

Part of charting a successful pathway is valuing client needs, as this person expresses:

> *I thought I was going to be somewhere that I didn't want to go. I thought it was going to be more of people pushing their own agenda, just to get paid and things like that. It wasn't a bad experience … It was very honest and very open … helpful … straightforward. This is what I need, this is the help I need. (Male, 32)*

It is important to note that this client also valued how the assistance was provided in addition to receiving important instrumental support (e.g., connection to housing services). Past paternalistic experiences had led him to expect similar treatment, yet he described his interaction as honest and genuine, demonstrating added relational benefits from his interaction with the navigator.

Relational support

Many clients related a sense of lost optimism in finding housing, something navigators helped to rebuild. Prior experiences of being denied housing can leave these individuals in disbelief that navigators will be successful in helping them secure housing:

> *I told her, I go, 'this place does not have a bed for me.' She's like, 'what do you mean?' She's like, 'I just talked to them.' I'm like, I go, 'I walked to this place in person.' I go, 'I've called them.' I'm like, 'they do not have a spot for me.' And she's like, 'let me explain something to you.' She's like, 'they have a bed waiting for you right now, they know your name, and they're expecting you.' And so, I'm like, 'really?' And she's like, 'yeah.' I'm like, 'you're not lying?' Because, like, this is the place I really wanted to be. I'd done the research, and, like, I talked to guys who have been here and I'm like, 'this is the spot.' (Male, 40).*

Previous encounters with rejection and stigmatization leave many individuals with no hope, something navigators can provide:

> *She just gave me a lot of hope. And, she was real useful, I thought. When I, like, first made that phone call, I was expecting this to be a waste of my time. And then after her talking to me, I realized, like, oh man, like, this could be something. Like, this might be really helpful and, it did, it was. It was super helpful. (Male, 40)*

Navigators appear to strengthen client-navigator relationships throughout the housing process by reducing client anxiety and stress:

> *I was really comfortable talking to the navigator and it made me feel at ease with all my issues that I had, as far as drugs and all that. She made me feel real comfortable telling her what's my drug choice and what she could do to help. (Male, 52)*

Also, one 30-year-old female stated, *"It was a stress relief. I felt like I had someone there for me and helping me, and, like, actually cared about my well-being. It made me feel good."*

More than the services provided, how navigators engage with clients appeared to instill self-worth. One client shared that the navigator was *"easy and informative. She spoke directly<u>with</u>me." (Male, 24)* To stress that one was spoken '*with*' suggests that clients are typically spoken "*at*" by staff tasked with helping them. Another client perceived something quite similar. When asked what she felt was the best part of the navigator program:

> *Her helping me. 'Cause I was, like I said, I was in dire straits. And for her to take her time and brainstorm with me, 'cause we were brainstorming together to figure out a way to help me out in my situation, [it] was beautiful. (Male, 57)*

Navigators seemed to successfully quell pre-conceived fears and broker positive, cooperative relationships between the client and recovery home staff by rewriting the traditionally paternalistic welfare model scripts of providing services.

Brokering relationships and co-production: the navigator as 'matchmaker'

Navigators recognize the importance of their position between clients and recovery homes, orchestrating these relationships to ensure successful placement and increase co-production. One navigator shared, *"I think it's been working. I think it's actually a fun experience, just having someone call in and us, kind of, play matchmaker in a weird way to give them the services that they need."* (*Navigator 2).*

By developing trust and rapport with their clients, navigators also develop increased opportunities by identifying client needs beyond housing, expanding available services, and pivoting their approaches:

> *So, one of the things that we started doing maybe halfway or three-quarters of the way through this last year [was] tracking other resources or other things that we helped our callers out with because … sometimes a caller will need other services. So, maybe they're not really even appropriate for recovery help, but they want some help with substance use. So, maybe referring them to a treatment center, or AA meeting, or, I think [referring to another navigator] you have helped someone with employment resources. So, that's something that we've expanded, probably since our initial interview and, you know, tracking that and seeing that, you know, we will always ask is there anything else we can help you with or, you know, kind of focus on … (Navigator 2).*

Navigators understand different housing programs offer different services and that clients will thrive when placed in a facility best suited to their needs. Through careful questioning, navigators ascertain client needs and preferences as they target potential housing options:

> *For some referrals, I ask about locations that they're comfortable in. Because you might have some referrals where a certain part of time, a certain part of Chicago or Cook County, is triggering. So, that's important to know, because I would never want to put anyone in a place that reminds them of where they just came from. So, that's an important question to always ask. (Navigator 2)*

This navigator further explained:

> *Like, if you have a referral who, they used to pick up drugs from the north side, then having them on the north side, where they know where all the spots are, might not be the best thing. So that, then you look in other areas. So, it's really, kind of, just gauging the best results for the referral. (Navigator 2)*

Once clients meet the necessary requirements for placement, navigators use their previously established connections with recovery homes to connect clients:

> *We've established really good relationships with the staff at the recovery homes. We have, you know, some people's cell phone numbers, we'll text and say, 'hey, you know, do you have a bed available? Can you phone screen this person?' (Navigator 1).*

The navigator continued to discuss how the client interview process is also informed by the known requirements of each recovery home, information that is updated regularly.

> *So, then the recovery home … will screen the patient … They have their own, you know, type of assessment. So, we, kind of, do, like, a phone screen and each recovery home has different criteria … And so, we coordinate them to connect with the recovery home. Sometimes we'll do a 3-way call, sometimes we … contact the recovery home first. (Navigator 1)*

Despite their connection with recovery home staff and knowledge of the process, navigators are barred from participating in the recovery home's initial intake and subsequent assessment of potential clients, resulting in

somewhat of a "black box" placement process. Although unable to advocate for their clients at this juncture, navigators attempt to broker a favorable outcome by advocating for their clients during initial calls to the recovery homes.

> *Kind of, maybe, go over a few questions they [the recovery home] might have about the individual … and just, you know, 'hey, they're on methadone or they're, whatever. They just got out of [detox], is that okay?' Or, you know, someone 'recently got a surgery, but they can, you know, move on their own, they can rewrap the bandage.' So, we definitely talk to [the recovery home] first. We try to do a warm hand off. (Navigator 1)*

This black box of recovery home decision-making was most evident for navigators when evaluating clients' mental health stability and MOUD usage. One navigator explained how she handles describing mental health status to recovery home intake staff:

> *We're not being deceitful. I just think, like, especially when it comes to the mental health piece, it could really go one way or the other. We're just taking a chance, you know. We want to be honest with everyone, of course, but sometimes it's almost like, 'let's just [answer] these big questions, leave it here, and [the recovery homes] can do the rest because they ultimately make that decision.' And I think we rarely have someone that won't even screen them if they have [an open bed]. Like, if they meet the basic [requirements], you know, whatever, if we say, 'can you screen this person,' they'll do it. (Navigator 3)*

While navigators appeared to understand and accept the black box approach and recognized how client mental health might play a role in recovery homes' decision-making, they conveyed discomfort with how some homes understand clients' prescribed methadone levels. While homes participating in this project were required to accept those who were CLS-involved *and* receiving MOUD, navigators were stunned when the interviewer revealed that clients were asked to provide their MOUD dosage levels and some clients were told their dosages were too high. Navigators considered this revelation a potential teaching moment that could build their relationship with recovery homes:

> *Now, if there is a cap for their dose [for placement], then that's probably something we need to either revisit as a larger group or even take it to a smaller group and, kind of, figure out, because maybe it's some education that needs to be used or something. (Navigator 3)*

The strategic placement and unique knowledge of patient navigators offer increased opportunities to continue conversations and coordinate efforts regarding service delivery. Rather than encountering a confusing system, clients who interact with a receptive and competent navigator are more likely to engage in the process. By providing understanding, instrumental, and relational support, navigators do much more than meet the immediate housing needs of their clients: they create something sustainably much larger—improved recovery health habits for self and others, and faith in the system.

Improved recovery health habits

Clients expressed that sensing the navigators' care and contribution of time and energy on their behalf helped increase motivation to engage with the process. The navigator program empowered some clients to engage in improved recovery health habits. This client indicated he was more likely to continue with recovery:

> *Optimistic. Because I was, like, eager to try something new. I was eager to get my life back. It was, like, if [the navigator] says they gonna help me, I might as well trust it. They haven't lied to me, so, I was, like, 'you know what, these people breaking their back for me in treatment, these people putting their neck out there for [me], so I'm gonna try to reciprocate that and do what they say.' (Male, 32).*

These improvements in motivation may extend to other healthcare efforts, as comments also revealed how these new partnerships between clients and the navigators impacted clients' overall self-esteem and sense of wellness. When asked whether he thought he would be accepted into a recovery home, one client shared:

> *You know, I didn't. Because it seemed like everybody I called, once they knew all my information about my medication … [but the navigator told me] 'there's no problem, oh that's not a problem, that's not a problem' and you know, actually I was accepted to both places … [The navigator] didn't treat me like a dope addict … that right there was the most powerful thing ever, to be treated like a human being, a normal person. That is powerful…Even if I didn't get a place, that means a lot." (Male, 53).*
>
> *Another client added:*
>
> *"The most helpful part of it, I would say, when I was informed that the best is yet to come, and then when the navigator was speaking to me and said that we're gonna do all we can to help you, and don't give up*

before the miracle happens. I like that. I really like that." (Male, 56).

Through this approach, navigator efforts seem to reverberate further than the immediate navigator-client relationship, as clients readily shared their success with others, encouraging friends to also contact the helpline. One person shared, "*I'll tell you, it was so helpful that I gave her number to, like, five other people I knew.*" (*Male, 40)*

As these examples indicate, the patient navigators' approach to building relationships with clients potentially strengthens self and other-care, helping clients improve their recovery health habits and those of others in their situation. The process of assessing needs and preferences through the navigator program also instilled faith in the health system, increasing the likelihood that clients will engage with the delivered services, a requirement for cultivating long-term recovery and ensuring programs are effective and successful.

Discussion

Stable housing is crucial yet difficult to access for those experiencing substance use and CLS issues, a subpopulation at increased risk for relapse and overdose (Binswanger et al., 2007; Joudrey et al., 2019; Mericle et al., 2017; Ranapurwala, 2018; Victor et al., 2021). Recovery housing is an evidence-based solution to address substance use and provide reintegration services for those released from prisons and jails (Mericle et al., 2017; Polcin, 2006, 2018a). Finding effective pathways to link this often-disenfranchised group to recovery housing is critical for addressing health disparities (Mericle et al., 2017, 2020; Polcin et al., 2023). With a paucity of research investigating navigator models within this context, this study provides the clients' perspective to help understand what does and does not work in the current efforts to link clients with recovery housing.

Engaging with something as fundamental as housing can be frustrating; attempting to access a service within an unfamiliar, formalized process can be positively daunting. This study provides support that an intervention such as client navigation can improve efficiency (Ashford et al., 2019), connects clients with appropriate services tailored to individual needs and preferences, and may strengthen client confidence and motivation to engage with housing and other recovery services. Our findings indicate navigators provided a service that was either previously unknown to the individuals or assisted them through a process that was perceived as intimidating and, at times, stigmatizing. This evidence also points toward clients not accustomed to being spoken *with* (as opposed to being spoken *to*) or having someone follow up to ensure their needs were effectively met. More than securing housing, interactions with navigators also seemed to calm fears of rejection that many clients harbored about the process, and, in so doing, bolstered client-navigator relationships. The evidence laid out above indicates navigators served a vital function in matching client needs with the expectations of the recovery home site (Paskett et al., 2011; Wang et al., 2015) and can do so based on previously established relationships with recovery home staff. Therefore, through the well-orchestrated engagement of co-production, navigators can match clients to a recovery home that meets their unique needs faster and more efficiently than clients might accomplish on their own (Bovaird et al., 2015; Needham & Carr, 2009).

For clients who have experienced stigma around seeking help, including the use of MOUD, navigators' approach in working with clients, specifically in taking time to ask them what they need and preferred in recovery housing options potentially altered clients' perceptions by placing clients in an equal partnership to find services (Bovaird & Loeffler, 2013; Coote, 2022; Needham & Carr, 2009). As opposed to more paternalistic approaches (talking "at" people), the navigator approach of talking "with" clients help alleviate trepidation associated with past experiences. Further, clients indicated this collaborative process motivated them beyond the immediate recovery housing issue – that they were more likely to continue a host of healthy recovery habits. The program's perceived success on behalf of participants may help to expand its reach through word of mouth and instilling trust in a system many may otherwise choose to avoid. By brokering the relationship between potential clients and recovery home staff who have historically rejected this population—particularly CLS-involved clients engaged with MOUD—navigators develop trust with a vulnerable population. This level of trust translates into a heightened willingness to seek help and, as one client explained, a dedication to recovery, demonstrating that the process of co-production generates effective health outcomes (Bovaird & Loeffler, 2013). Further, through a close and trusting relationships with clients, recovery housing navigators may glean important information about how potentially discriminatory practices and help recovery homes to come into alignment with The U.S. Department of Justice's guidance on protections for people with opioid use disorder who are protected under the American with Disabilities Act (DOJ, 2022).

A concerning note comes from clients who shared the belief that recovery housing programs may continue to discriminate against those who use MOUD, although not in ways previously observed. Recovery housing programs involved in this program were required to accept clients'

prescribed MOUD, yet some homes asked potential clients about their dosage levels during the initial screening process. While the current data represents study participants *perceived* this question to reject clients using high doses (i.e., the data do not provide definitive proof), such a finding speaks to the potential need for more conversation/education around MOUD usage and treatment support.

The results of this study provide several implications. First, providing a single point of contact for individuals attempting to engage with recovery services appears to improve efficiency. Rather than attempting to find relevant services within a confusing system, clients' needs and preferences can be matched quickly and effectively by an individual providing informational and relationship brokering services (Davis, 2008; Paskett et al., 2011). Second, providing this instrumental support in an understanding way (i.e., not stigmatizing) leads to relational support (DiClemente et al., 2016). Clients expressed improved perceptions of both the specific service (recovery housing) and other general services. Third, this improved perception may lead to higher levels of service engagement; that is, clients appeared to be more willing to engage in recovery services (Bovaird & Loeffler, 2013). Finally, services within recovery ecosystems may continue to discriminate against potential clients engaged in MOUD, though this current finding may be more related to stigma against individuals on higher dosages rather than the use of this medication altogether.

Results also point to the need for further investigation. As this study provides exploratory analysis, more research is required to reach causal and more generalizable conclusions regarding improvements in efficiency and perceptions, as well as co-production activities. A study involving a larger sample size across a more representative geographic area is required, as well as one that includes both psychometrically sound instruments measuring constructs like motivation and more distal outcomes (e.g., continued engagement with services). More investigation is needed to explore whether recovery services continue to create barriers to entry for people prescribed MOUD.

Limitations

Given the nascency of this line of inquiry, the current study serves as an opening salvo into the question of housing navigation for CLS-involved individuals who use substances but also includes several limitations. The exploratory nature of this analysis provides data from a small sample within one geographic area, so results cannot be generalized beyond this limitation. Further, the data represents individuals who could be reached by phone while those most marginalized and disconnected from support were potentially lost to contact, and therefore, we may be missing valuable data to improve services for those who need it most. The inability to contact a significant portion of those seeking services introduces sample bias, however their absence illuminates ongoing challenges some populations experience accessing vital services and those research activities which can build evidence to address them.

Conclusion

This study evaluated a recovery housing navigation program, specifically investigating the role navigators play in improving CLS-involved individuals with recovery housing. Qualitative data from semi-structured interviews with clients was evaluated for common themes triangulated and expanded using separate interviews with patient navigators. Results indicate housing navigation, specifically through co-production, improved service engagement efficiency by brokering information and the formal relationship between clients and services. Additionally, clients expressed improved perceptions of housing and recovery services more generally and higher levels of motivation to continue engagement with healthy recovery habits. Though more work is needed to make causal and generalizable interpretations possible, navigation services can improve proximate outcomes, which will lead to downstream improvements (e.g., longer periods of recovery, and lower overdose rates).

Acknowledgements

Mona Stivers provided detailed editing services. This work is supported in part by the U.S. Department of Justice Comprehensive Opioid, Stimulant, and Substance Use Programs (2020-AR-BX-0074).

Author contributions

JD collected, analyzed, and interpreted the data. PH assisted in the interpretation of the data. JD and PH examined and organized the literature review. All authors read and approved the final manuscript.

Funding

Not applicable.

Data availability

Data sharing not applicable to this article as no datasets were generated or analyzed during the current study.

Declarations

Ethics approval and consent to participate

The Institutional Review Board at Chestnut Health Systems in Chicago approved this study. Consent was obtained from each participant during the project enrollment process. Additionally, each participant signed a consent to contact to be reached at a later date by the qualitative researcher.

Consent for publication

Not applicable.

Competing interests

The authors declare they have no competing interests.

Author details

[1]Chestnut Health System's Lighthouse Institute, 221 W. Walton Street, Chicago, IL 60610, USA

[2]Cook County Health, 1950 W. Polk Street, Chicago, IL 60612, USA

Received: 18 August 2023 / Accepted: 5 September 2024
Published online: 14 September 2024

References

Almquist, L., & Walker, S. (2022). Reciprocal associations between housing instability and youth criminal legal involvement: A scoping review. *Health Justice*, *10*(15), 2–14. https://doi.org/10.1186/s40352-022-00177-7

Ashford, R., Brown, A., Ryding, R., & Curtis, B. (2020). Building recovery ready communities: The recovery ready Ecosystem model and community framework. *Addiction Research* & Theory 28(1). https://doi.org/10.1080/16066359.2019.1571191

Baggett, T., Hwang, S., O'Connell, J., Porneala, B., Stringfellow, E., Orav, E., Singer, D., & Rigotto, N. (2013). Mortality among homeless adults in Boston: Shifts in causes of death over a 15-Year period. *JAMA Internal Medicine*, *173*(3), 189–195. https://doi.org/10.1001/jamainternmed.2013.1604

Binswanger, I. A., Stern, M. F., Deyo, R. A., Heagerty, P. J., Cheadle, A., Elmore, J. G., & Koepsell, T. D. (2007). Release from prison—A high risk of death for former inmates. *New England Journal of Medicine*, *356*(2), 157–165. https://doi.org/10.1056/NEJMsa064115

Bovaird, X., & Loeffler, X. (2013). *We're all in this together: Harnessing user and community co-production of public outcomes*. In C. Straite (Ed.), *Making sense of the future: Do we need a new model of public services?* (pp. 1–15) University of Birmingham: INLOGOV. https://www.birmingham.ac.uk/Documents/college-social-sciences/government-society/inlogov/publications/2013/chapter-4-bovaird-loeffler.pdf

Bovaird, T., Ryzin, G. G. V., Loeffler, E., & Parrado, S. (2015). Activating citizens to participate in collective co-production of public services. *Journal of Social Policy*, *44*(1), 1–23. https://doi.org/10.1017/S0047279414000567

Bronson, J., Zimmer, S., & Berzofsky, M. (2020). Drug use, dependence, and abuse among state prisoners and jail inmates, 2007–2009. *U.S Department of Justice Special Report*. https://bjs.ojp.gov/content/pub/pdf/dudaspji0709.pdf

Candela, A. (2019). Exploring the function of Member checking. *The Qualitative Report*. https://doi.org/10.46743/2160-3715/2019.3726

Cernasev, A., Hohmeier, K. C., Frederick, K., Jasmin, H., & Gatwood, J. (2021). A systematic literature review of patient perspectives of barriers and facilitators to access, adherence, stigma, and persistence to treatment for substance use disorder. *Exploratory Research in Clinical and Social Pharmacy*, *2*. https://doi.org/10.1016/j.rcsop.2021.100029

Charmaz, K. (2014). *Constructing grounded theory*. Sage Publications Ltd. https://us.sagepub.com/en-us/nam/constructing-grounded-theory/book235960

Clayman, M., Salisbury-Afshar, E., DePatie, H., Ali, M., & Arnold, J. (2020). *Assessment of medications for opioid use disorder (MOUD) treatment related services in Marion County, Indiana. American Institutes of Research*.https://www.rmff.org/wp-content/uploads/2021/05/RMFF_Federal-Opioid-Funding-Report_Final.pdf

Coote, A. (2022). Towards a sustainable welfare state: The role of universal basic services. *Social Policy and Society*, *21*(3), 473–483. https://doi.org/10.1017/S1474746421000385

Davis, C., Darby, K., Likes, W., & Bell, J. (2008). Social workers as patient navigators for breast cancer survivors: What do African-American medically underserved women think of this idea? *Social Work in Health Care*, *48*(6), 561–578. https://doi.org/10.1080/00981380902765212

de Viggiani, N. (2007). Unhealthy prisons: Exploring structural determinants of prison health. *Sociology of Health & Illness*, *29*(1), 115–135. https://doi.org/10.1111/j.1467-9566.2007.00474.x

DeGuzman, R., Korcha, R., & Polcin, D. (2019). I have more support around me to be able to change: A qualitative exploration of probationers' and parolees' experiences living in sober living houses. *The International Journal of Therapeutic Communities*, *40*(1), 51–65. https://doi.org/10.1108/TC-04-2018-0008

DiClemente, C. C., Norwood, A. E. Q., Gregory, W. H., Travaglini, L., Graydon, M. M., & Corno, C. M. (2016). Consumer-centered, collaborative, and comprehensive care: The core essentials of recovery-oriented system of care. *Journal of Addictions Nursing*, *27*(2), 94–100. https://doi.org/10.1097/JAN.0000000000000120

Duffy, P., & Baldwin, H. (2013). Recovery post treatment: Plans, barriers and motivators. *Substance Abuse Treatment Prevention and Policy*, 8(6). http://www.substanceabusepolicy.com/content/8/1/6

Durose, C., Needham, C., Mangan, C., & Rees, J. (2017). Generating 'good enough' evidence for co-production. *Evidence & Policy*, *13*(1), 135–151. https://doi.org/10.1332/174426415X14440619792955

Fazel, S. (2016). Mental health of prisoners: Prevalence, adverse outcomes, and interventions. *Lancet Psychiatry*, *3*(9). https://doi.org/10.1016/S2215-0366(16)30142-0. 871 – 81.

Ferguson, W. J., Cloud, D., Spaulding, A. C., Shelton, D., Trestman, R. L., Altice, F. L., Champion-Lippmann, C., Thomas, D., & Taxman, F. S. (2016). A call to action: A blueprint for academic health sciences in the era of mass incarceration. *Journal of Health Care for the Poor and Underserved*, *27*(2), 5–17. https://doi.org/10.1353/hpu.2016.0051

Freeman, H. (2012). The origin, evolution, and principles of patient navigation. *Cancer Epidemiology Biomarkers & Prevention*, *21*(10), 1614–1617. https://doi.org/10.1158/1055-9965.EPI-12-0982

Gutierrez, C. (2021). E. Patterson (Ed.), Risk and implications of COVID-19 among the community supervised population. *Criminology Public Policy* 20 3 437–461 https://doic.org10.1111/1745-9133.12563.

Han, B., Williams, B., & Palamar, J. (2020). Medical multimorbidity, mental illness, and substance use disorder among middle-aged and older justice-involved adults in the USA, 2015–2018. *Journal General Internal Medicine*, *6*(5), 1258–1263. https://doi.org.0.1007/s11606-020-06297

Hartung, D. M., McCracken, C. M., Nguyen, T., Kempany, K., & Waddell, E. N. (2023). Fatal and nonfatal opioid overdose risk following release from prison: A retrospective cohort study using linked administrative data. *Journal of Substance Use and Addiction Treatment*, *147*, 208971. https://doi.org/10.1016/j.josat.2023.208971

Jason, L. A., Davis, M., & Ferrari, J. (2007). The need for substance abuse after-care: Longitudinal analysis of Oxford House. *Addictive Behaviors*, *32*(4), 803–818. https://doi.org/10.1016.j.addbeh.2006.06.014

Jason, L. A., Light, J. M., Stevens, E. B., & Beers, K. (2014). Dynamic social networks in recovery homes. *American Journal of Community Psychology*, *53*(3), 324–334. https://doi.org/10.1007/s10464-013-9610-6

Jason, L. A., Majer, J. M., Bobak, T. J., & O'Brien, J. (2022). Medication assisted therapy and recovery homes. *Journal of Prevention & Intervention in the Community*, *50*(2), 178–190. https://doi.org/10.1080/10852352.2021.1934940

Joudrey, P. J., Khan, M. R., Wang, E. A., Scheidell, J. D., Edelman, E. J., McInnes, D. K., & Fox, A. D. (2019). A conceptual model for understanding post-release opioid-related overdose risk. *Addiction Science & Clinical Practice*, *14*(1), 17. https://doi.org/10.1186/s13722-019-0145-5

Kepple, N. J., Parker, A., Whitmore, S., & Comtois, M. (2019). Nowhere to go? Examining facility acceptance levels for serving individuals using medications for opioid used disorder. *Journal of Substance Abuse Treatment*, *104*, 42–50. https://doi.org/10.1016/j.jsat.2019.06.004

Kirk, D. S., & Wakefield, S. (2018). Collateral consequences of punishment: A critical review and path forward. *Annual Review of Criminology*, *1*(1), 171–194. https://doi.org/10.1146/annurev-criminol-032317-092045

Knight, K., Hiller, M., & Simpson, D. (2012). Evaluating corrections-based treatment for the drug-abusing criminal offender. *Journal of Psychoactive Drugs, 31(3), 299–304*.https://doi.org/10.1080/02791072.1999.10471760

Komaromy, M., Stone, A., Peterson, A., Gott, J., Koenig, R., & Taylor, J. (2023). Facilitating exit from encampments: Combining low-barrier transitional housing with stabilizing treatment for substance related problems. *Addiction Science & Clinical Practice*, *18*(66). https://doi.org/10.1186/s13722-023-00420-y

Krawczyk, N., Negron, T., Nieto, M., Agus, D., & Fingerhood, M. I. (2018). Overcoming medication stigma in peer recovery: A new paradigm. *Substance Abuse*, *39*(4), 404–409. https://doi.org/10.1080/08897077.2018.1439798

Lo Sasso, A. T., Byro, E., Jason, L. A., Ferrari, J. R., & Olson, B. (2012). Benefits and costs associated with mutual-help community-based recovery homes: The Oxford House model. *Evaluation and Program Planning*, *35*(1), 47–53. https://doi.org/10.1016/j.evalprogplan.2011.06.006

Majer, J. M., Jason, L. A., Hickey, P., Joshua, N., Jeong, H., & Bobak, T. J. (2020). Social support among oxford house residents utilizing medication-assisted treatments. *Alcoholism Treatment Quarterly*, *38*(2), 199–214. https://doi.org/10.1080/07347324.2019.1678445

Manuel, J., Yuan, Y., Herman, D., Svikis, D., Nichols, O., Palmer, E., & Deren, S. (2017). Barriers and facilitations to successful transition from long-term residential substance abuse treatment. *Journal of Substance Abuse Treatment*, *74*, 16–22. https://doi.org/10/1016/j.jsat.2016.12.001.

Martin, R. A., Stein, L. A. R., Rohsenow, D. J., Belenko, S., Hurley, L. E., Clarke, J. G., & Brinkley-Rubinstein, L. (2021). Using implementation interventions and peer recovery support to improve opioid treatment outcomes in community

supervision: Protocol. *Journal of Substance Abuse Treatment*, *128*, 108364. https://doi.org/10.1016/j.jsat.2021.108364
McCollister, K., & French, M. (1998). The economic cost of substance abuse treatment in criminal justice settings. *Treatment of drug offenders: Policies and issues, 22–38.*https://www.researchgate.net/publication/312889922_The_economic_cost_of_substance_abuse_treatment_in_criminal_justice_settings
Mericle, A. A., Polcin, D. L., Hemberg, J., & Miles, J. (2017). Recovery housing: Evolving models to address resident needs. *Journal of Psychoactive Drugs*, *49*(4), 352–361. https://doi.org/10.1080/02791072.2017.1342154
Mericle, A. A., Karriker-Jaffe, K., Patterson, D., Mahoney, E., Cooperman, L., & Polcin, D. L. (2020). Recovery in context: Sober living houses and the ecology of recovery. *Journal of Community Psychology*, *48*(8), 2589–2607. https://doi.org/10.1002/jcop.22447
Miles, J., Howell, J., Sheridan, D., Braucht, G., & Mericle, A. (2020). Supporting individuals using medications for opioid use disorder in recovery residences: Challenges and opportunities for addressing the opioid epidemic. *The American Journal of Drug and Alcohol Abuse*, *46*(3), 266–272. https://doi.org/10.1080/00952990.2020.1719410
Needham, C., & Carr, S. (2009). Co production: An emerging evidence base for adult social care transformation. *Social Care Institute of Excellence*https://www.researchgate.net/publication/237126419_Co_production_An_Emerging_Evidence_Base_for_Adult_Social_Care_Transformation
Paskett, E., Harrop, J., & Wells, K. (2011). Patient navigation: An update on the state of science. *CA Cancer Journal for Clinicians*, *61*(4), 237–249. https://doi.org/10.3322/caac.20111
Phelps, M., Osman, I., Robertson, C., & Shlafer, R. (2022). Beyond pains and gains: Untangling the health consequences of probation. *Health & Justice*, *10*(1), 1–29. https://doi.org/10.1186/s40352-022-00193-7
Pho, M., Erzouki, F., Boodram, B., Jimenez, A. D., Pineros, J., Shuman, V., Claypool, E. J., Bouris, A. M., Gastala, N., Reichert, J., Kelly, M., Salisbury-Afshar, E., Epperson, M. W., Gibbons, R. D., Schneider, J. A., & Pollack, H. A. (2021). Reducing opioid mortality in Illinois (ROMI): A case management/peer recovery coaching critical time intervention clinical trial protocol. *Journal of Substance Abuse Treatment*, *128*, 108348. https://doi.org/10.1016/j.jsat.2021.108348
Polcin, D. L. (2006). What about sober living houses for parolees? *Criminal Justice Studies*, *19*(3), 291–300. https://doi.org/10.1080/14786010600921712
Polcin, D. L. (2018a). Role of recovery residences in criminal justice reform. *International Journal of Drug Policy*, *53*, 32–36. https://doi.org/10.1016/j.drugpo.2017.10.009
Polcin, D. L. (2018b). Role of recovery residences in criminal justice reform. *International Journal of Drug Policy*, *53*, 32–36. https://doi.org/10.1016/j.drugpo.2017.10.009
Polcin, D. L., Korcha, R. A., Bond, J., & Galloway, G. (2010). Sober living houses for alcohol and drug dependence: 18-Month outcomes. *Journal of Substance Abuse Treatment*, *38*(4), 356–365. https://doi.org/10.1016/j.jsat.2010.02.003
Polcin, D. L., Mericle, A. A., Braucht, G. S., & Wittman, F. D. (2023). Moving social model recovery forward: Recent research on sober living houses. *Alcoholism Treatment Quarterly*, *41*(2), 173–186. https://doi.org/10.1080/07347324.2023.2167528
Ranapurwala, X., Shanahan, M., Apostolos, A., Proescholdbell, S., Naumann, R., Edwards, D., & Marshall, S. (2018). Opioid overdose mortality among former North Carolina inmates: 2000–2015. *American Journal of Public Health*, *108*(9), 1207–1213. https://doi.org/10.2105/AJPH.2018.304514
Reif, S., Preethy, G., Braude, L., Dougherty, R., Daniels, A., Ghose, S., & Delphin-Rittmon, M. (2014). Recovery housing: Assessing the evidence. *Psychiatric Services, 65(3).* https://doi.org/10.1176.appi.ps.201300243
Saldana, J. (2021). *The coding manual for qualitative researchers*. Sage Publications, Ltd.
Stanojlović, M., & Davidson, L. (2021). Targeting the barriers in the substance use disorder continuum of care with peer recovery support. *Substance Abuse: Research and Treatment*, *15*. https://doi.org/10.1177/11782218209769888
Szalavitz, M. (2018). January 17). Opinion | the wrong way to treat opioid addiction. *The New York Times*. https://www.nytimes.com/2018/01/17/opinion/treating-opioid-addiction.htmll
United States Department of Justice Office of Public Affairs (2022). Justice Department issues guidance on protections for people with opioid use disorder under the Americans with Disabilities Act. https://www.justice.gov/opa/pr/justice-department-issues-guidance-protections-people-opioid-use-disorder-under-americans
VERBI Software. (2022). *MAXQDA 2022 [Computer software]*. VERBI Software. maxqda.com.
Victor, G. A., Bailey, K., & Ray, B. (2021). Buprenorphine treatment intake and critical encounters following a nonfatal opioid overdose. *Substance Use & Misuse*, *56*(7), 988–996. https://doi.org/10.1080/10826084.2021.1901933
Wang, M. L., Gallivan, L., Lemon, S. C., Borg, A., Ramirez, J., Figueroa, B., McGuire, A., & Rosal, M. C. (2015). Navigating to health: Evaluation of a community health center patient navigation program. *Preventive Medicine Reports*, *2*, 664–668. https://doi.org/10.1016/j.pmedr.2015.08.002
Wexler, H. K. (1995). The success of therapeutic communities for substance abusers in American prisons. *Journal of Psychoactive Drugs*, *27*(1), 57–66. https://doi.org/10.1080/02791072.1995.10471673
White House (2023, January 11). Dr. Rahul Gupta releases statement on CDC's new overdose death data. *White House Press Release*. https://www.whitehouse.gov/ondcp/briefing-room/2023/01/11/dr-rahul-gupta-releases-statement-on-cdcs-new-overdose-death-data2/#:~:text=Rahul%20Gupta%2C%20Director%20of%20the,period%20ending%20in%20August%202022
Williams, A. R., Nunes, E. V., Bisaga, A., Levin, F. R., & Olfson, M. (2019). Development of a cascade of care for responding to the opioid epidemic. *The American Journal of Drug and Alcohol Abuse*, *45*(1), 1–10. https://doi.org/10.1080/00952990.2018.1546862
Wood, C. A., Duello, A., Miles, J., Lohmann, B., Gochez-Kerr, T., Richardson, K., Anderson-Harper, R., & Winograd, R. P. (2022). Acceptance of medications for opioid use disorder in recovery housing programs in Missouri. *Journal of Substance Abuse Treatment*, *138*, 108747. https://doi.org/10.1016/j.jsat.2022.108747
Yamamoto, A., Needleman, J., Gelberg, L., Kominski, G., Shoptaw, S., & Tsugawa, Y. (2019). Association between homelessness and opioid overdose and opioid-related hospital admissions/emergency department visits. *Social Science & Medicine*, *242*, 112585. https://doi.org/10.1016/j.socscimed.2019.112585
Zywiak, W. H., Neighbors, C. J., Martin, R. A., Johnson, J. E., Eaton, C. A., & Rohsenow, D. J. (2009). The important people drug and alcohol interview: Psychometric properties, predictive validity, and implications for treatment. *Journal of Substance Abuse Treatment*, *36*(3), 321–330. https://doi.org/10.1016/j.jsat.2008.08.001

Publisher's note