Published in final edited form as:

J Dual Diagn. 2012 January 1; 8(3): 238–246. doi:10.1080/15504263.2012.697448.

Substance Abuse Recovery after Experiencing Homelessness and Mental Illness: Case Studies of Change Over Time

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Abstract

Objective—This paper addresses how consumers with dual diagnosis, who were formerly homeless but are now living in supportive housing, understand their recovery from substance abuse (i.e., substance abuse or dependence). Specifically, this study examined: What can be learned about substance abuse recovery from consumers considered to be doing well; how past substance abuse fits into their present-day narratives; and how (if at all) policies of harm reduction versus abstinence are regarded as affecting recovery efforts.

Methods—As part of a federally-funded qualitative study, 38 individuals who met criteria for having achieved a measure of success in mental health recovery were purposively sampled from two supportive housing agencies – one using a harm reduction and the other an abstinence model. Researchers conducted in-depth interviews and used case study analysis, the latter including the development of case summaries and data matrices, to focus on substance abuse recovery in the larger context of participants' lives.

Results—Recovery from substance abuse was depicted as occurring either through discrete decisions or gradual processes; *achieving* recovery was distinct from *maintaining* recovery. Emergent themes related to achievement included: (a) pivotal events and people (b) maturation, and (c) institutionalization. Central themes to maintaining recovery were: (a) housing, (b) self-help, and (c) the influence of significant others.

Conclusions—These findings capture a complex picture of overcoming substance abuse that largely took place outside of formal treatment and was heavily dependent on broader contexts. Equally important is that consumers themselves did not necessarily view substance abuse recovery as a defining feature of their life story. Indeed, recovery from substance abuse was seen as overcoming one adversity among many others during their troubled life courses.

Keywords

recovery; harm reduction; abstinence; homeless; supportive housing

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DISCLOSURES

The authors (Henwood, Padgett, Smith, and Tiderington) report no conflicts of interest and have no financial relationships with commercial interests.

Pseudonyms have been used for all study participants and the presentation of findings was not detailed enough to allow for identification.

Substance abuse is the most common and clinically significant comorbidity among people with serious mental illness (Drake et al., 2001), with some estimates indicating that half or more of people diagnosed with schizophrenia and other serious mental illnesses would qualify as having a substance use disorder over their lifetime (Kuno, Rothbard, Averyt, & Culhane, 2000; Regier et al., 1990). While the majority of clients with dual diagnosis attain full remission and/or substantial reduction in drug/alcohol use over a 10-year period (Drake et al., 2006), trajectories of recovery vary, with some improving rapidly and others suffering through numerous cycles of relapse (Laudet, 2008; Xie, Drake, & McHugo, 2006).

The concept of recovery is now part of the lexicon of both mental health and addiction services (Gagne, White, & Anthony, 2007), and achieving recovery from substance abuse is considered to be a necessary precursor to mental health recovery (New Freedom Commission on Mental Health, 2003; Weiss et al., 2005). However, the fact that dual diagnoses are associated with childhood adversity and adult homelessness points to the need to consider 'complex recovery,' or rather the multiple challenges such individuals must face (Padgett et al., in press). Homelessness itself exacerbates both symptoms of mental illness and substance abuse and makes recovery less likely (Drake, Osher, & Wallach, 1991; Mueser, Drake, & Wallach, 1998). This helps account for why individuals diagnosed with severe mental illnesses, most of whom have co-occurring substance use disorders, disproportionately constitute the chronically homeless population (U.S. Department of Housing and Urban Development, 2010). For these individuals, recovery from substance abuse is fraught with challenges ranging from constant exposure to drugs and alcohol on the streets to lack of access to detoxification and rehabilitation services designed to serve their dual needs (Maisto, Carey, Carey, Purnine & Barnes, 1999; Minkoff, 2006, 2008). It is, then, all the more remarkable when a man or woman is able to overcome substance abuse amidst such trying circumstances (Hipolito, Carpenter-Song & Whitley, 2011).

For individuals with dual diagnoses who are also homeless, contrasting policies of abstinence or harm reduction in homelessness service programs are likely to play a significant role in their substance abuse recovery. Abstinence-based, congregate housing has dominated traditional service systems and is informed by a therapeutic community model in which recovery from substance abuse is supported by and reinforced through a structured environment and peer community (Liberty et al., 1998; McLellan, Carise, & Kleber, 2003). This approach, however, has not been widely effective at engaging or retaining people who are experiencing long-term homelessness and residing in shelters or on the streets (Padgett, Henwood, Abrams, & Davis, 2008; Tsemberis & Eisenberg, 2000).

Sobriety is a particular barrier for many people, with providers commonly attributing service disengagement to substance abuse relapse (Stanhope, Henwood, & Padgett, 2009). Harm reduction approaches can be understood as a pragmatic response that enables consumers to stay engaged in services while actively using (Drucker & Hantman, 1995). Whether living in a congregate setting such as 'wet housing' (Collins et al., 2011) or an independent apartment not subject to daily surveillance (Tidderington, Stanhope, & Henwood, 2012), the goal of a harm reduction approach is to decrease some of the negative impacts associated with drug and alcohol use while the person continues to use. Although some experts critique harm reduction as ineffective for those with severe addictions (Kertesz et al., 2009), within homelessness services this approach has been shown to improve a variety of outcomes at reduced costs (Larimer et al., 2009; Padgett, Stanhope, Henwood, & Stefancic, 2011; Tsemberis, Gulcur, & Nakae, 2004).

Adoption of harm reduction within homeless services is, however, far from widespread; and little consensus exists on the optimal means of achieving control over substance use. For

example, the Substance Abuse and Mental Health Services Administration's most recent definition of mental health recovery stated "abstinence is the safest approach for those with substance use disorders" (SAMHSA, 2011).

The current study draws upon in-depth interviews with 38 formerly homeless individuals enrolled in two supportive housing programs who had experienced serious mental illness, substance abuse, and homelessness. By study design, these individuals were: 1) enrolled in either a Housing First program that endorsed harm reduction or a more traditional abstinence-based program; and, 2) nominated by program staff as having achieved a measure of success in mental health recovery (including control over substance abuse). The main study questions driving this inquiry were: (1) What can we learn about substance abuse recovery from clients considered to be doing well in supportive housing programs? (2) How does past substance abuse fit into consumers' present-day narratives? and (3) How (if at all) do program policies of harm reduction versus abstinence affect consumers' recovery efforts?

METHODS

Sampling and Recruitment

Interviews for this report were part of a study of mental health recovery in which 40 participants were sampled and recruited from two agencies providing supportive housing in New York City; one used a Housing First approach and the other used a graduated model from more restrictive to least restrictive settings, sometimes referred to as 'treatment first' (Padgett, Gulcur, & Tsemberis, 2006). Both types of programs utilized a supported housing model in which individuals lived in scatter-site, fair-market value apartments (rented from private landlords through program subsidies) and received mobile support services located off-site (Blanch, Carling, & Ridgway, 1988; Rog, 2004). Purposive sampling was used to recruit clients who demonstrated markers of mental health recovery using the following inclusion criteria: DSM Axis I diagnosis (e.g., schizophrenia, bipolar disorder, or major depression), over 21 years of age, English-speaking, Global Assessment of Functioning (GAF) score above 65, housing stability, absence of current (but history of) substance use disorder (abuse or dependence), and one or more signs of mental health recovery such as having a job, being involved in meaningful activities, taking active part in a social group, and/or having a stable partner.

Two senior staff from each program were asked to nominate 20 individuals – 10 who represented shorter tenure in supportive housing (five years or less) and 10 who had tenures of longer than five years – who met the inclusion criteria. To avoid biases in the nomination process, the two staff members from each agency independently nominated eligible individuals and only those who were jointly nominated were asked to participate. Of the 40 individuals jointly nominated, all but nine agreed to participate in the study, and a second round of joint nominations was used to generate the final sample size. Those who refused were from the treatment first program; their reasons for refusal were the lack of time or disinterest in study participation.

Study participants were paid a \$30 incentive per interview plus a roundtrip Metrocard valued at \$4.50 for transportation if they came to the study offices. All study protocols were approved by the authors' university human subjects committee in accordance with the Declaration of Helsinki. These protocols included a complete discussion of the study with potential participants by trained interviewers who then obtained written informed consent before enrollment into the study.

Data Collection Procedures

Minimally structured in-depth interviews, which lasted on average 90 minutes, were conducted by three trained interviewers with prior research and/or clinical experience with this population. Interviews took place in the participant's apartment, the study offices, or in a private room at the program site offices. Participants were asked to describe their current and past experiences, both positive and negative, that led them to their current status. Interviewers were trained to probe about their experiences with housing and homelessness, employment, substance use, mental and physical health, service utilization, and social and family relationships. Interviewers completed a demographic questionnaire on each participant and a post-interview feedback form that documented observations, reactions, and significant details about the interview and the participant. Interviews were digitally recorded, transcribed verbatim, and entered into Atlas.ti software for analysis.

Data Analysis

Case study analysis (Patton, 2002), which prioritizes depth over breadth, was employed in order to include contextual factors that can be lost when using thematic approaches such as grounded theory. This consisted of developing case summaries for each participant based on transcripts, interviewer feedback forms, and a demographic questionnaire. The case summaries included information about the participant's family background, education, work history, social and romantic relationships, program experience, physical and mental health, drug/alcohol use, homeless experience, trauma history, other miscellaneous items of importance, and salient quotes. Team meetings were held to discuss emergent themes through the use of within and cross-case study analyses (Patton, 2002). A case summary matrix was also developed to better organize and conceptualize themes emerging from the data (Miles & Huberman, 1994). Finally, co-coded material that identified meaningful passages within the transcripts regarding substance use were extracted through the Altas.ti program and used to both further elucidate the findings from the case study analyses as well as provide illustrative quotes. The use of memo-writing to track and further develop emergent ideas was used throughout this process (Charmaz, 2006).

RESULTS

Characteristics of the Participants

Table 1 presents a description of the 31 study participants. Although we recruited 40 individuals into the study, two individuals were excluded from the analysis because of either an abbreviated/incomplete interview or difficulty understanding the person due to psychiatric symptoms, four others maintained that they never abused substances, and three chose not to fully discuss the subject. Of the 31 remaining, 27 reported achieving long-term abstinence from drugs and alcohol after being heavily dependent and four reported ongoing occasional substance use.

Thematic Findings

In terms of lessons learned about recovery from substance abuse, we report participants' attributions, which reflect their personal 'narratives of recovery' (McIntosh & McKeganey, 2000), although we probed when possible to obtain the contexts surrounding each narrative event. Participants varied in the ways they told their recovery stories, some providing more polished accounts and others grappling with how to verbalize what happened and why. Nonetheless, there were recognizable patterns. First, while some described recovery as a discrete and memorable decision, others recalled it as a gradual occurrence over a period of time. Second, participants' attributions differed for what helped them *achieve* recovery and what helped them *maintain* recovery (although these influences sometimes overlapped).

Thematic findings representing these patterns are depicted in Figure 1 and presented below through case study descriptions and verbatim quotes.

Patterns in achieving substance abuse recovery: Discrete decisions and gradual recoveries

While eight individuals achieved recovery upon entry into their supportive housing program or thereafter, most study participants discussed non-program-related factors as influencing their substance abuse recovery.

Pivotal Moments and People—When achieving recovery was a discrete turning point, participants recalled the event with vivid clarity. Key individuals often made a difference. Paul (all names are pseudonyms), a 59 year old Caucasian man, who started drinking alcohol at the age of 10 and using cocaine and heroin four years later within the context of being abused by his adopted mother, attributed his 25 years in recovery to a ‘spiritual awakening’ following an unexpected act of kindness during a hospital stay. While Paul was hospitalized for a gangrenous infection in his hand related to drug use, his doctor wanted to amputate, but another physician stepped in to conduct the operation and saved his hand:

“I believed that that doctor for whatever reason took an interest in doing the work to save my hand. The other doctor’s attitude to me was ‘fucking junky cut off his hand and get him the fuck out of here. Get him out of my life.’”

The spiritual awakening came as he was waking up from the operation expecting that his hand had been amputated:

“I could still picture it perfectly and I wouldn’t look at my hand because I know, I knew that they had cut my hand off and then I heard a voice and it was as clear as I hear you talk to me or any voice, it was clearer. It was the most clearest voice I ever heard and it said to me ‘You don’t have to do that anymore.’ And for whatever reason I knew exactly what they were talking about: drugs. You don’t have to do that anymore. And then the voice said ‘It’s over.’ And I knew what that was- -no more drugs.”

Paul currently takes psychiatric medication to treat a diagnosed schizoaffective disorder, is in contact with his two adult sons, and is in a 13-year committed relationship with a woman he met in Alcoholics Anonymous.

In several cases, close family members made a dramatic difference. For example, Herbie, a 56-year old African American musician who described having a happy childhood with good role models, found himself twice divorced and estranged from his ex-wives after struggling with untreated bipolar disorder. He still has contact with his two daughters and grand-daughter, however, and recounts:

“My eldest child had requested that I stop. She had come of age, like say, 20, 21. We were invited to [another city] to a show and she said ‘no dad cause you’re gonna get messed up again aren’t you?’ I thought for a hard second, looked her dead in the eye and said, ‘You know something, no. No I won’t.’ That was 5–6 years ago. I’ve been sober since then...no 12 steps, no AA, none of that bullshit. Just a promise to my child.”

Maturation and Gradual Recovery—Those who spoke about gradually achieving recovery described it as something that simply evolved and was recognizable only in hindsight. James, who works part-time and hopes to get off disability benefits in the near future, is a 48-year old African American who started hearing voices after the death of his mother at the age of 16 and subsequently became addicted to drugs. He explains:

I guess, as my life evolved, it just wasn't no need or desire for it. I mean, I stopped for long periods and you'd think about it and you might have a drink or you might smoke a joint, but as time went on it, it just wasn't a factor anymore. And I stopped counting, I don't know, 8–9 years ago. I didn't even think about it, to tell you the truth.

Others talked about a more complicated process of growth that included maturation and getting older. Sharon, a 60 year-old African American who describes herself as a “homebody” maintains regular contact with her two children. She explained that her mother cared for the children while Sharon was actively using, and remembered that the last time she used was prior to a psychiatric hospital admission. Nevertheless, she reflected on how she stopped using saying, “I just got tired of being sick and tired. (pause) You know...that... that was the whole thing, you know. (pause) ...and wantin' to do for my kids...and growin' up, you know, um...getting' older.” This participant's use of 12-step phrasing (“tired of being sick and tired”) reflected a familiarity with the language of rehabilitation that will be discussed further below.

Institutionalization—Being in a long-term institutional setting, whether a hospital or prison, can set the stage for recovery by removing participants from their familiar environment. Often this was described as an unplanned occurrence. Robert is a 49-year old African American who was honorably discharged from the military shortly after enlisting because of hearing voices. Having used drugs since the age of 14, he explained:

“I just went into the hospital so I could sleep and eat. I had no idea that that was going to be the beginning of the recovery process. I didn't know that day that this would be the start of the rest of my life. I didn't know what day. I just wanted to get out of that cold and rain. So I went to the hospital...I stayed in the hospital like I said for like four months, so the desire to use was gone. Four months, if you ain't get high in four months, your chances is good that you might just stop.”

Ed, a 59-year old African American who started using heroin at the age of 16, had been diagnosed with schizophrenia at a young age and still continues to take medication despite not having experienced any symptoms for years. He identified repeated incarcerations as the venues for eventually achieving recovery.

“Gradually, as the years...from '68 going all the way to '83, every time I went to jail I stopped taking a certain kind of drug, you know what I mean, to get me high. And so as the time passed it was...it was really nothing to quit, you know. You say you had enough, you know? Because it wasn't gettin' you nowhere.”

Patterns in maintaining recovery: Present day realities

Efforts to maintain recovery varied between those consumers who actively worked to stay clean and sober while reminding themselves of the potential consequences of relapse, and those whose attention to maintenance was less frequent and more targeted around specific events or situations. A couple of participants described the process as occurring on a more sub-conscious level through ‘drug dreams.’ Violet, a 53-year old African American who reported significant childhood trauma, recounted how she was able to achieve recovery while staying in a shelter:

“...it's going on 21 years now, that I'm clean. And do you know, there's always... if I do get a drug dream, which is far and few, I know if I get a drug dream there is something that I'm not confronting in my subconscious or else I would not get that dream. So if I confront it then I don't get drug dreams. So I use it as a tool now. And I don't use excuses, you know.”

The following factors were identified as contextual elements that influenced participants' maintenance of recovery from substance abuse.

Housing—Mindful that maintaining sobriety was a requirement for staying housed in the abstinence-based program, Larry, a 41-year old African American who had been diagnosed with schizophrenia while incarcerated in his early 30's, recounted a clear choice, "Either be on the streets, using drugs, or have a place to live, drug free. It was just a decision I had to make." Less definitively, Carter, a 52-year old African American diagnosed with schizophrenia in his late teens, continued to drink and use marijuana despite repeated psychiatric hospitalizations. He identified program requirements as the reason for becoming sober: "Well, one thing is, it's part of [the supportive housing] program's thing. I'd probably still be drinking somewhere. But you know, it's a good enough reason to stop."

Housing First participants, aware that their housing was not contingent on sobriety, nevertheless saw the advantages of maintaining their recovery. Tim, a 50-year old African American who is in the process of becoming a certified addictions counselor, described:

"Having my own place where I can be myself is huge, and not being, where I live is just, it's just also, I got very lucky, I got very fortunate in the apartment that I have and um, it has a lot to do with it [recovery]."

Of the four individuals who reported ongoing or occasional use, three were from the Housing First program. While one abstinence-based program participant admitted to occasional use of marijuana, another was worried that the program would terminate him after drinking a beer despite having been clean and sober for 17 years.

Self-Help—While formal services such as detoxification and inpatient treatment were not a prominent part of participants' accounts of achieving recovery, groups such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) were often invoked as assisting participants' ability to maintain recovery. Robert, who was described above as achieving recovery through a long-term hospitalization, added:

"That's how I had success in staying clean, 'cause I built a strong foundation. I still have people in my [AA/NA] support group from back then [1993]. They still in my life."

Others, however, focused more on their own convictions in maintaining recovery. James, whose recovery process was described above, notes:

"... it's not an option, it's just something that I have to do. The day I don't [remain abstinent], then it's the beginning of a downfall. You know, it only takes a small fragment ... to loosen a brick of my stability."

Some participants actively rejected self-help groups as trapping them in an unpleasant past. Jonathan, a 49-year old African American enrolled in Housing First who works part time, describes:

"I could not bring myself to say, for example, AA, alcoholics anonymous, 'My name is [x] and I'm an alcoholic. Or NA, 'My name is [x], and I'm an addict' ... I would say I'm an ex-drug addict or I'm an ex-alcoholic but that was something in the past."

Across participants, personal conviction to maintain abstinence was often based on a desire to do better and on a fear of negative consequences from substance use, particularly with regards to one's health. Scott is a 50-year old Caucasian who described himself as the "pariah" of his family and whose father attempted to strangle him. He expressed these dual

motivating factors within the same thought: “I have this strive to do better and I, I know, I know I will lose everything if I use, I know that, okay. I know I will end up dead if I use.”

The Influence of Significant Others—Most participants agreed that having supportive individuals in their lives helped to maintain abstinence. Additionally, it might also entail rejecting others who were still using. Robert, who finds support in AA, as described above, also mentioned, “I surrounded myself with recovering people. They was still using, a lotta clients, they didn’t stop using, I couldn’t hang out with them.”

Ronald, a 40-year old African American who no longer has contact with his family and described a desire to “be left alone,” talked about his grandfather as inspiring him to return to rehabilitation a last time:

“I went down South and my grandfather went down there and he wasn’t drinking and drugging. He was teaching me to stay away from drinking and to pick my own friends... I had a positive influence from him. But I still need some help and then I went to that rehab and now I’m just clean.”

While family could be a positive influence in one’s recovery, their influence could come from threats to sever ties. Virginia, a 54-year old African American who comes from a large supportive family, stated “My daughters, two daughters...they said ‘we’re not going have a crackhead for a grandmother and if you don’t get better, we won’t talk to you and we won’t let you see the kids no more.’”

Some participants recognized the potential negative influence of others to such a degree that their strategy for maintaining recovery focused mainly on isolating themselves. Larry, who was described above as making a clear choice to accept abstinence-based housing, articulated his strategy:

“I just go away from everyone. I go to the store to have my coffee then go back into the house...I acknowledge them [neighbors] because they acknowledge me, but I just keep on going. I say, ‘how ya doing’ ...I don’t get too close with people.”

DISCUSSION

The results of this study address how consumers with dual diagnosis who have experienced homelessness describe their recoveries from substance abuse. Consistent with other studies, these individuals had varying trajectories with some recounting a pivotal turning point and others describing a more gradual exit or ‘aging out’ of substance use activities (Drake, et al., 2006; Weiss, et al., 2005). Although substance abuse is better managed as a chronic condition (Dennis & Scott, 2007), participants who recovered typically out-grew and/or decided to stop using. In addition, study participants noted environmental influences through the positive influence of supportive persons as well as being removed from their usual surroundings through hospitalization or incarceration. The latter highlights the importance of contextual and environmental factors that impact health-related behaviors (Marmot et al., 2008), but also the complexity: involuntary institutionalization, including incarceration, can have positive effects on substance use, yet is hardly conducive to mental health recovery.

Recovering from substance abuse was rarely attributed to formal treatment, despite the fact that participants had been enrolled in detoxification and group therapy programs. This finding is consistent with other studies showing a limited role for formal treatment in achieving abstinence among homeless clients (O’Toole, Pollini, Ford & Bigelow, 2008). We need to identify the circumstances under which formal treatment can be useful but also to avoid assuming that it is necessary and sufficient for recovery. Some participants were outspoken about rejecting formal or peer supports, suggesting that maintaining a sense of

autonomy and self-determination may be critical to recovery efforts as well as important in treatment settings (Markland, Ryan, Tobin, & Rollnick, 2005).

Conforming to the action and maintenance stages of change (Prochaska et al., 1994), these participants distinguished between their efforts to dramatically reduce or stop substance use and efforts to maintain their recovery once achieved (McIntosh & McKeganey, 2000; Drake, Mueser, & Brunette, 2007). Housing was not seen as crucial to achieving abstinence, but it was a definite motivator for maintaining recovery. This was true not only for those living under abstinence-based policies but also for those in harm reduction programs. Previous research shows that access to 'housing first' positively affects reducing use of substances when compared to abstinence-based programs because over one-half of the latter group 'vote with their feet' by dropping out of programs and returning to a transient life on the streets (Padgett et al., 2011). This revolving door of homelessness and institutional stays in hospitals, shelters, and jails is all too often activated by relapsing into substance abuse (Hopper, Jost, Hay, Welber, & Haugland, 1997; Tsemberis & Eisenberg, 2000). Rather than leveraging needed resources such as housing to promote abstinence, approaches that tap into intrinsic motivational may be more effective (Allen, 2003; Drake et al., 2001; Rollnick, Miller, & Butler, 2008). Housing may not convince someone to stop using substances, but having housing and future prospects may help someone maintain their recovery.

Regardless of the type of housing participants occupied, social support was cited both as an influential factor in attempts to quit substance use as well as in maintaining recovery. This finding accords with previous research (Alverson, Alverson, & Drake, 2000; Drake, Wallach, Alverson, & Mueser, 2002; Hipolito et al., 2011; Padgett, Henwood, Abrams, & Drake, 2008), highlights the negative consequences of depleted social networks (Hawkins & Abrams, 2007), and provides some explanation as to why individuals may choose to isolate themselves (Gulcur et al., 2007). It also speaks to the importance of pro-social activities including competitive employment (Bond et al., 2007). While having meaningful daily activities can be helpful in maintaining recovery, the majority of study participants were unemployed, which is consistent with overall employment rates among individuals diagnosed with serious mental illness (Mueser et al., 2004; Twamley, Jeste, & Lehman, 2003). Supported employment is an effective approach in this regard (Bond et al., 2007), and participants may not need to be abstinent from all substances in order to benefit (Mueser, Campbell & Drake, 2011).

Participants themselves did not necessarily view substance abuse recovery as a defining feature of their life stories. Indeed, substance abuse was just one source of adversity among many others over their troubled life courses.

Strengths and Limitations of the Study

This study documents processes of recovering from substance abuse grounded in the lived experiences of individuals who have achieved a measure of success in coping with serious mental illness and histories of homelessness. As such, it represents a rare opportunity for understanding the contexts of recovery amidst severe adversity. Due to the fact that this study prioritized participants' depictions of how they recovered from substance abuse, we were not able to triangulate such accounts with other sources of data (although such corroboration was not considered necessary given the study's goals). Legitimate concerns about recall bias or selective memory are mitigated by the emphasis here on their subjective accounts, yet it should also be noted that there is evidence supporting the validity of self-report (Clifasefi, Collins, Tanzer, Burlingham, & Larimer, 2011). The results are not intended to be generalizable but are in accordance with extant literature as discussed above. By study design, the sampling criteria relied upon post-hoc accounts of 'recovered' individuals, which could be a strength because these individuals also experienced times

when recovery seemed out of reach. Additional strengths of the study include the development of individual case summaries as well as a case study matrix that was independently reviewed by multiple research team members, during within and cross-case analysis, which increases the “trustworthiness” of these findings (Padgett, 2012).

Conclusion

The journey to recovery from substance abuse usually implies an endpoint of complete abstinence (McIntosh & McKeganey, 2000; SAMHSA, 2011). Our findings contribute to a growing consensus that for dually diagnosed persons—and especially for the subset who have experienced homelessness—this journey may follow several paths and be largely independent of traditional substance abuse treatment approaches. The factors that help individuals achieve recovery—whether sharply defined events or gradual withdrawal—are distinct from those that help them maintain their recovery. In the latter case, having stable housing and program staff committed to harm reduction serves to inhibit rather than enable substance use, as clients feel trusted and active in deciding what is in their best interests. Nevertheless, the recovery process can be complicated and unpredictable, reinforcing the need for treatment providers to remain supportive and hopeful through inevitable relapses.

Acknowledgments

This study was funded by the National Institute of Mental Health, grant #1R01MH084903. The authors would like to thank the study participants who generously shared their stories.

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Figure 1.
Contextual elements influencing recovery from substance abuse

Table 1

Demographic Characteristics

<i>N</i> = 31 (%)		
Sex		
Male	26	(84)
Female	5	(16)
Race/Ethnicity		
African-American	19	(61)
American-Indian/ Native-American	2	(6.5)
Caucasian	3	(10)
Hispanic-American	5	(16)
Mixed Race	2	(6.5)
Education		
Grade School	5	(16)
High School	13	(42)
College	11	(35.5)
Post-Graduate	2	(6.5)
Marital Status		
Married	0	
Divorced	8	(26)
Separated	4	(13)
Never Married	18	(58)
Widowed	1	(3)
Have Children		
Yes	14	(45)
No	17	(55)
Employment Status		
Unemployed	23	(74)
Part-Time Employment	8	(26)
Full-time Employment	0	
Mean Age (<i>SD</i>)	51	(11.1)