The Meaning of Recovery from Co-Occurring Disorder:

Views from Consumers and Staff Members Living and Working in Housing First Programming

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Funding supporting this project was provided by the National Institute on Drug Abuse (NIDA) (R36DA027770), the National Institutes of Health (NIH)/National Center for Advancing Translational Sciences (NCATS) (KL2TR001106), National Institute of Mental Health (NIMH) (R24MH074670), VA Quality Enhancement of Research Initiative (RRP 12-504), and VA Health Service Research and Development (CIN-13-416).

This is the author's manuscript of the article published in final edited form as:
Watson, D. P., & Rollins, A. L. (2015). The Meaning of Recovery from Co-Occurring Disorder: Views from Consumers and Staff Members Living and Working in Housing First Programming. International Journal of Mental Health and Addiction, 1-15. http://dx.doi.org/10.1007/s11469-015-9549-y

Abstract

The current study seeks to understand the concept of recovery from the perspectives of consumers and staff living and working in a supportive housing model designed to serve those with co-occurring disorder. Interview and focus group data were collected from consumers and staff from 4 housing programs. Data analyzed using an approach that combined case study and grounded theory methodologies demonstrate that: consumers' and staff members' views of recovery are highly compatible and resistant to abstinence-based definitions of recovery; recovery is personal; stability is a foundation for recovery; recovery is a process; and the recovery process is not linear. These themes are more consistent with mental health-focused conceptions of recovery than those traditionally used within the substance abuse field, and they help demonstrate how recovery can be influenced by the organization of services in which consumers are embedded.

Key words: recovery; co-occurring disorder; homelessness; Housing First

The Meaning of Recovery from Co-Occurring Disorder: Views from Consumers and Staff Members Living and Working in Housing First Programming

Among individuals with serious mental illnesses, substance use disorder is one of the most common and clinically significant comorbidities (Kessler, Chiu, Demler, & Walters, 2005), and the term "co-occurring disorder" is frequently used in the behavioral health literature to describe those diagnosed with both illnesses. Those with co-occurring disorder are at higher risk for a number of negative outcomes (e.g., poor treatment response, homelessness, incarceration, substance use relapse, re-hospitalization) than those with a single disorder (Abram & Teplin, 1991; Carter, Fisher, & Isaac, 2013; Caton et al., 2005; Drake, Wallach, & Hoffman, 1989; Susser, Lin, & Conover, 1991). One reason proposed for these negative outcomes is a lack of understanding of recovery as it relates to co-occurring disorders, which is rooted in the separation between mental health and substance abuse treatment systems that ignores the complex realities of co-occurring disorders (Drake, O'Neal, & Wallach, 2008; White, Boyle, & Loveland, 2005). Qualitative research that investigates understandings and lived experiences of recovery as it relates to those with co-occurring disorders has the potential to guide the integration of mental health and substance abuse treatment systems to better serve this group; however, a paucity of research in this area currently exists (Carter, Fisher, & Isaac, 2013; Cruce, Öjehagen, & Nordström, 2012).

The current study attempts to address this lack of research through a qualitative investigation of recovery in Housing First programming, a model of permanent supportive housing developed in the United States specifically **to serve individuals who are chronically homeless and living with co-occurring disorder**. The model has diffused widely across North

America (Polvere, Macnaughton, & Piat, 2013), and it has begun to spread to Europe in recent years, where it has been the subject of critique (Hansen Löfstrand & Juhila, 2012; Pleace & Bretherton, 2013). Incompatibilities that exist between the substance abuse and mental health systems' respective conceptualizations of recovery are considered before focusing specifically on Housing First programming.

Recovery Viewed from Two Separate Systems

The concept of recovery from substance use disorders has been a major concern in the addictions field since the 1930s (Alcoholics Anonymous, 1939). Within substance abuse treatment circles, addiction is often viewed as a chronic disease from which the individual will never be cured. The only way for the "addict" to prevent negative consequences of their condition is to abstain from substance use entirely. As such, recovery in the addictions field is almost always equated with abstinence (White et al., 2005), or perhaps, we could conceive of abstinence as the only outcome that seems to matter in many addiction treatment circles. For all intents and purposes, the process of addiction recovery involves the same "12 steps", which do not begin until the individual admits they have a problem and commits to eliminating substance use from their life (i.e., eliminate the primary symptom of their illness). From that point, the recovery process is focused on maintaining the abstinence that the individual has achieved. Because of this focus, many programs (e.g., employment, residential, or mental health focused) that work with individuals who have addictions will not serve them until they have a demonstrated period of abstinence (often between 30 and 90 days).

While serious mental illnesses are also understood to be largely chronic and incurable conditions, the concept of recovery advocated within the mental health field is markedly different. Mental health recovery goals are usually focused on coping with symptoms and

improvements in quality of life despite illness—i.e., recovery *without* the absence of symptoms (Anthony, 1993). Recovery in mental health is often conceptualized as a highly individualized process where consumers define the desired outcomes from their own varying perspectives (Borg & Davidson, 2007) often with an emphasis on community integration (Bond, Salyers, Rollins, Rapp, & Zipple, 2004) and quality of life (Deegan & Drake, 2006), rather than absence of symptoms. As such, mental health recovery focuses on engagement in life pursuits that are meaningful to the individual despite the presence of symptoms (Anthony, 1993), and, as opposed to those programs focused on substance abuse, the majority of programs specializing in services for those with serious mental illness do not require patients to have attained specific outcomes before engagement. The conceptualizations of mental health recovery are more consistent with the notion of resilience than the absence of symptoms—that the consumer finds adaptive ways to cope with adversity, rather than to succumb to dysfunction (Masten, Best, & Garmezy, 1990).

The dissonance that currently exists between the two broad understandings of recovery discussed above overwhelmingly leads clinicians to designate one of these disorders as primary and one as secondary (typically as a designation of convenience for the service system rather than diagnostic certainty) when both disorders are present. This translates into difficulty for those living with co-occurring disorder to find treatment that addresses their substance use in a holistic way, and highlights the need to better understand recovery from serious mental illness and substance use disorder as a co-occurring process.

Housing First: Study Setting for Co-occurring Disorder Recovery

The Housing First model of permanent supportive housing is a residential model for serving chronically homeless individuals with co-occurring disorder that approaches recovery from both illnesses in a unified manner. Housing First, as its name suggests, was originally

designed to serve consumers who are chronically homeless, regardless of their interest in abstinence or engagement in therapeutic services (Tsemberis, 1999). As such, the model emphasizes immediate access to housing without precondition, meaning that, unlike traditional housing approaches, consumers are not required to meet sobriety goals or demonstrate that they are managing their mental health symptoms before being housed. Additionally, mental health and substance abuse services are typically available but not required as a condition for maintaining housing (Tsemberis, 1999).

The unique approach of this model makes it an ideal context for exploring recovery from co-occurring disorder. Housing First programs have been shown to lead to a number of positive outcomes often associated with recovery including: high housing stability (Collins, Malone, & Clifasefi, 2013; Tsemberis, 1999); strong client self-reported relationships with mental health/substance abuse providers (Mares & Rosenheck, 2010); reduced substance use and abuse (Padgett, Stanhope, Henwood, & Stefancic, 2011); reduced emergency room visits and hospitalizations for detoxification and other reasons (Sadowski, Kee, VanderWeele, & Buchanan, 2009); and reduced involvement in criminal activity (Bean et al., 2013). A handful of previous studies (all of them qualitative) have attempted to understand recovery (mental health and/or substance abuse) from the perspective of those engaged in Housing First programming. Three of these studies targeting Housing First clients with mental illness have demonstrated how participants viewed housing as an essential foundation for recovery because of its ability to foster hope and stable social relationships (Kirst, Zerger, Harris, Plenery & Stergiopoulos, 2014; Patterson; Rezansoff, Currie, & Somers, 2013; Polvere, Macnaughton, & Piat, 2013) . Cabassa, Nicasio, and Whitley (2013) recruited individuals with co-occurring disorder from a Housing First program in order to better understand the recovery process through the Photovoice method. They also demonstrated the importance of social support in participants' recovery, as well as spirituality and achievements in education and/or employment. Also focusing on clients with co-

occurring disorder, Henwood, Padgett, Smith, and Tiderington's (2012) found that recovery from substance use disorder was seen as one issue among many that needed to be addressed in participants' lives (i.e., substance abuse did not take central focus). In sum, these studies demonstrate findings similar to those found in the broader literature on recovery from serious mental illnesses, which stresses the importance of such factors as hope, social support, and holistic approaches to treatment, as well as demonstrating the uniqueness of the recovery process for specific individuals.

The current study differs from the previous literature on recovery within Housing First programming because (a) data were collected from multiple Housing First programs, rather than a single one and because (b) it includes data collected from staff members, an important perspective considering the significant influence staff can have over the implementation and delivery of services (Lietz, Lacasse, Hayes, & Cheung, 2014; Lipsky, 2010). The primary questions guiding our inquiry were: How do participants understand/define recovery from both mental illness and substance use disorders within Housing First programming?; How do these understandings compare and contrast with those they may have experienced in more traditional program settings?; How are staff and consumer understandings of recovery similar or different?

Method

The current study draws upon focus group and individual interview data gathered from staff and consumers at four Housing First programs as part of a larger, federally funded study. The larger study was set within a symbolic interactionist framework that combined both case study (useful for setting the boundaries of a study, i.e., unit of analysis, number of cases) and grounded theory (a step-by-step process for building emergent theory) methods to compare four Housing First programs located in the same

large Midwestern city. The combining of case study and grounded theory approaches has been described in detail by Eisenhardt and Graebner (2007), and a detailed description of the methods of the larger study can be found elsewhere (Watson, Orwat, Wagner, Shuman, & Tolliver, 2013).

Program Sampling and Participant Recruitment

Programs. The research team developed a sampling list of seven Housing First programs with assistance from local experts (i.e., individuals working closely with local government offices to provide training and technical assistance to Housing First programs). Researchers purposefully selected four of the seven programs (i.e., cases) that had the most differences in terms of (a) consumer capacity (program size), (b) primary population served (e.g., men, women, people living with HIV/AIDS, the general homeless population), (c) years providing Housing First programming, and (d) housing type (single-site or multiple-site;[1] see Table 1). Selection of cases based on their differences is an approach to strengthening validity when the sample size is small (Eisenhardt, 1989). While programs differed in the specific subpopulations of chronic homeless individuals they served, they all housed consumers with co-occurring disorder. Readers can find a more detailed description of these programs in a previously published paper (Watson, Wagner, & Rivers, 2013).

Study participants. The study included 4 consumer focus groups (24 total study participants), 3 staff focus groups (18 total study participants), 21 consumer interviews, and 16 staff interviews. The final sample included a total of 60 unique study participants, with 20 individuals who participated in both a focus group and an interview. Consumer interview

[1] Single-site programs are those where all housing and services are delivered at the same location. Multiple-site (also referred to as scattered-site) programs are those where housing is operated by private landlords at more than one location.

participants were housed at their current programs for a range of 9 months to 10 years, with an average of 3.5 years (SD = 2.7 years). Staff interview participants had worked in their programs from 1 to 20 years, with an average of 6.1 years (SD = 5.3 years). Data for years housed and worked were not collected for focus group participants, but should be similar considering the overlap in participants in each type of data collection activity. Gender, race, and ethnicity of participants by data collection activity are presented in Table 2.

At the request of researchers, the management from each of the programs invited potential study participants to focus groups based on their ability to speak knowledgeably about organizational policies and practices, and in the case of consumers, a co-occurring disorder diagnosis and an ability to interact in a group setting with minimal difficulty. For the interview portion of the study, management at each organization provided a list of all consumers with co-occurring disorder and a list of all staff who interacted regularly with consumers as part of their job duties. Researchers randomly selected study participants when there were more than five on a list (those participants who participated in focus groups were not excluded from interview selection). Additional consumer participants were added at one site when the initial interviews failed to yield sufficient data (participants were visibly uncomfortable answering the study questions). .

Procedure

All data collection activities were semi-structured, audio recorded, and lasted between 45 minutes and 1.5 hours. Focus groups were completed at each agency before beginning individual interviews. The purpose of the focus groups was to gather initial information about the programs to develop questions for individual interviews (i.e., the focus groups provided breadth of information related to the programs, while individual interviews provided depth of information

related to individual program and recovery experience). The interviewer did not ask directly about recovery in the focus groups; questions instead focused on policies and procedures, processes, services, and consumer-staff interactions. While recovery was not a specific part of the focus group guide, it often came up in conversations; however, it was not discussed in great detail. In the individual interviews, participants were asked "What is recovery (for you/for your clients)?" The interviewer probed for specifics related to mental health or substance abuse after each participant provided an initial answer to this question. Probes were entirely dependent upon the context of the conversation. Generally if a participant only spoke of substance abuse recovery, then the interviewer probed for information related to mental health recovery and vice versa. Participants received a gift card ($30 for consumers and $5 for staff who were also being paid by their employers for their time). All procedures were approved by the relevant Institutional Review Board.

Analysis

The first authorconducted all data collection and carried out all analyses—a standard procedure for interpretive qualitative studies (Morse, 2012)—with the assistance of NVIVO 8. The first author is a sociologist with four years prior experience working in behavioral health treatment, and he had no prior direct working relationship with any of the housing programs. He followed an inductive process of data analysis where themes were first identified within each case/program using a process of open coding (Miles, Huberman, & Saldaña, 2014). He then compared cases/programs to look for similarities and differences in themes, a process of enhancing validity in case study research (Eisenhardt & Graebner, 2007). He then compared themes as they emerged by source (consumer or staff), an approach to enhancing validity of qualitative findings (Patton,

2002). The analysis was completed at the point of theoretical saturation, which was established at the point when iteration between data and theory yielded no new insights into the phenomena of interest (Eisenhardt, 1989). Individual member checking was not possible given time and resource constraints, so themes were shared with an expert in Housing First programming to check vailidity (Patton, 2002). She confirmed the content was consistent with her experience.

Results

Analysis resulted in six themes related to the primary research question: (1) consumers' and staff members' views of recovery are highly compatible; (2) resistance to abstinence-based definitions of recovery; (3) recovery is personal; (4) stability is a foundation for recovery; (5) recovery is a process; and (6) the recovery process is not linear.

Highly Compatible Views

The first of these themes was that *consumers' and staff members' views of recovery were highly compatible*. This overarching theme is **demonstrated through the discussion of the other five themes below**, which demonstrate strong parallels that existed between consumer and staff experiences and understandings of recovery. In most cases, it would be difficult to contrast staff and consumer understandings of recovery due to the consistencies in perspectives offered.

Resistance to Abstinence-Based Definitions

A second major theme was that consumers and staff *regularly demonstrated resistance to abstinence-based definitions of recovery* prevalent within the field of substance abuse treatment. For instance, one participant's description of his recovery included a reaction to sobriety guidelines such as those regularly used to determine housing readiness in abstinence-based programs:

> Like I was sayin', I don't have to be sober, for ninety days…Getting me into that environment [permanent housing] became the number one thing [for his current housing program] to do first, and then out of that we were able to identify what the cause of the [behavioral health] problem was, treat the cause, and then go onto to stability in the other areas [of his life]. (consumer)

Like most consumers who had previous experience with traditional housing programs, this individual found the immediate stability offered by the Housing First model to be more helpful to his recovery than sobriety requirements that acted as a barrier to housing stability for him in the past.

A selection from another interview demonstrates the staff perspective on this issue: “I think we’re so programmed in our society that recovery equals abstinence…a lot of our [consumers] think that” (staff). This passage demonstrates a common sentiment among participants that “recovery” is something the larger society in the United States associates primarily with substance use, which they often demonstrated was a contrast to their own thinking. Because of this, both staff and consumers often had difficulty discussing recovery at the beginning of interviews. For instance, one consumer did not like using the word “recovery” to describe consumers’ experiences because of the perceived association with abstinence: “Most of us are brainwashed to believe recovery is abstinence. In that regard…I find it difficult to use [those] word[s] ‘in recovery’” (consumer). These discussions demonstrated an incompatibility between the abstinence-based concept of recovery and the lived experiences of study participants described in more detail below. Because of this, substance abuse-specific recovery (e.g., recovery as abstinence), rather than general mental health recovery, was the primary focus in early portions of most interviews. However, study participants were able to

discuss recovery in greater detail and with consideration toward issues other than substance use once conversations gained momentum.

The Personal Nature of Recovery

This sentiment, that recovery is a unique and personal experience for each consumer, was repeated again and again by participants:

> "Everybody's recovery is different. Everybody looks at it different…I can't discriminate and say my recovery is different [better] than someone else's because what their recovery consists of may be important to them". (consumer)

As the above quote demonstrates, consumers often discussed how the things that were "important" or meaningful in their recovery were likely different for other individuals and how this was okay. The following quote demonstrates the staff perspective related to this theme:

> Yeah, it [recovery] can look like many different things…We're not expecting a tenet [consumer] that comes, is always on time to every appointment to see a case manager, that is always participating in everything. (staff)

Other staff members demonstrated the understanding of recovery as unique and personal by discussing their expectation of consumers, or, more importantly, how they did not have specific expectations because each consumer was different.

This theme was also strongly reflected in discussions that emphasized the importance of individual goals:

> The one thing that [my program] did was they gave me the opportunity to make the decision [to quit using] at *my own pace* and [in] my own time [emphasis added]…They [staff] said, "We'll help you in either way you wanna go". "If you wanna use, we'll help you on that." (consumer)

This quote demonstrates the value consumers placed on the ability to work on the issues they felt were important at a pace they were comfortable with. Staff members also frequently pointed out the importance of individual goals for consumers:

> Well I think [informant states another staff member's name] has said before that every participant's different and they all have different goals. And so, what does recovery look like. I think it really is about meeting the client *where they're at* [emphasis added]. (staff)

The phrase "where they're at" was used fequently by the staff members at all programs, and it brings forth the same sentiment as the phrase "at my own pace", which was highlighted in the previous quote and regularly used by consumers. Both of these phrases highlight the notion that recovery does not fit a predetermined mold that people can move through on a predicted schedule.

Stability as a Foundation

While recovery was highly personal, staff and consumers often described recovery from homelessness as the primary recovery occurring in Housing First programming because it provides the *stability consumers needed to move forward with recovery* in other areas of their lives:

> If we can relate it to *homelessness recovery* [emphasis added], for me recovery was going from either living on the streets or transitioning from house to house to house or staying in unsafe environments, to having an apartment of my own, with secure shelter. If I look at recovery for my medical condition, it's going from a place where I'm not taking meds and continually getting sicker, to a point where now I'm 99.9 percent adherent, meaning I'm taking my medications every day, on time, as prescribed. In terms of financial recovery, it means that I'm no longer taking my money and just spending it on whatever

> or blowing it every week and now being able to budget and making sure that I have funds available to pay the rent, the utilities. To make sure that I have enough food all month and things like that. Going from a place where that wasn't a stable area in my life where that is a stable area in my life. I think there's different areas of recovery and the…program has taken me from a place where it was a non-stable area in my life to where its a very stable area in my life, in all of those areas. (consumer)

Therefore, while goals were highly personal and individualized, recovery from homelessness was *the recovery* that unified all of their experiences.

One consumer's response to the question "What effect does housing have on your mental health?" highlights the significant degree of overlap between homelessness recovery and mental health recovery:

> [In] my case, I don't have to worry about it [mental health]. I know that I don't have to worry about it cause I got my housing covered. (consumer)

This consumer no longer felt he had to worry about his mental health because of the stability he had gained from his housing.

Analysis further demonstrated that homeless recovery is a holistic recovery that goes beyond—and in some cases might not even include—simply controlling symptoms associated with mental illness and/or substance use disorder. Indeed, the primary goal of recovery often centered around housing and housing stability:

> We'll [my program] get[s] you housing. "We [the program] don't care about the other, we do care, but we don't care about the interactions of the other areas in your life cause we'll help you through those." "But the first thing that we're gonna do is put you in some stable housing." "And then as other issues arise, we'll deal with those as they come up to keep

> you in the stable housing." Like I was sayin', I don't have to be sober, for ninety days…Getting me into that environment became the number one thing to do first, and then out of that we were able to identify what the cause of the problem was, treat the cause, and then go onto to stability in the other areas. (consumer)

Staff provided similar descriptions of homeless recovery as those highlighted above by consumers:

> Recovery first is, just staying housed. Because that's a recovery from homelessness. AndI think right now we have between 70 and 75 percent [of consumers] who are [were] chronicallyhomeless. So the first thing that, that is the primary issue for everyone coming to us. Andthat is, I think also ties into Housing First, is you're homeless, you're biggest issue is beinghomeless, so recovery is staying permanently housed. Whether that's with us or whether that is with usfor a while and then going somewhere else. So I think that is the first thing. (staff)

Recovery as a Process

When speaking about her personal recovery, one consumer described described it as a journey she was on:

> Well, I did look at it as an outcome you know, in the beginning, but once I learned more and went to meetings and I learned more about the program then I did see and I do see that it's a[n] ongoing, a *journey* that I'll be on for the rest of my life [emphasis added]. (consumer)

The concept of recovery as a journey parallels it to a process that consumers move through, rather than a category they exist within. When recovery is viewed as a process, the focus shifts from attempting to cure or eliminate the problem to living with it: "I don't think you ever get rid

of it [mental illness]. I think you just learn how to control [it]…you *control it* where you can live a *pretty well normal life* [emphasis added]" (consumer).

Staff demonstrated similar points of view: "I don't think of recovery as…you have or you haven't recovered, I think of it as a process, and I don't know if I like the word "recovery" really as much as I like 'growth'" (staff). The importance of growth, betterment, and/or self-improvement to the recovery process was frequently discussed, indicating that one could not be in recovery without this goal: "[I]t [recovery] means that you always have a goal to try to do better for yourself" (consumer). These discussions stood in stark contrast to more disease-oriented models that view recovery as an outcome. Indeed, the specific model that staff discussed as guiding their work was the Transtheoretical/Stages of Change model (DiClemente & Velasquez, 2002), which provides a framework for understanding the process individuals go through when making changes in their lives:

> … [W]e recognize that people have a different *stage of change* [emphasis added], and that there's a spectrum to that. And so we embrace and accept people along that spectrum and try to meet them where they're at…And then based on that, we help them um to achieve their goals. (staff)

Recovery is Not Linear

The final theme evidenced by the analysis was that the *recovery process is not linear*. Despite their recognition that growth or forward progression was the ultimate recovery goal, study participants also described the recovery process to include both improvements and regressions, which is also consistent with the stages of change approach previously discussed. Consumer and staff considered relapse to be part of the recovery process because of this nonlinearity:

> I really do think that *relapse is a part of recovery* [emphasis added]. I think that anyone who is in recovery has had unsuccessful efforts to stop or control use, and I think that's just kind of, I think, more practical. That's what's happening in people's lives when they're in recovery. (staff)

One study participant's discussion of his experience being kicked out of an abstinence-based housing program for a substance use relapse highlights the consumer perspective on this issue:

> Those *relapses don't define who I am. They don't define my recovery* [emphasis added]. They don't define what I'll be in the future. And they don't negate everything I did in that nineteen months [at a traditional housing program] …The relationships of primary importance in my life aren't ruined because of those, but kind of even enhanced. My relationship with myself…I know more about who I am and what I am. I'm more comfortable with that. And that helps me to, in a way, I relate to other people, these other relationships [better]. (consumer)

This statement reinforces the connections between relapse and recovery by framing it as a learning experience that helped him to move forward in other areas that were important to him in his life and to his overall recovery.

Another consumer described relapses as a vacation consumers take from their progress:

> I think people take vacations, people who are mentally ill that I know…[T]hey take their meds, they feel better, and for whatever reasons they stop taking them. And symptoms might reappear…[S]o part of it is, the person that is mentally ill being aware that if they don't take their meds then their going to maybe have some behavioral, some mental whatever's. And [they] either say "I'm gonna go through it anyway cause I'm just sick and tired of these damn medications and

> their side effects", or because they wanna drink, or because they wanna use. (consumer)

In her understanding, people choose not to take their medications because they do not want to deal with side effects that they often see as being worse than the symptoms of their mental illness or because they get something more from substance use than they do from their medications.

Staff members' reasoning for approaching relapse as part of recovery was purely for pragmatic reasons because they understood symptoms (psychotic episodes, substance use and abuse) as expressions of consumers' illnesses that were bound to express themselves:

> You can look at all the stats in the world and it's 75 percent of the people don't, do not stay abstinent or sober, however you wanna put it, after they've been through treatment and things like that. And so *there's gonna be slipups* [emphasis added]. And how are you gonna handle those slip ups? Is it one [slip up] and your out? Is it two [slip ups] and your out? I think those are things that are [what need to be considered] if that's the model [i.e., Housing First] that you're gonna go for. (staff)

This staff member demonstrates how it is important for providers working in a Housing First program that accepts people with co-occurring disorders to understand relapse as part of the recovery process because they need to be cognizant of how they are going to handle it when it inevitably occurs.

Discussion

Overall, the findings demonstrated that study participants' understandings of recovery were more consistent with those advocated by the mental health field than the substance abuse field. Three of the above themes, recovery as a process, the personal nature of recovery, and the non-linear nature of the recovery process, directly reflect definitions of recovery found within the

mental health literature (Anthony, 1993; Borg & Davidson, 2007). Also, the way in which consumers related their mental health and substance abuse recovery to their recovery from homelessness and need for stability reflects discussions of recovery as a holistic process that are frequent within mental health literature. This theme is also consistent with the findings of previous Housing First studies that have pointed to housing as an important starting point for building a strong positive identity (Benjamin Foster Henwood et al., 2013; Polvere et al., 2013). Similar themes can be found within a number of consumer-centered policies that are focused specifically on mental health recovery (Jacobson & Greenley 2001; White et al., 2005), and consistent also with the U.S. Substance Abuse and Mental Health Services Administration's (SAMHSA) mental health recovery consensus statement, as person-centeredness and self-directedness, holistic wellness, and non-linearity are all key elements within it (Del Vecchio, 2012).

These themes are not surprising within the literature on serious mental illness. However, this literature has largely focused on recovery related to a single diagnosed disorder (Hipolito, Carpenter-Song, & Whitley, 2011). As such, the findings described above are important because they **demonstrate the overlap in the experiences of those living with a single disorder and those living with co-occurring disorder**. The frequent overlap between serious mental illness and substance abuse suggests that a significant number of participants in previous recovery studies were likely living with a co-occurring disorder; however, recovery related specifically to co-occurring disorder has not been sufficiently investigated (Carter et al., 2013). Additionally, our findings demonstrate **significant overlap in consumer and staff definitions of recovery**, which, as far as the authors are aware, has not been demonstrated within a single study.

The incompatibility between abstinence-based services and definitions of recovery and the lived experiences of people living with co-occurring disorder has been discussed in the literature (Cruce et al., 2012; Davidson & White, 2007). The findings presented above add another layer to this by demonstrating both (a) that participants' discussions of recovery were more consistent with those found in the mental health literature (as opposed to the substance abuse literature) and (b) an outright refusal to accept abstinence-based definitions of recovery (not just an incompatibility of experience). Based on this, it could be reasoned that recovery from co-occurring disorder (at least within Housing First programming) might be more similar to recovery from serious mental illness than it is to recovery from substance abuse. However, this assumption rests heavily on traditional understandings of recovery as promoted within within the substance abuse treatment field, whereas recent research has demonstrated that recovery from substance use, as it is experienced by consumers, might be more variable than the strict abstinence-based definition leads one to believe (Laudet, 2007).

The social construction of mental illness is a significant theme within the mental health literature (Figert, 2011), and the findings here demonstrate how recovery can also be viewed through a constructionist lens. The way in which participants contrasted their understandings of recovery with those that they perceived were held by the larger society demonstrate how the **meaning of recovery is dependent on social context**. For many consumers and staff who participated in this study, recovery once meant the remission of symptoms associated with substance use, and improvement in mental health was seen as a secondary goal. This was when they were working or receiving services from programs that followed a strict abstinence-based approach as it related to substance use. As such, they often equated the word "recovery" with abstinence at the beginning of interviews. However, in these cases, further discussion

demonstrated that recovery in Housing First programming was different from recovery in more highly structured programs, and that it was more congruent with lived experience as it relates to co-occurring disorder.

From an organizational perspective, the findings highlight how recovery from co-occurring disorder is a process that involves interaction between individuals and program structures, processes, and philosophies in which they are embedded (Yanos, Knight, & Roe, 2007). Organizational mental health studies have demonstrated the importance of this connection (Goffman, 1961; Scheid, 2003); however, the majority of this work was conducted generations ago in traditional institutional environments. This is problematic considering that most mental health consumers today receive services in community-based settings similar to those that utilize the Housing First approach. More specifically, the findings add to the growing literature on housing as a community-based mental and behavioral health intervention (Leff et al., 2009; Tsemberis, Kent, & Respress, 2012), as they strongly suggest that the structure and overarching principles of Housing First programming (e.g., housing without treatment requirements, stagewise and person-driven goals) shapes consumer and staff recovery experiences and understandings in ways that are different from the programs they were previously engaged in. It may indeed be the structure of Housing First programming that led to the significant overlap between consumer and staff understandings and experience.

Regarding the study's limitations, the findings here represent a unique subpopulation of people living with co-occurring disorder (i.e., those who are formerly chronically homeless and living in Housing First programming) within a limited geographic area and might not be generalizable beyond this group. However, the collection of data from multiple programs does improve the theoretical generalizability of the findings beyond that of previous Housing First

studies (Eisenhardt & Graebner, 2007). Additionally, the collection of data from both staff and consumers is a particular strength of this study, as it allows for the concept of recovery to be assessed from multiple levels (Loveland, Weaver Randal, & Corrigan, 2005)—thus enhancing validity (Patton, 2002). Because of the retrospective nature of study participants' discussions of their prior programs, the extent to which they struggled with abstinence-only definitions of recovery before encountering their current Housing First programs cannot be ascertained. An interesting question to investigate in future studies might be whether and how participants' understandings of recovery change over time? Additionally, there is a need for future quantitative work in this area that investigates the connection between various recovery-centered outcomes and the different structures, processes, and philosophical orientations guiding service provision.

Authors X and Y declare that they have no conflict of interest.

All procedures followed were in accordance with the ethical standards of the responsible committee on human experimentation (institutional and national) and with the Helsinki Declaration of 1975, as revised in 2000 (5). Informed consent was obtained from all patients for being included in the study.

References

Abram, K. M., & Teplin, L. A. (1991). Co-occurring disorders among mentally ill jail detainees: Implications for public policy. *American Psychologist, 46*(10), 1036–1045. doi:10.1037//0003-066X.46.10.1036

Alcoholics Anonymous. (1939). *The big book*. New York, NY: Alcoholics Anonymous World Services.

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal, 16*(4), 11-23. doi:10.1037/h0095655

Bean, K. F., Shafer, M. S., & Glennon, M. (2013). The impact of housing first and peer support on people who are medically vulnerable and homeless. *Psychiatric Rehabilitation Journal, 36*(1), 48–50. doi:10.1037/h0094748

Bond, G. R., Salyers, M. P., Rollins, A. L., Rapp, C. A., & Zipple, A. M. (2004). How evidence-based practices contribute to community integration. *Community Mental Health Journal, 40*(6), 569–88. doi:10.1007/s10597-005-2603-7

Borg, M., & Davidson, L. (2007). The nature of recovery as lived in everyday experience. *Journal of Mental Health, 17*(2), 129–140. doi:10.1080/09638230701498382

Cabassa, L. J., Nicasio, A., & Whitley, R. (2013). Picturing recovery: A photovoice exploration of recovery dimensions among people with serious mental illness. *Psychiatric Services, 64*(9), 837–842. doi:10.1176/appi.ps.201200503

Carter, M., Fisher, C., & Isaac, M. (2013). Recovery from comorbidity: Depression or anxiety with alcohol misuse—A systematic and integrative supradisciplinary review and critical appraisal. *SAGE Open, 3*(4), 2158244013512133. doi:10.1177/2158244013512133

Caton, C. L., Dominguez, B., Schanzer, B., Hasin, D. S., Shrout, P. E., Felix, A., … Hsu, E. (2005). Risk factors for long-term homelessness: Findings from a longitudinal study of first-time homeless single adults. *American Journal of Public Health*, *95*(10), 1753–1759. doi:10.2105/AJPH.2005.063321

Collins, S. E., Malone, D. K., & Clifasefi, S. L. (2013). Housing retention in single-site Housing First for chronically homeless individuals with severe alcohol problems. *American Journal of Public Health, 103*(S2), S269-S274. doi:10.2105/AJPH.2013.301312

Cruce, G., Öjehagen, A., & Nordström, M. (2012). Recovery-promoting care as experienced by persons with severe mental Illness and substance misuse. *International Journal of Mental Health and Addiction, 10*(5), 660–669. doi:10.1007/s11469-011-9363-0

Davidson, L., & White, W. (2007). The Concept of Recovery as an Organizing Principle for Integrating Mental Health and Addiction Services. *The Journal of Behavioral Health Services and Research, 34*(2), 109–120. doi:10.1007/s11414-007-9053-7

Deegan, P. E., & Drake, R. E. (2006). Shared decision making and medication management in the recovery process. *Psychiatric Services, 57*(11), 1636–1639. doi:10.1176/appi.ps.57.11.1636

Del Vecchio, P. (2012, March 23). *SAMHSA's Working Definition of Recovery Updated*. Retrieved from http://blog.samhsa.gov/2012/03/23/defintion-of-recovery-updated/

DiClemente, C. C., & Velasquez, M. M. (2002). Motivational interviewing and the stages of change. In W. R. Miller & S. Rollnick (Eds.), *Motivational interviewing: Preparing people for change* (pp. 201–216). New York, NY: Guilford Press.

Drake, R. E., O'Neal, E. L., & Wallach, M. A. (2008). A systematic review of psychosocial research on psychosocial interventions for people with co-occurring severe mental and substance use disorders. *Journal of Substance Abuse Treatment*, *34*(1), 123–138. doi:10.1016/j.jsat.2007.01.011

Drake, R. E., Wallach, M. A., & Hoffman, J. S. (1989). Housing instability and homelessness among aftercare patients of an urban state hospital. *Hospital Community Psychiatry*, *40*(1), 46–51.

Eisenhardt, K. M. (1989). Building theories from case study research. *The Academy of Management Review*, *14*(4), 532-550. doi: 10.5465/AMR.1989.4308385

Eisenhardt, K. M., & Graebner, M. E. (2007). Theory building from cases: Opportunities and challenges. *Academy of Management Journal*, *50*(1), 25–32. doi: 10.5465/AMJ.2007.24160888

Figert, A. E. (2011). The consumer turn in medicalization: Future directions with historical foundations. In B. A. Pescosolido, J. K. Martin, J. D. McLeod, & A. Rogers (Eds.), *Handbook of the sociology of health, illness, and healing: A blueprint for the 21st century* (pp. 291–307). New York, NY: Springer.

Goffman, E. (1961). The moral career of the mental patient. In E. Goffman (Author), *Asylums: Essays on the social situation of mental patients and other inmates* (pp. 125–169). New York, NY: Anchor Books.

Hansen Löfstrand, C., & Juhila, K. (2012). The discourse of consumer choice in the Pathways Housing First Model. *European Journal of Homelessness*, *6*(2), 47–68.

Henwood, B. F., Hsu, H.-T., Dent, D., Winetrobe, H., Carranza, A., & Wenzel, S. (2013). Transitioning from homelessness: A "fresh-start" event. *Journal of the Society for Social Work and Research*, *4*(1). doi:10.5243/jsswr.2010.

Henwood, B. F., Padgett, D. K., Smith, B. T., & Tiderington, E. (2012). Substance abuse recovery after experiencing homelessness and mental illness: Case studies of change over time. *Journal of Dual Diagnosis*, *8*(3), 238–246. doi:10.1080/15504263.2012.697448

Hipolito, M. M. S., Carpenter-Song, E., & Whitley, R. (2011). Meanings of recovery from the perspective of people with dual diagnosis. *Journal of Dual Diagnosis*, *7*(3), 141–149. doi:10.1080/15504263.2011.592392

Jacobson, N., & Greenley, D. (2001). What is recovery? A conceptual model and explication. *Psychiatric Services*, *52*(4), 482–485. doi:10.1176/appi.ps.52.4.482

Kessler, R. C., Chiu, W. T., Demler, O., Merikangas, K. R., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-Month DSM-IV disorders in the national comorbidity survey replication. *Archives of General Psychiatry*, *62*(6), 617–627. doi:10.1001/archpsyc.62.6.617

Kirst, M., Zerger, S., Harris, D. W., Plenert, E., & Stergiopoulos, V. (2014). The promise of recovery: Narratives of hope among homeless individuals with mental illness

participating in a Housing First randomised controlled trial in Toronto, Canada. *BMJ Open*, *4*(3), e004379. doi:10.1136/bmjopen-2013-004379

Laudet, A. B. (2007). What does recovery mean to you? Lessons from the recovery experience for research and practice. *Journal of Substance Abuse Treatment*, *33*(3), 243–256. doi:10.1016/j.jsat.2007.04.014

Leff, H. S., Chow, C. M., Pepin, R., Conley, J., Allen, I. E., & Seaman, C. A. (2009). Does one size fit all? What we can and can't learn from a meta-analysis of housing models for persons with mental illness. *Psychiatric Services*, *60*(4), 473–482. doi:10.1176/appi.ps.60.4.473

Lietz, C. A., Lacasse, J. R., Hayes, M. J., & Cheung, J. (2014). The role of services in mental health recovery: A qualitative examination of service experiences among individuals diagnosed with serious mental illness. *Journal of the Society for Social Work and Research*, *5*(2), 000. doi:10.1086/675850

Lipsky, M. (2010). *Street-Level Bureaucracy: Dilemmas of the Individual in Public Service*. New York, NY: Russell Sage Foundation.

Loveland, D., Randall, K. W., & Corrigan, P. W. (2005). Research methods for exploring and assessing recovery. In R. O. Ralph & P. W. Corrigan (Eds.), *Recovery in mental illness: Broadening our understanding of wellness* (pp. 19–59). Washington, DC: American Psychological Association. doi: 10.1037/10848-002

Mares, A. S., & Rosenheck, R. A. (2010). Twelve-month client outcomes and service use in a multisite project for chronically homelessness adults. *The Journal of Behavioral Health Services and Research*, *37*(2), 167–183. doi:10.1007/s11414-009-9171-5

Miles, M. B., Huberman, A. M., & Saldaña, J (2014). *Qualitative data analysis: A methods sourcebook* (Third Edition edition.). Thousand Oaks, Californinia: Sage.

Masten, A. S., Best, K. M., & Garmezy, N. (1990). Resilience and development: Contributions from the study of children who overcome adversity. *Development and Psychopathology*, *2*(4), 425–444. doi:10.1017/S0954579400005812

Morse, J. M. (2012). *Qualitative health research: Creating a new discipline*. Walnut Creek, CA: Left Coast Press.

Padgett, D. K., Stanhope, V., Henwood, B. F., & Stefancic, A. (2011). Substance use outcomes among homeless clients with serious mental illness: Comparing Housing First with Treatment First programs. *Community Mental Health Journal*, *47*(2), 227–232. doi:10.1007/s10597-009-9283-7

Patterson, M. L., Rezansoff, S., Currie, L., & Somers, J. M. (2013). Trajectories of recovery among homeless adults with mental illness who participated in a randomised controlled trial of Housing First: A longitudinal, narrative analysis. *BMJ Open*, *3*(9), e003442. doi:10.1136/bmjopen-2013-003442

Patton, M. Q. (2002). *Qualitative research and evaluation methods*. Sage Publications.

Pleace, N., & Bretherton, J. (2013). The case for Housing First in the European Union: A critical evaluation of concerns about effectiveness. *European Journal of Homelessness _ Volume*, *7*(2). Retrieved from http://www.york.ac.uk/media/chp/documents/2013/np_and_jb.pdf

Polvere, L., Macnaughton, E., & Piat, M. (2013). Participant perspectives on Housing First and recovery: Early findings from the At Home/Chez Soi project. *Psychiatric Rehabilitation Journal*, *36*(2), 110–112. doi:10.1037/h0094979

Sadowski, L. S., Kee, R. A., VanderWeele, T. J., & Buchanan, D. (2009). Effect of a housing and case management program on emergency department visits and hospitalizations among chronically ill homeless adults: A randomized trial. *Journal of the American Medical Association, 301*(17), 1771–1778. doi:10.1001/jama.2009.561

Scheid, T. L. (2003). Managed care and the rationalization of mental health services. *Journal of Health and Social Behavior, 44*(2), 142–161.

Susser, E. S., Lin, S. P., & Conover, S. A. (1991). Risk factors for homelessness among patients admitted to a state mental hospital. *American Journal of Psychiatry*, *148*(12), 1659–1664.

Tsemberis, S. (1999). From streets to homes: An innovative approach to supported housing for homeless adults with psychiatric disabilities. *Journal of Community Psychology, 27*(2), 225–241. doi:10.1002/(SICI)1520-6629(199903)27:2<225::AID-JCOP9>3.0.CO;2-Y

Tsemberis, S., Kent, D., & Respress, C. (2012). Housing stability and recovery among chronically homeless persons with co-occuring disorders in Washington, DC. *American Journal of Public Health, 102*(1), 13–16. doi:10.2105/AJPH.2011.300320

Watson, D. P., Orwat, J., Wagner, D. E., Shuman, V., & Tolliver, R. (2013). The Housing First Model (HFM) Fidelity Index: Designing and testing a tool for measuring integrity of housing programs that serve active substance users. *Substance Abuse Treatment, Prevention, and Policy, 8*(1), 16. doi:10.1186/1747-597X-8-16

Watson, D. P., Wagner, D. E., & Rivers, M. M. (2013). Understanding the critical ingredients for facilitating consumer change in Housing First programming: A case study approach. *The Journal of Behavioral Health Services & Research, 40*(2), 169–179. doi:10.1007/s11414-012-9312-0

White, W., Boyle, M., & Loveland, D. (2005). Recovery from addiction and from mental illness: Shared and contrasting lessons. In R. O. Ralph & P. W. Corrigan (Eds.), *Recovery in mental illness: Broadening our understanding of wellness* (pp. 233–258). Washington, DC: American Psychological Association.

Yanos, P. T., Knight, E. L., & Roe, D. (2007). Recognizing a role for structure and agency: Integrating sociological perspectives into the study of recovery from severe mental illness. In W. R. Avison, J. D. McLeod, & B. A. Pescosolido (Eds.), *Mental health, social mirror* (pp. 407–436). New York, NY: Springer.

Table 1

Characteristics of Sample Programs (n = 4)

Program	Consumer capacity	Target population	Years providing Housing First programming	Housing type
1	54	Chronic homeless with dual diagnosis	11	Single-site
2	93	Homeless women	8	Single-site
3	38	Homeless men with dual diagnosis	7	Multiple-site
4	10	Homeless with HIV/AIDS	7	Multiple-site

Table 2

Consumer and Staff Demographics by Data Collection Activity Participated

	Focus group only	Interview only	Focus group & interview	Total	Percent
Consumers (total =37)					
Gender					
Female	10	7	2	19	51%
Male	6	6	6	18	49%
Race					
African American	13	8	7	28	76%
Caucasian	3	5	1	9	24%
Hispanic/Latino	3	0	0	3	8%
Staff (total = 23)					
Gender					
Female	6	3	7	16	70%
Male	1	1	5	7	30%
Race					
African American	4	2	5	11	48%
Caucasian	3	2	7	12	52%
Hispanic/Latino	0	0	1	1	4%