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In their own words: Content analysis of pathways to recovery among individuals with the lived experience of homelessness and alcohol use disorders

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Abstract

Background—Alcohol use disorders (AUDs) are more prevalent among homeless individuals than in the general population, and homeless individuals are disproportionately affected by alcohol-related morbidity and mortality. Unfortunately, abstinence-based approaches are neither desirable to nor highly effective for most members of this population. Recent research has indicated that homeless people aspire to clinically significant recovery goals beyond alcohol abstinence, including alcohol harm reduction and quality-of-life improvement. However, no research has documented this population's preferred pathways toward self-defined recovery. Considering principles of patient-centred care, a richer understanding of this population's desired pathways to recovery may help providers better engage and support them.

Methods—Participants (N = 50) had lived experience of homelessness and AUDs and participated in semi-structured interviews regarding histories of homelessness, alcohol use, and abstinence-based treatment as well as suggestions for improving alcohol treatment. Conventional content analysis was used to ascertain participants' perceptions of abstinence-based treatment and mutual-help modalities, while it additionally revealed alternative pathways to recovery.

Results—Most participants reported involvement in abstinence-based modalities for reasons other than the goal of achieving long-term abstinence from alcohol (e.g., having shelter in winter months, "taking a break" from alcohol use, being among "like-minded people"). In contrast, most participants preferred alternative pathways to recovery, including fulfilling basic needs (e.g., obtaining housing), using harm reduction approaches (e.g., switching from higher to lower alcohol

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content beverages), engaging in meaningful activities (e.g., art, outings, spiritual/cultural activities), and making positive social connections.

Conclusions—Most people with the lived experience of homelessness and AUDs we interviewed were uninterested in abstinence-based modalities as a means of attaining long-term alcohol abstinence. These individuals do, however, have creative ideas about alternative pathways to recovery that treatment providers may support to reduce alcohol-related harm and enhance quality of life.

Keywords

Pathways to recovery; Homelessness; Alcohol use; Drinking; Qualitative analysis; Content analysis

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The prevalence of alcohol use disorders (AUDs) is 10 times greater among homeless individuals than in the general population (Fazel, Khosla, Doll, & Geddes, 2008; Grant et al., 2004) and homeless individuals are disproportionately affected by alcohol-related morbidity and mortality (Hwang, Wilkins, Tjepkema, O'Campo, & Dunn, 2009). As a result of these alcohol-related problems and lack of resources, homeless people with AUDs repeatedly and disproportionately access emergency medical and criminal justice services and thereby place considerable utilization and cost strains on publicly funded systems (Dunford et al., 2006; Kushel, Perry, Bangsberg, & Clark, 2002; Larimer et al., 2009).

One potential solution would be to increase these individuals' access to alcohol treatment. Lack of interest in abstinence-based goals and approaches, however, poses a significant barrier to treatment engagement (Collins et al., 2012; SAMHSA, 2014). Thus, abstinence-based approaches are neither desirable to nor highly effective for this population (Collins et al., 2012; Hwang, Tolomiczenko, Kouyoumdjian, & Garner, 2006; Orwin, Scott, & Arieira, 2005; Zerger, 2002). In fact, previous work has shown that individuals in this population have made, on average, 16 abstinence-based treatment attempts during their lifetimes (Larimer et al., 2009). Theoretical and empirical data suggest that such repeated, 'failed' treatment attempts may erode self-efficacy and self-control for later behaviour change (Marlatt & Gordon, 1985; Muraven & Baumeister, 2000).

Although existing alcohol treatments have been neither highly engaging nor effective for this population, treatment experiences have contributed to these individuals' knowledge about recovery goals and pathways to recovery. Recent research has indicated that these individuals have clinically meaningful recovery goals beyond the preset, abstinence-based goals that are prescribed in traditional, abstinence-based modalities (Collins et al., 2015). Some of these self-generated goals are nonabstinence-based, alcohol-related goals (e.g., decreasing alcohol-related harm, reducing alcohol use), whereas others involve quality-of-life or health improvement (Collins et al., 2015). Thus, patient-defined recovery does not always involve abstinence, and recovery means different things to different people. Research has also indicated that alcohol use is not static; intermittent or even sustained abstinence or use reduction is a part of many individuals' alcohol use trajectories (Klingemann, Sobell, & Sobell, 2010; Witbrodt, Borkman, Stunz, & Subbaraman, 2015). Taken together, the aforementioned studies have indicated that (a) alcohol use and other behaviours related to

health and quality of life are malleable and (b) many members of this population are interested in and have successfully engaged in behaviour change in pursuit of their own recovery goals. No research to date, however, has documented this population's self-defined pathways to recovery.

Documenting self-defined pathways to recovery is important for the development of more relevant and effective patient-centred interventions. Patient-centred interventions require a comprehensive understanding of peoples' values, preferences and needs (IOM, 2001). Enhanced understanding of this population's lived experience may help providers (a) more effectively engage homeless people with AUDs and (b) better capitalize on their existing knowledge and experience with behaviour change (Buck, Rochon, Davidson, McCurdy, & McCurdy, 2004). In this way, homeless individuals with AUDs can guide the development of more relevant and effective treatment to better address the needs of this multimorbid and high systems-utilizing population.

This study features a conventional content analysis of interviews with individuals with the lived experience of homelessness and AUDs. The aim of this study was to describe—in their own words—participants' perceptions of various pathways to recovery, including both existing treatment modalities and self-defined pathways to recovery.

Method

Participants

Participants were 50 individuals with the lived experience of AUDs and homelessness who were recruited from local agencies serving homeless individuals by providing low-barrier shelter or housing in Seattle, Washington. These settings also offered onsite nursing, some meals, programming (e.g., drop-in groups), and case management. Participants were purposively sampled to include individuals in various stages of self-defined recovery as well as both currently or formerly homeless individuals. According to the US federal definition, homelessness is lacking a fixed, regular and adequate nighttime residence; having a primary nighttime dwelling that is not a regular sleeping accommodation; living in a supervised shelter or transitional housing; exiting an institution that served as temporary residence when the individual had previously resided in a shelter or place not meant for human habitation; or facing imminent loss of housing when no subsequent residence is identified and insufficient resources/support networks exist (The McKinney-Vento Homeless Assistance Act, 2009). Although no formal diagnostic assessments were conducted as a part of this study, all participants had severe alcohol use disorders as this was a primary criterion for entry into these particular community-based services.

Participants had an average age of 53.24 (*SD* = 7.39) years and were predominantly male (16% female; *n* = 8). Of the overall sample, 46% self-identified as White/European American, 24% as American Indian/Alaska Native/First Nations, 18% as Multiracial (all of whom identified as American Indian/Alaska Native plus another race), 10% as Black/African American, and 2% as Other. Additionally, 8.5% of the sample identified as Hispanic/Latino(a).

Measures

A set of single-item sociodemographic questions assessed participants' age, gender, race and ethnicity. These items were used to provide the sample description.

Open-ended prompts were used in interviews to ascertain potential pathways to recovery. Prompts included: "What kinds of services do you participate in right now that you find helpful?" "A lot of treatment programs ask people to stop drinking. Have you been to such a treatment program? If so, what was that like for you?" "How would you describe the role that alcohol plays in your life?" "If you could make the perfect treatment, how would that look?" These prompts were part of a larger, semi-structured interview that comprised open-ended questions about participants' experiences of homelessness, alcohol use, and treatment, as well as suggestions for enhancement of treatment, supportive services, and housing programs.

Procedures

Interested individuals were identified by staff at agencies where participants were seeking services to address co-occurring AUDs and homelessness. Research staff then approached those individuals at the agency sites to ask if they would like to participate. Interested individuals were provided with an explanation of the purpose and procedures of the study, as well as their rights and roles as participants. After obtaining written, informed consent, research staff conducted 45- to 60-min interviews using the aforementioned prompts. Participants received a $20 payment upon completion of the interview. All procedures were reviewed and approved by the Institutional Review Board at the University of Washington.

Data management and analysis plan

Sessions were audio recorded and transcribed for qualitative analysis. Transcripts were stripped of identifying information prior to data coding. The goal was to provide a conventional content analysis of pathways to recovery. Conventional content analysis is a qualitative research method used to interpret the content of text data through a systematic classification process involving coding and identifying themes (Hsieh & Shannon, 2005; Krippendorff, 2004) In conventional content analysis, the researcher does not start with preconceived, theory-based notions about what types or categories of codes will be identified. Instead, the researcher allows the data to drive the codes and categories (Hsieh & Shannon, 2005).

Atlas.ti version 7 (Friese, 2012) was used to manage study data. Qualitative data were independently coded using a constant comparative process (Charmaz, 2006; Miles & Huberman, 1994). Initial coding was conducted using a line-by-line technique, whereby coders narrated the actions occurring in the interviews (Charmaz, 2006). Following independently conducted initial coding, we created a codebook during consensus meetings, wherein incident-by-incident codes were pooled and idiosyncratic or redundant codes were collapsed or removed. In the next coding phase, we used the codebook to independently double-code 10% of the interviews until adequate intercoder consistency (80%) was established (Miles & Huberman, 1994; Shek, Tang, & Han, 2005). Any discrepancies and issues in coding were addressed during weekly coding meetings and resolved via consensus.

Once adequate intercoder consistency was achieved (81.3%), the remaining interviews were coded independently. We reviewed primary findings with a subset of participants prior and subsequent to the drafting of this manuscript (i.e., member checking) and took additional steps to ensure resonance (i.e., portraying an adequately complete picture of participants' experience), credibility (i.e., ensuring logic of and sufficient groundedness of codes and themes), and usefulness (i.e., offering interpretations that can further work in this field) (Charmaz, 2006).

Results

Pathways to recovery were means participants had used, were currently using, were hoping to use, or were planning to use to achieve their self-defined recovery goals. Pathways to recovery encompassed both formalized, well-established approaches (e.g., abstinence-based treatment and mutual-help support groups) as well as self-defined pathways to recovery. The latter pathways included any alternative means used that participants explicitly connected to positive outcomes or goal achievement.

Formalized abstinence-based approaches

Participants described two primary exposures to abstinence-based approaches: abstinence-based treatment and mutual help groups (i.e., twelve-step groups). Because participants often referred to them together, we discuss both in this section, differentiating between quotes applying to more formalized treatment and peer-led, mutual help groups.

The topic of abstinence-based approaches elicited mixed responses from participants, sometimes within the same interview. The primary themes that emerged regarding formalized, abstinence-based approaches were not unidimensional but dialectical in nature. They included (a) relationships (appreciating affiliation versus resenting power imbalances), (b) expectations (viewing inpatient treatment as a 'time out' versus a 'sit and spin'), and (c) institutionalization (seeking stability versus rejecting institutional control).

Relationships: appreciating affiliation and resenting power imbalances

Participants valued some relationships they had formed within abstinence-based settings, particularly noting the importance of providers' and peers' humility, empathy and sense of collaboration. For example, one participant valued "the [counsellor] who actually admits that he's not infallible." He went on to say "the best [counsellor he] ever had … was more of a listener. Unless he felt there was a point where he needed to interject, he pretty much let the group run itself. That was the one treatment that worked for a while." Another participant highlighted the social support in twelve-step groups: "I've gone to AA, and it does help because you're around like-minded people."

In contrast, some participants resented the power imbalances they experienced in relationships in abstinence-based settings. Providers in abstinence-based treatment settings were described as hierarchically minded, "high and mighty," and keeping patients "under [their] thumb all the time." One participant who had achieved abstinence said, "I feel that way, too, so I understand it now [that I am abstinent], but that's not the right attitude to use." The same participant suggested providers instead "listen to us. Find a way to compromise …

Work with me instead of telling me what to do. Come up with a plan that works for both of us … I think that would help everybody in treatment." Concerns about power imbalances were also present when participants expressed their thoughts about abstinence-based mutual help groups. One participant stated, "You go in there, and there are people who are already there. Everybody's at different levels. 'I've got 28 days sober!' And you're a god!"

Expectations: viewing inpatient treatment as a 'time out' versus 'sit and spin'

Participants' expectations of abstinence-based modalities varied. Some participants valued inpatient treatment as a "time out" from the hardships of life on the streets and from the 24-hour job of obtaining, drinking, and recovering from the effects of alcohol. One participant said, "It gives you a little bit of time to clean your system out." Another participant noted that "it was just to get out of the cold. You'd never caught my butt in one during the summer." Participants typically did not view formalized, abstinence-based treatment as an effective pathway to maintaining long-term abstinence. As one participant concluded, "There's a place in your life where you've been drinking that hard and that long. You just want to take a time out, and treatment is safe because it is a safe place … to get healthy again. And then, you come home and you feel better and you go crack a beer … Treatment wasn't really about getting sober."

Conversely, the temporary respite afforded by inpatient treatment was perceived negatively by some participants. These participants reported that treatment didactics on managing craving and avoiding relapse inadequately prepared them to maintain abstinence in their day-to-day lives. One participant referred to it as "just a game" and went on to say,

> It's a fucking dry-out session. They call it 'sit-and-spin.' Twenty-eight days is a sit-and-spin. You're getting healthy, then you're out. And you go straight to [the convenience store] or straight to the fucking liquor store or whatever. Sit-and-spin is 28 days. It's worthless. Some people, maybe … most of them, no. It doesn't work.

Another participant reported that abstinence-based, inpatient treatment lulls people into a sense of safety and security they cannot replicate when they return to homelessness. He maintained that this illusion can increase individuals' vulnerability on the streets.

> Treatment is vacation. So, then you come back into the world, and you find out very, very quickly that practically no one is on the same page as you as far as … being open and honest. You come back on the streets, and the blade's still there… The bar you went to is still there… The dope man is still there. And there you are with this brand-new, 'just-got-out-of-treatment' thing.

Institutionalization: seeking stability versus resisting institutional control

Some participants valued the sense of stability that inpatient, abstinence-based treatment provided. One participant equated being in inpatient treatment to "being a normal person… You have meals at the same time, you go to bed at the same time, you're around the same people, you know what's going to happen next, and there's a rhythm to it."

Most individuals, however, expressed concerns about institutionalization within abstinence-based treatment facilities, which underscored feelings of marginalization. One participant had been to private treatment facilities when her employer had paid for them, but since becoming homeless, had been relegated to increasingly poorly maintained facilities. That participant wondered if this signalled an institutional disparity based on socioeconomic disadvantage. She said, “I don’t know if the staff is paid as well in these places or if they care as much, but that has been something that I’ve realized: There’s a place that well-to-do people go and are cared for in a certain way, and there’s a place that poor people go and are cared for in another way, and I don’t know if that’s societal or what.” A sentiment of marginalization was shared regarding peers in mutual help groups. One participant noted, “Oh, this ‘AA all the way,’ and ‘the only way to stay sober is AA’ … There are other ways to stay sober … And, you know, you just feel like when you go to AA, you feel like you’re a failure.”

Within abstinence-based institutions, many participants felt the rules and practices were oppressive, particularly when these were at odds with their personal belief systems and interests. One participant recounted, “We can’t drink. You gotta study God … I don’t even think you can smoke in [inpatient, abstinence-based treatment] anymore. And it was just good food, good people, sober people, but it was still—I just hated it. I didn’t like the twelve steps. Never have, never will.” Another participant said, “I was forced to come here, but I’m still here. I’m following the rules. Take the leash off, and let me have at least a little bit of freedom. That was jail without the bars. That’s basically how I felt.”

Alternative, self-defined pathways to recovery

Participants were explicitly asked about perceived positive and negative aspects of abstinence-based approaches. In the course of their interviews, however, many participants spontaneously shared their thoughts on alternative pathways to recovery they had successfully used, were using, or hoped to use to achieve their self-defined recovery goals. As shown in Table 1, alternative pathways to recovery were diverse in their nature, and nearly all participants (96%) mentioned using at least one. In the following sections, we report in more detail on the alternative pathways described by the majority (>50%) of participants.

Basic needs fulfilment

As shown in Table 1, the most frequently mentioned alternative pathway to recovery entailed participants getting their basic needs met. Attaining and maintaining housing was viewed as a fundamental step in being able to set and pursue other goals. Those participants who had finally attained permanent, supportive housing after many years on the streets were very happy about this fact. One participant said, “Actually, this is the first place that I’ve lived in for four whole consecutive years and have not moved in my life. It’s totally awesome.” Another participant said he was “happy to get off the street … happy to lay in a nice bed.” Many participants who had achieved permanent, supportive housing indicated that in-house staffing and services were also important. For example, one participant recounted that he had been “in and out of the hospital a lot, and [staff] call me on the intercom, make sure I’m ok. Yesterday, I had an appointment with the psychiatrist. He

called me and reminded me of that. I feel like I am taken care of because it's a 24-hour staff, and I know them, and they know me." Permanent, supportive housing was viewed as a foundation from which participants could make choices about their lives. As one participant concluded, "You have your own freedom to do what you want." After citing housing attainment as a primary pathway to recovery, participants reported that fulfilment of other basic needs was also fundamental to helping them achieve their goals. Among these were obtaining social services, such as social security disability payments and health insurance (see Table 1).

Harm reduction counselling

The second most frequently mentioned alternative pathway to recovery was engagement in harm reduction counselling within participants' service provision in the community. Most participants had experienced counselling in harm-reduction oriented housing, shelter or case management settings, where case managers' and counsellors' primary guiding principle was to 'meet people where they're at' both in the community and in their motivation to change (Collins et al., 2011). One participant shared his experience of learning about harm reduction after many stints in abstinence-based treatment, shelter and housing settings: "I think that harm reduction is basically in its infancy … I didn't hear about it until I moved here … The thought of meeting someone where they're at and getting them to have the willingness to make even subtle changes to make life better … I hear that loud and clear … There no is one-size-fits-all."

Participants noted the qualities most desired in providers are being a good listener, conveying acceptance, and respecting people's autonomy. These aspects are summarized in one participant's perspectives on harm reduction providers, "[In this setting] it's ok to be what you are, and if it's drunk every day, it's drunk every day … It's good to have encouragement, but I also know that if I get drunk tomorrow, [my provider] is not going to go, 'Oh, God!' It's just, 'Okay.' There are many pathways to recovery."

Another aspect of harm reduction counselling that participants considered crucial was being viewed as a multifaceted individual and not just as someone with an AUD. As long as providers held to this perspective, many participants were interested in counselling and felt they and their peers could benefit from it. One participant observed, "Everybody needs a little bit more counselling. The counsellors need to talk to them more … Make them not stop [drinking] but slow down." When asked about suggestions for approaches providers could use during counselling, one participant shared, "I really have no problem with drinking. I would like to talk about my goals." This point was repeated by various participants; however, different participants were interested in different modalities. On the one hand, some participants were interested in talking about their goals in a group setting with their peers, because "a group might offer a wider stance of opinions." On the other hand, some participants wanted to talk about their goals more privately in one-on-one sessions with a professional.

Despite their general interest, some participants were reluctant to participate in counselling given the high degree of provider turnover in the settings they attended. One participant asked, "Why go through it again? You know answering all those questions …. It's hard to,

you know, have to face that new person or new counsellor when they come in because you don't know what they're like until you get yourself introduced to them and see how they're real and react toward you." Thus, participants recommended having more consistency in providers to ensure trust-building and a more secure therapeutic alliance: "[My counsellor's] been here for a year and a half … He knows me because we've gotten to know each other over these months. So, I trust him."

Engagement in meaningful activities

Most participants valued hobbies and occupations that imparted a sense of meaning to their lives. These meaningful activities included artistic endeavours (e.g., music, painting, writing), outings (e.g., going to libraries, museums, zoos), engagement in ethnic and religious communities (attending events at cultural centres, participation in church or spiritual services), educational classes, working, and volunteering.

Participants also drew connections between engagement in meaningful activities and reductions in alcohol use, improvement in quality of life, and achievement of recovery goals. For example, one participant talked about the importance of fishing as a hobby and noted that "only once in a while I would drink when I was fishing … because I was skipper out there. No hard liquor." Fishing provided him with time away from drinking and was also an activity from which he derived pleasure and a sense of responsibility (i.e., piloting a fishing boat).

Another participant shared an ongoing, transactional relationship between engagement in meaningful activities and drinking reduction:

> Participant: I enjoy drinking on occasion, but not like I used to every day, where it was an obsession, a compulsion. And that, for me, was an excruciation exercise. I was training my mind not to think about alcohol. And when I finally did that, I noticed my behaviour change as well.
>
> Interviewer: What did you notice about your behaviour change and what do you feel like changed?
>
> Participant: I wasn't drinking all the time. And I was doing other things. You know, like reading a book or just going for a walk, window shopping or going to [an outdoor community space] and being surprised that there's something happening out there.

Based on his lived experience, another participant shared suggestions for using meaningful activities to initially distract from and eventually unlearn drinking behaviours:

> Being part of nature, and not [having] to be involved with taverns or bars or things of this nature. Just be distracted temporarily. And do it enough times, and it becomes somebody's mindset … It becomes a part of daily behaviour. Like you—I—can go days without drinking. There's times when I actually avoid it, or even if somebody offers me a beer, I say, "You know what? I don't want to drink today."

Building and fostering of social networks

Participants cited social connections, particularly serving others and relying on others for support, as important pathways to recovery. One participant was excited to have been nominated "Resident of the Month" in his new housing program. He reported, "I help them where I can help. I see people that live on this floor that don't have much. So, when I am cooking, give me a plate. Yeah, come on over and eat."

Some participants expressed concern about their peers' health and well-being and that they looked out for one another. One participant noted, "I'm not a medic but I was keeping tabs on his foot, and I kept telling him, 'You need to go to [safety net hospital]. I would go with you.' And then he was telling me, 'No, my appointment's not until the 17th.' I was trying to get him in [early] because I noticed what was going on with his foot, and I was concerned about that. So, I had a talk with [his case manager]."

One participant who had isolated herself in the early phases of her recovery talked about how making social connections was a positive experience for her: "I'm like, 'Wow! Today I am going to go ask [name] if he wants to go get a smoothie … But [name] and I didn't know where we could get a smoothie, and I didn't even know what a smoothie was. This is how out of step I am with reality … Then he said, 'Let's go over to the food court, and we'll talk.' And I didn't really want to do that, but I did. I ended up having a really wonderful time. And I'm glad I did it." She went on to express how becoming more socially engaged helped her to integrate into the larger community, which created a positive feedback loop:

> Well, [name] walked by in the same food court, and he sat down with us. So, here's three of us from [housing project] sitting down and having a conversation. We're among regular people, and we don't feel like we are outcasts. My lifestyle now, I don't feel like an outcast. I don't feel like everyone is looking at me and going, "What's wrong with her? Run!" I know that's probably what I looked like to people who were clean and sober for a while; people out there who are judgmental.

Natural alcohol recovery trajectories

Rounding out the most frequently mentioned pathways to recovery was natural recovery. The initial step for many individuals who described a natural recovery pathway was recognition of the negative consequences of their drinking. For some, recognizing the negative consequences entailed a discrete experience akin to hitting rock bottom. For example, one participant recalled,

> Uh, found her in bed with, with her boyfriend, right? And I had a [firearm]. And so I considered killing 'em both. And I said, "Fuck this shit, man." So, I jump in my truck and, went back home. And stopped drinking, stopped doing drugs.

For others, this process was more a slow recognition of accumulating or persistent negative alcohol-related consequences over time. This recognition precipitated participants' decision to make changes to avoid or reduce negative alcohol-related consequences. For example, one participant stated, "You know one thing I don't do anymore? Get drunk … Because, you know, if I hurt myself, I'm gonna be in the hospital." Another person recounted:

> I learned not to pick up another beer. Every day I remind myself that it just don't mix with my medicines I've taken. I tried it so many times, and I know the results if I do. I know the consequences. I could lose my place like I did before. I could lose my housing. Lose everything, you know? If I drink again, I'll get back to my old habits. I don't like that. That's the past.

When asked how they were able to or hoped to make the desired changes to their drinking, many participants said they had achieved or wanted to achieve their recovery goals on their own, without formalized treatment. As one participant resolved, "I ain't gonna wait for anybody to figure it out for me, so I have to do it myself. Find a solution and march on."

Some participants mentioned specific harm-reduction strategies they used to reduce alcohol-related harm or to taper their use prior to quitting. One frequently mentioned strategy was changing from beverages with higher to lower alcohol content, such as taking "a break from hard liquor, you know. Just beers and something." Another was slowly reducing use over time: "I used to drink 20, 24-ounce [malt liquors] … then, eventually, I weaned myself to like 6 cans a day." Avoiding triggers to heavy drinking was another common strategy. For instance, one participant stated, "If there is a group of people that are drinking a whole bunch…I reach a certain point, and I'll excuse myself. I had enough, and then I go back to my room." Participants also talked about spacing their drinks so they wouldn't become as acutely intoxicated, as well as trying to buffer the effects of alcohol on their body (e.g., "When I go to sleep I always have a jug of water on my table.")

Other participants said they chose to become abstinent for either discrete or extended periods. Those who were abstinent for discrete time periods talked about wanting to be sober for certain important activities (e.g., selling papers, volunteering) or to take a break from drinking (e.g., "Well, I just suffer with the DTs and get over them and don't drink for a few days"). Some individuals had experienced sustained periods of abstinence. Most of those individuals said they "just quit" or "just [said] no" but did not provide more specific information on how they achieved abstinence (e.g., "I don't know. I just don't want to drink no more."). Few participants associated maintenance of longer-term abstinence with abstinence-based treatment attendance, and those participants typically also mentioned that reconnecting with family, obtaining housing, and having other needs met were also essential to their recovery.

Discussion

The present study is the first to document perceptions of formalized abstinence-based modalities and preferred alternative pathways to recovery among people with the lived experience of homelessness and AUDs. Participants were asked specifically about their prior experience in abstinence-based modalities, and their responses reflected dialectic themes regarding the importance of the relationships in, expectations of, and institutionalization of both abstinence-based treatment and mutual help groups. Participants had mixed responses to abstinence-based modalities, which have been documented in other studies of homelessness and alcohol use (Collins et al., 2012; Orwin, Garrison-Mogren, Jacobs, & Sonnefeld, 1999; Padgett, Henwood, Abrams, & Davis, 2008; Zerger, 2002). Specifically,

they appreciated positive relationships with providers and peers in mutual help groups, as well the reprieve and stability found in abstinence-based inpatient treatment. Nonspecific therapeutic factors, including a collaborative and compassionate therapeutic style, were typically referred to positively. This finding corresponds to recent work that identified the therapeutic alliance as a key factor in predicting alcohol outcomes in treatment (Hartzler, Witkiewitz, Villarroel, & Donovan, 2011; Maisto et al., 2015). Participants also valued treatment for reasons unintended by providers. For example, participants referred to inpatient treatment as a brief reprieve from the streets and the 24-h demands of severe AUDs —not as a means of achieving and maintaining long-term abstinence. In contrast, some participants resented the short-lived stability that treatment affords (e.g., shelter, food, activities), which highlights the importance of prioritizing this population's fulfilment of basic needs over abstinence from substances. Ultimately, fulfilling basic needs can facilitate recovery, whereas recovery is very difficult to achieve when people's basic needs are not consistently met. (Henwood, Derejko, Couture, & Padgett, 2015) Further, participants were frustrated by the institutionalization of abstinence-based modalities and their resulting feelings of disempowerment. This sense of disempowerment paired with participants' repeated treatment 'failures' precipitate an internalized sense of shame around drinking and homelessness that may erode self-efficacy for future recovery attempts. Taken together, these findings indicate that, in this population, abstinence-based approaches do not have the desired effects of helping these individuals achieve stability, build relevant skills, and maintain abstinence in the way that treatment providers intend.

Participants spontaneously offered their views on alternative pathways to recovery that they felt had been, were currently, or could be helpful in achieving recovery and healing. The most frequently mentioned alternative pathways included meeting basic needs (e.g., housing), participating in harm-reduction counselling in service settings, engaging in meaningful activities (e.g., art, outings, attendance at cultural events), building adaptive social connections, and achieving natural recovery (e.g., tapering use on one's own). These findings indicated that people with the lived experience of homelessness and AUDs are capable of identifying and following self-defined and clinically meaningful pathways to recovery.

Limitations

This study was carried out in a specific context: in low-barrier facilities in a mid-sized progressive city in the US Pacific Northwest. Thus, findings may not generalize to other communities where such services are less available and less known to homeless people with AUDs as potential options. Further, the sociodemographic features of the sample deserve consideration. Only 16% of participants were female, whereas women represented just over a quarter of the national homeless population in 2013 (US Department, 2013, 2014). Relatedly, only 10% of participants were Black, whereas they represent over half of the US homeless population (US Department, 2013). Finally, the average age of the current sample was 53 years. Although this is representative of the larger US homeless population with AUDs, the voice of younger homeless individuals with AUDs was not well-represented in our sample (US Department, 2014). The generalizability of these findings should be carefully considered in their interpretation and application within other populations, settings,

and approaches. That said, this study is the first to document self-defined pathways to recovery in a marginalized population affected by AUDs and thereby provides an important foundation for subsequent studies.

Conclusions and future directions

Participants' voiced interest in basic needs fulfilment, positive relationship building, and self-determined recovery indicate points for alcohol treatment enhancement in this population. First, participants named fulfilment of basic needs as the primary pathway to stability and recovery. Thus, provision of permanent supportive housing, health care and other services is key to laying a strong foundation upon which positive behaviour change may be built. Second, participants indicated a need for consistent therapeutic relationships with compassionate providers who can "meet them where they are at" in their communities and in their motivation for behaviour change. Finally, participants named various clinically meaningful pathways to recovery that have and could support positive behaviour change, including engaging in harm-reduction services, participating in meaningful activities, strengthening social connections, and integrating into the broader community. Thus, this population's recovery may be best promoted by having affected individuals suggest their own goals and pathways while providers offer instrumental and moral support towards the achievement of those goals. These points should be considered by treatment and service providers to forge more patient-centred and potentially effective pathways to engagement, recovery, and healing.

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Table 1

Alternative pathways to recovery listed in rank order of percentage of unique responses.

Rank	Category	Examples	Participants endorsing %(n)
1	Basic needs fulfilment		96(48)
	Housing	"Obtaining housing is a way to avoid jail"	92(46)
	Healthcare utilization	"I did the liver treatment for Hepatitis C and I did that successfully"	58(29)
	Obtaining social services	"I did get ABD and Medicaid"	44(22)
	Obtaining goods	"So I ended up buying an arch support for $50"	40(20)
2	Harm-reduction approaches		94(47)
	Counselling	"[Counsellor] helped me get off the cheap shit. She said we'll help you. We'll put you on alcohol management."	92(46)
	Case management	"I went to the Sobering Centre a few times. One of the nurses there–they gave me a caseworker I guess."	54(27)
3	Engagement in meaningful activities	"But I go lift weights usually four times a week. So that's really helped me a lot."	84(42)
4	Building and fostering of social networks	"I like being sought after and paternal"	84(42)
5	Natural recovery trajectories		66(33)
	Not wanting help	"I ain't going to wait around for anybody to figure it out for me, so I have to do it myself"	32(16)
	Self-imposed harm reduction	"I'm back to trying not to drink hard alcohol"	28(14)
	Self-imposed abstinence	"The way I quit was just saying no"	18(9)
	Not otherwise specified	"I just sobered up somehow"	12(6)
6	Other	"You've got to be level-headed"	60(30)
7	External motivation	"I drank like everybody else, but then I–the cops caught up with me"	32(16)
8	Therapy/treatment (not substance use related)	"I got two shrinks. They help."	22(11)
9	Improved diet	"You've got to eat right"	18(9)
10	Behavioural activation	"You need to get outside a little bit more, get some fresh air, clear your mind"	18(9)
11	Substitution with less harmful drugs (i.e., cannabis)	"And after two weeks, which is how long it took me to smoke an ounce of weed, I was done. No more speed."	16(8)
12	Spirituality	"I have the Lord."	12(6)
13	Complementary and alternative medicine approaches	"It's the guided meditation."	4(2)