International Journal of Drug Policy 27 (2016) 89–96

Contents lists available at ScienceDirect

International Journal of Drug Policy

journal homepage: www.elsevier.com/locate/drugpo

Research paper

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

Susan E. Collins [a,*], Connor B. Jones [a], Gail Hoffmann [a], Lonnie A. Nelson [b], Starlyn M. Hawes [a], Véronique S. Grazioli [a], Jessica L. Mackelprang [a], Jessica Holttum [a], Greta Kaese [a], James Lenert [a], Patrick Herndon [a], Seema L. Clifasefi [a]

[a] Department of Psychiatry and Behavioral Sciences, University of Washington – Harborview Medical Center, 325 Ninth Ave, Box 359911, Seattle, WA 98104, USA
[b] Department of Health Services, University of Washington School of Public Health, 1100 Olive Way, Suite 1200, Seattle, WA 98101, USA

ARTICLE INFO

Article history:
Received 5 May 2015
Received in revised form 19 July 2015
Accepted 4 August 2015

Keywords:
Pathways to recovery
Homelessness
Alcohol use
Drinking
Qualitative analysis
Content analysis

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 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.

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

* Corresponding author. Tel.: +206 744 9181; fax: +206 744 9939.
E-mail addresses: collinss@uw.edu (S.E. Collins), cbj5@uw.edu (C.B. Jones), gaileh2@uw.edu (G. Hoffmann), lonnin@uw.edu (L.A. Nelson), hawess@uw.edu (S.M. Hawes), graziv@uw.edu (V.S. Grazioli), jlmack11uw@gmail.com (J.L. Mackelprang), jkholttum@gmail.com (J. Holttum), gmkaese@uw.edu (G. Kaese), jamesml@uw.edu (J. Lenert), herndp@uw.edu (P. Herndon), seemac@uw.edu (S.L. Clifasefi).

http://dx.doi.org/10.1016/j.drugpo.2015.08.003
0955-3959/

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