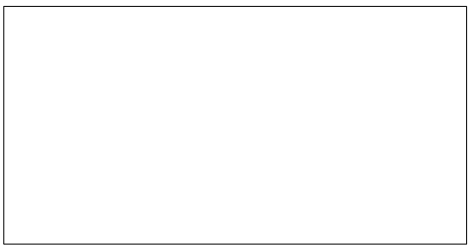
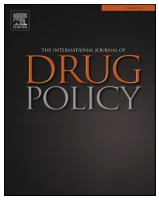


International Journal of Drug Policy 130 (2024) 104528

Contents lists available at ScienceDirect

International Journal of Drug Policy

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



Systematic Review

The recovery experiences of homeless service users with substance use disorder: A systematic review and qualitative meta-synthesis☆

Branagh R. O'Shaughnessy [a,*], Paula Mayock [a], Aimen Kakar [b]

[a] School of Social Work and Social Policy, Trinity College Dublin, College Green, Dublin 2, Ireland
[b] Carlow Psychology Clinic, Carlow, Ireland

ARTICLE INFO

Keywords:
homelessness
Substance use disorder
Recovery
Systematic review
Qualitative meta-synthesis

ABSTRACT

Background: The relationship between homelessness and substance use disorder (SUD) is layered and complex. Adults pursuing recovery while dealing with homelessness and SUD face many challenges. Little research has inspected qualitative first-person accounts of recovery in the context of homelessness and SUD, and few studies have employed conceptualisations of recovery beyond abstinence. In this systematic review study, we examine the qualitative literature on the recovery experiences of adult homeless service users with SUD.

Methods: 2,042 records were identified via database and secondary searching strategy. After title and abstract and full text screening, 15 eligible studies remained. Critical Appraisal Skills Programme quality appraisal criteria was used to assess potential bias in the studies. Meta-ethnography was employed to synthesise extracted data.

Results: Four themes were generated from the extracted data: Two sides of the Service Coin; Navigating Relationships; Recovery Practices and Personal Attributes; and Housing as Foundational for Recovery.

Conclusion: Unconditional housing, a broad array of supports, opportunities to contribute to society, and family reunification supports all facilitate the development of recovery for adults with SUD experiencing homelessness. Implications for policy are discussed.

Introduction: substance use and homelessness

Homelessness remains an intractable problem across Europe (OECD, 2021) and the United States (National Alliance to End Homelessness, 2024). Substance use disorder (SUD) is estimated to be about ten times more prevalent among adults experiencing homelessness compared to the general population (Gutwinski et al., 2021). Street-dwelling individuals are at increased risk of drug overdose, violent victimisation and involvement in criminal activity associated with drug use (Aldridge et al., 2018; Baggett et al., 2010; Parsell & Parsell, 2012). Homelessness and SUD are complex, overlapping problems (McNaughton, 2008; Neale, 2001). Research on the ecology of homelessness and SUD suggests that childhood poverty, lifetime adversity and housing shortages contribute to the likelihood that an individual experiences both homelessness and SUD (Bramley & Fitzpatrick, 2018; Padgett et al., 2012). In this article we systematically review the qualitative literature on the perspectives of adults with SUD experiencing homelessness as they work towards recovery in the context of accessing homelessness services.

Substance use at an individual level is often cited as both a cause and consequence of homelessness (McVicar et al., 2015). According to the social selection model (Baum & Burnes, 1993; Fountain et al., 2003), as individuals' substance use progressively worsens, the social and material resources (or 'capital') available to them become depleted, leaving them socially isolated, poor, and without a home (Ayed et al., 2020; Neale & Stevenson, 2015). Thus, according to the social selection model, a regression or 'drift' occurs that leads people into a situation of overlapping homelessness and SUD (Johnson et al., 1997; Mayock & O'Shaughnessy, 2023). Another framework for understanding the relationship between homelessness and SUD is the social adaptation model (Coumans & Spreen, 2003; Johnson & Fendrich, 2007), which conceptualises substance use as a behavioural adaptation to life in the context of homelessness. However, recent studies have proposed a more nuanced understanding of the trajectory of homelessness and SUD (e.g. Bramley & Fitzpatrick, 2018; Padgett et al., 2016b). According to this body of research, the relationship between homelessness and SUD is better conceptualised as an assemblage of disadvantage (Karadzhov,

☆ Thanks to Dr. Aoife Burke who contributed to the search and screening procedures of this review.
* Corresponding author at: School of Social Work and Social Policy, Trinity College Dublin, College Green, Dublin 2, Ireland.
E-mail address: oshaughb@tcd.ie (B.R. O'Shaughnessy).

https://doi.org/10.1016/j.drugpo.2024.104528

Available online 24 July 2024

2023; Padgett et al., 2016b; Vangeest & Johnson, 2002): a complex interplay between individual-level vulnerabilities, such as mental health problems and substance use issues, that are sequelae of chronic, often lifetime disadvantage. Structural disadvantages often create and sustain adverse conditions for individuals where substance use and mental health symptoms worsen and are in turn exacerbated by the absence of a home. The goal of service providers in homelessness services is to support individuals to exit homelessness (Gaboardi et al., 2019). However, without a clear understanding of the nexus of homelessness and SUD, and the role of recovery in the lives of individuals with overlapping experiences of homelessness and SUD, this goal will remain challenging.

Service responses to homelessness and SUD

Services designed to address homelessness and SUD generally fall under two approaches: treatment-led and housing-led. Treatment-led approaches were borne out of the biomedical model to address SUD and homelessness (Lyon-Callo, 2000) and approach recovery as complete abstinence from substances (El-Guebaly, 2012; Laudet, 2007; White, 2007). Treatment-led services exist on a continuum of support intensity ranging from high-support residential treatment settings, "dry" homeless shelter settings, and "halfway houses", or transitional housing, which involve less intensive monitoring by service professionals (Johnsen & Teixeira, 2010; Wong et al., 2006). Treatment-led homelessness services expect service users to comply with the supports offered to address the causes of their homelessness (Gulcur et al., 2003; Johnsen & Teixeira, 2010; Sahlin, 2005) and, once enrolled in a service, the individual is expected to take steps to remediate their SUD or other personal issues until they are deemed "housing ready" by service professionals (Dordick, 2002). However, research has consistently shown that many individuals, such as those considered to have "complex needs", struggle to move through and exit the treatment-led service continuum, with many becoming trapped in a cycle of worsening mental health and substance use issues and unmet housing and support needs (Baptista & Marlier, 2019; Hopper et al., 1997; Padgett et al., 2008).

In the last 25 years, the treatment-led service continuum has come under scrutiny as unfairly authoritarian and misaligned with the complex path of recovery (Tsemberis & Eisenberg, 2000; Watson & Rollins, 2015). Ideas about housing readiness have been critiqued for denying the basic human right of housing to vulnerable individuals with co-occurring mental health and substance use issues (Greenwood et al., 2013; Padgett et al., 2016a). In the 1990's, the Pathways Housing First project was developed in New York to meet the needs of individuals with complex mental health, substance use and housing needs who were cycling between the streets, homeless shelters and psychiatric institutions (Tsemberis, 1999; Tsemberis & Asmussen, 1999). Housing First (HF) is now a well-known permanent supported housing programme for homeless adults that has been disseminated to over 26 countries in Europe, North America, Australia and Asia (Baptista & Marlier, 2019; Padgett et al., 2015; Pleace & Bretherton, 2012; United States Interagency Council on Homelessness, 2022). HF offers scattered-site independent housing upfront, along with tailored multi-disciplinary supports provided either directly, or brokered by existing community services (Tsemberis, 2010).

The harm reduction approach is employed by HF practitioners to support individuals with SUD. Harm reduction refers to approaches that encourage the realisation of service user-driven goals and emphasise positive developments in individuals' lives linked to the aims of reducing harm and holistically improving quality of life (Zerger, 2002). Harm reduction approaches do not require sobriety or abstinence and, instead, recognise the complexity of recovery (Deegan, 1988), which may include phases of relapse, for example. Given the paradigm shift from treatment-led towards housing-led and harm reduction approaches under way within homeless service sectors globally, research that seeks to understand how service users navigate services and embark on a journey of recovery is warranted. In the present review, we examine the qualitative literature on the recovery experiences of adults with SUD in the homelessness service system.

Recovery

Complementary to the harm reduction approach employed by HF practitioners is the recovery approach (Watson & Rollins, 2015). The harm reduction and recovery approaches are aligned because they both recognise the individual's choice (e.g. to use substances or to abstain), potential to grow as a person, and their specific support needs and preferences. The recovery approach involves maximising service users' self-determination, growth potential, dignity, self-respect, and facilitating the development of meaningful roles and relationships in their lives (Farkas et al., 2005; Rogers et al., 2005). In the recovery approach, abstinence or sobriety are not considered essential to the recovery process (Anthony, 1993; Davidson & Roe, 2007). However, conceptualisations of recovery vary depending on disciplinary approach, underlying understanding of the cause of SUD and homelessness, and beliefs about how best to address SUD and homelessness. In this systematic review, we employ a definition of recovery adapted from the field of mental health, which views recovery as a long-term continuous process, defined subjectively by the individual, and involving improvements in interdependent life domains such as housing, relationships and meaningful roles (Deegan, 1988; Ralph, 2000; Rogers et al., 2005; Spaniol et al., 2003). Within this definition, recovery also involves adapting to life with SUD and, in some cases, a co-occurring mental health disorder (Rogers et al., 2005).

The present review

Historically, the literature on recovery from SUD has been dominated by quantitative research aimed at measuring reductions in, or abstinence from, substance use in diverse populations. Given that present-day conceptualisations consider recovery to be a holistic process that may or may not include abstinence, sobriety, or reduced substance use (Rogers et al., 2005; Deegan, 1988; Ridgway, 2001; Ralph, 2000; Spaniol et al., 2003), it is important to examine individuals' accounts of the recovery journey. To the authors' knowledge, to date, no review has synthesised the qualitative research literature based on first-person experiences and accounts of recovery in the context of homelessness and SUD. Given the complexities associated with the social problems of homelessness and SUD, an examination of the state of qualitative research on recovery among individuals experiencing homelessness is warranted. In this study, we aim to systematically synthesise the qualitative research evidence base on the recovery experiences of adult homeless service users with SUD.

Method

Search strategy

This review was pre-registered on PROSPERO (ID CRD42022368439). A two-part search strategy was employed to identify studies: 1) relevant databases were searched using keywords; and 2) secondary searching was completed by checking the reference lists of selected published articles. Search terms were entered as boolean phrases to aggregate electronic database, EBSCO host, and relevant keywords were entered to Scopus, Web of Science, Pubmed and Pubpsych. The keywords related to homelessness, substance or alcohol use, recovery and qualitative methods, and are presented in detail in Table 1, supplementary material. The databases included were: Academic Search Complete, AMED, CINAHL, General Science Full Text (H. W. Wilson), MEDLINE, PsycARTICLES, PsycINFO, PubMed, Scopus, Web of Science, Pubpsych, General Science Full Text, Healthsource: Nursing/Academic Edition and Social Sciences Full Text (H. W. Wilson). Searches included the full range of publication years up to January 2023 (when the search

procedure was completed).

Published articles related to recovery in the context of homelessness and SUD, or associated factors, were collated for secondary searching. The reference lists of these selected articles were searched to access additional articles for screening and eligibility-checks.

Inclusion/exclusion criteria

Population

The population examined was homeless service users with substance use disorder. Homeless service users included single adults (18+ years of age) of any gender engaged with any homeless service, including outreach and drop-in services; accommodation (temporary, emergency,

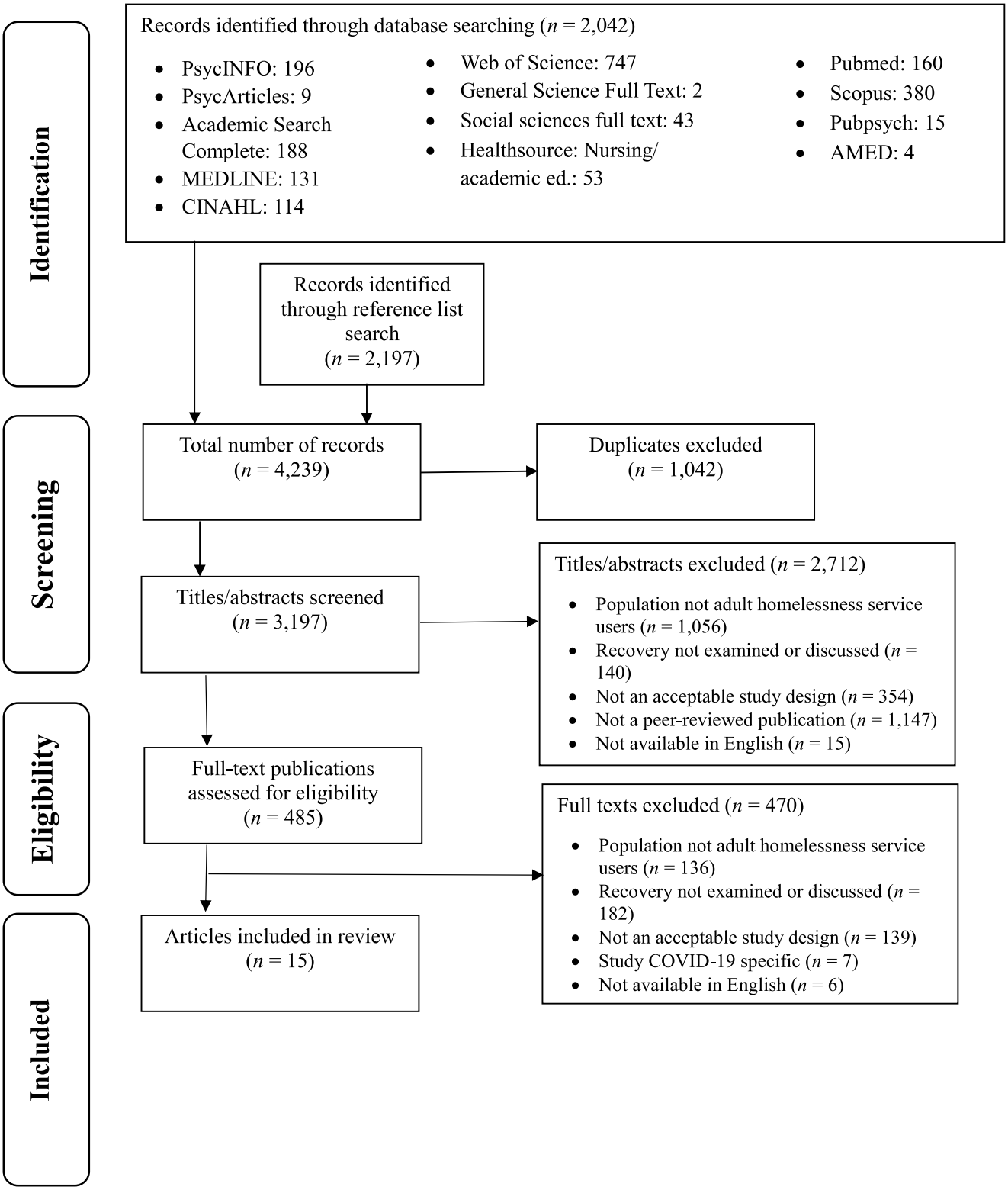


Fig. 1. PRISMA flow diagram.

transitional) services; and housing with supports. Only single adults who were not accompanied by a partner, spouse or child(ren) were included. Adults with histories of homelessness using a permanent supported housing service were also eligible. Substance use disorder was defined as the recurrent use of drugs and/or alcohol which leads to clinically significant impairment, including health problems, disability, and a failure to meet major responsibilities (Substance Abuse and Mental Health Services Administration, 2023).

Recovery definition

A broad definition of recovery was applied such that recovery was not exclusively defined as abstinence from substance use, or the remission of SUD symptoms, but rather as the pursuit and achievement of positive outcomes in various life domains (Rogers et al., 2005). Recovery was defined as a long-term continuous process, defined subjectively by the individual and involving improvements in interdependent life domains such as housing, relationships, and meaningful roles (Rogers et al., 2005; Deegan, 1988; Ridgway, 2001, Ralph, 2000; Spaniol et al., 2003).

Design

Qualitative study designs, including ethnographic, interview and photo elicitation studies were included. Quantitative study designs, including experimental, cohort, correlational, naturalistic, descriptive, cross-sectional and longitudinal survey studies, were excluded.

Publication type

Peer reviewed publications available in the English language were included. Grey literature, dissertations and theses were excluded.

Abstract screening and full-text review

Fig. 1 outlines the search, screening and eligibility check phases of this review. We identified 2,042 records via the search procedure. Secondary searching the reference lists of important and relevant articles yielded a further 2,197 records. After the removal of duplicates, 3,197 records were screened by two independent reviewers via titles and abstracts. The first author then reviewed 485 full texts, which were then checked by the third author. These reviewers met to discuss and agree inclusion and exclusion decisions by consensus. Where the reviewers could not decide about the eligibility of a study, it was forwarded to the second author who had the final say. After full-text screening, it was decided that 15 articles were eligible for review.

Quality appraisal

We applied the Critical Appraisal Skills Programme (CASP) (2018) quality appraisal criteria to assess potential bias in the studies. The CASP tool includes 10 questions that assess the validity, trustworthiness, and usefulness of results in qualitative research. Table 2 available in supplementary material presents the results of the CASP quality appraisal assessment. Author one and author three independently applied CASP criteria and then met to agree the scores via consensus. Where a consensus was not reached, author two made the final decision. Generally, the studies met the criteria for valid reliable and useful qualitative research. Item six, which refers to adequately considering the relationship between researcher and participants, was unclear or absent in most studies ($n = 12$). Item seven refers to consideration of ethical issues (consent procedure, ethical review board approval, and other ethical considerations), and three studies did not meet this criterion due to insufficient detail. No studies were excluded based on CASP quality appraisal results.

Data extraction and qualitative meta-synthesis

Information extracted from eligible studies is presented in Table 3. Study information included the research aim, design, and sample characteristics. To extract qualitative findings, a data extraction form was designed by the first author with input from the third author. Completed extraction forms were imported to NVIVO and coded by the first and third authors.

For data synthesis, we employed meta-ethnography (Noblit & Hare, 1988). Meta-ethnography is an inductive and interpretive form of knowledge synthesis used to reduce and derive understanding from multiple accounts, narratives, or studies while preserving the original essence of the account (Campbell et al., 2011; Noblit & Hare, 1988). Noblit and Hare's (1988) meta-ethnographic approach, which included the following stages, was employed: (1) getting started (defining research question); (2) describing what is relevant to initial interest (searching); (3) reading the studies; (4) determining how the studies are related; (5) translating the studies into one another; (6) synthesizing translations; (7) expressing the synthesis.

Results

Overview of the design characteristics of included studies

A majority of the 15 studies were located in the USA ($n = 9$), followed by Canada ($n = 3$) and the UK ($n = 2$). One study used data collected in both the UK and USA (Karadzhov, 2023). The majority of studies employed a traditional qualitative interview-based approach ($n = 9$). Two used photo elicitation (Cabassa et al., 2013; Tran Smith et al., 2015), one used a qualitative and community-based participatory research approach (Farquhar et al., 2014), one employed an ethnographic design (Flanagan & Briggs, 2016), one used the generic qualitative research approach (Ross-Houle & Porcellato, 2023), which reports on people's subjective experiences, views, attitudes, beliefs or reflections on topics in their external world (Percy et al., 2015), and one used Burawoy's extended case method (Padgett et al., 2016b). Regarding data analysis, a majority of studies employed thematic analysis ($n = 5$), case study analysis ($n = 3$), phenomenological analysis ($n = 2$) or content analysis ($n = 2$). The remainder used meta-theme analysis (Flanagan & Briggs, 2016), framework analysis (Neale & Stevenson, 2015) and the constant comparative method of grounded theory (Cabassa et al., 2013).

Across the selected studies, the total number of participants was 429 (72.38% male, 27.12% female, 0.5% transgender). Sample sizes ranged from eight (Flanagan & Briggs, 2016; Moneyham & Connor, 1995) to 74 (Padgett et al., 2016b). Where mean age was reported, it ranged from 37.1 to 56 years. Six studies included a mix of participants living in both supported housing and in traditional shelter services, while five recruited participants who resided in permanent supported housing. One study included participants residing in shelters (Neale & Stevenson, 2015) and one included formerly homeless adults who were engaging with a recovery day-programme (Moneyham & Connor, 1995). Most studies included participants with SUD (including Alcohol Use Disorder (AUD)) ($n = 9$), followed by individuals with a dual diagnosis of mental health disorder and SUD ($n = 3$). Two included participants with a combination of AUD and SUD (Neale & Stevenson, 2015; Paul et al., 2018). One study (Farquhar et al., 2014) did not explicitly report the prevalence of SUD but there was evidence throughout the paper that the participants had experience of managing SUD. Where available, information related to the specific kind of SUD (i.e. related to opioid, alcohol, crack cocaine use etc.) is presented in Table 3.

Findings

Following Noblit & Hare's (1988) guidance on the conduct of qualitative meta-ethnographic analysis – which, as outlined earlier, encompasses new interpretations while maintaining the original essence of the authors' and respondents' accounts – the following four themes were developed: Two Sides of the Service Coin; Navigating Relationships;

Table 3
Characteristics of eligible studies ($N = 15$).

Author(s), Year, Location	Research aim	Study design Design type Sampling method Data collection method Analytic method	Sample size Mean age Gender (% male) Ethnicity	Participant information Housing/Case management (CM) status SUD status* Mental health (MH) status
Padgett et al. (2022), New York, NY, USA	To understand the life course contexts of substance use recovery.	- Qualitative - Purposive sampling - Longitudinal in-depth interviews (0,6,12 and 18 mos) - Cross-case analyses	- $N = 15$; - Aged 45-63; - 80% male; - 93% African-American	- Permanent supported housing with CM; - 100% SUD, 91.6% polysubstance use, mostly alcohol and crack followed by marijuana and cocaine ; - MH not reported.
Marshall et al. (2022), Hamilton, ON, Canada	To explore the perspectives of individuals with lived experiences of homelessness on their daily living needs and how existing supports are enabling them to meet these needs during and following homelessness.	- Qualitative - Purposive sampling - In-depth interviews - Thematic analysis	- $N = 36$ - Unhoused median age = 49 (Range 25–66), housed median age = 50 (Range 32–73); - 63% male; - Ethnicity not reported	- Shelters: $n = 19$; housing with CM: $n = 17$; - SUD: 73.7% unhoused, 41.2% housed; - Mood disorder: 15.8% unhoused, 29.4% housed; anxiety: 10.5% unhoused, 17.6% housed; stress/ trauma: 5.3% unhoused, 23.5% housed.
Karadzhov (2023), Glasgow, Scotland, UK and New York, NY, USA	To explore individuals' attitudes toward, and experience of, personal recovery.	- Qualitative - Intensity sampling - Semi-structured life story interviews - Interpretative phenomenological analysis	- $N = 18$ ($n = 10$ NYC, $n = 8$ Glasgow). - Mean age = 48 - 87% male; - 50% White, 22% African-American, 16% Hispanic, 11% Asian	- Temporary/emergency accommodation; CM not reported - 67% with history of SUD; - Depression: 44.4%; anxiety: 38.8%; schizophrenia/psychosis: 22.2%; bipolar disorder: 5.5%.
Ross-Houle and Porcellato (2023), North-east England, UK	To explore the relationship between adverse significant life events, homelessness and alcohol consumption within one UK city, through a recovery capital lens.	- Generic qualitative research approach - Purposive sampling - Semi-structured interviews - Thematic analysis	- $N = 12$; - Aged 27-52; - 75% male; - 66% White British, 33% White Eastern European	- Mix of rough sleeping, shelter-residing and previously homeless participants, CM not reported; - 100% polysubstance use (AUD primary); - MH not reported.
Kerman and Sylvestre (2020), Toronto, ON, Canada	To examine how currently and formerly homeless people with mental illness viewed their service use to be helpful or unhelpful to their recovery.	- Qualitative - Convenience sample - In-depth interviews - Thematic analysis	- $N = 52$ currently ($n = 26$) and formerly homeless adults ($n = 26$); - Mean age homeless participants = 41.85 ($SD = 8.80$), mean age housed participants = 47.62 ($SD = 10.73$); - 46% male; - Ethnicity not reported	- 100% of homeless sample in shelters; - 34.6% (of housed sample) delinked housing and supports; 30% social housing; 11.5% private rented; 11.5% linked housing and supports; 7.7% staying with family/friends; - 62% with SUD; - Depression: 46.2% unhoused, 42.3% housed; PTSD: 42.3% unhoused, 40.8% housed; Bipolar: 19.2% unhoused, 38.5% housed; Anxiety: 30.8% unhoused, 26.9% housed; Schizophrenia: 11.5% unhoused, 15.4% housed; Personality: 15.4 unhoused, 7.7% housed.
Paul et al. (2018), Toronto, ON, Canada	To explore the personal perceived strengths, attitudes and coping behaviors of homeless adults of diverse ethnoracial backgrounds experiencing mental illness.	- Qualitative - Purposeful sampling - In-depth semi-structured interviews - Thematic analysis	- $N = 36$ - Mean age = 37.1, ($SD = 11.3$); - 77.8% male; - 22.2% Black African and Black Canadian, 16.7% Black Caribbean and mixed ethnicity, 11% Middle Eastern, 8.3% South-Asian and 2.8% Latinx	- 33.3% HF, 36.1% ethnoracially adapted HF, and 30.6% treatment as usual; - 36.1% SUD, 27.8% AUD, 41.6% either AUD or SUD; - Depression: 41.7%; psychotic disorder 36.1%, PTSD: 27.8%.
Padgett et al. (2016b), New York, NY, USA	To examine the multi-dimensional meaning of recovery in formerly homeless adults with serious mental illness and co-occurring substance abuse	- Burawoy's extended case method - Maximum variation sampling and purposive sampling - In-depth interviews - Case study analyses	- $N = 74$, $n = 39$ from Study A and $n = 35$ from study B; - Study A mean age: 47.1 (SD 10.42), Study B mean age: 50 ($SD = 11$); - 56% male; - 41-57% African American, 12-38% White, 14-18% Hispanic	- All housed in transitional or permanent supportive housing, CM not specified; - All participants had serious mental illness & history of homelessness and SUD.
Collins et al. (2016), Seattle, WA, USA	To describe—in their own words—participants' perceptions of various pathways to recovery, including both existing treatment modalities and self-defined pathways to recovery.	- Qualitative - Purposive sampling - Semi-structured interviews - Content analysis	- $N = 50$; - Mean age = 53.24 ($SD = 7.39$); - 84% male; - 46% White, 24% American Indian/Native Alaskan, 18% multiracial, 10% Black, 8.5% Latinx	- Low barrier shelter or in housing with CM; - 100% AUD; - MH not reported.
Flanagan and Briggs (2016), Atlanta, GA, USA	To examine how persons who are homeless act as change agents to transform addictive behaviors in the context of social complexity.	- Ethnography - Convenience sampling	- $N = 8$; - Age not reported; - 87.5% male;	- Shelters or at a religious service with on-site housing with supports and medical services, CM not reported; - 100% SUD;

(*continued on next page*)

Table 3 (*continued*)

Author(s), Year, Location	Research aim	Study design Design type Sampling method Data collection method Analytic method	Sample size Mean age Gender (% male) Ethnicity	Participant information Housing/Case management (CM) status SUD status* Mental health (MH) status
		- Participant observation, unobtrusive observation, and in-depth interviews - Meta-theme analysis	- 50% African-American, 50% White	- MH not reported.
Tran Smith et al. (2015), New York, NY, USA	To explore the role of place in recovery for persons with complex needs.	- Photo elicitation - Purposive sampling - Photographs and interviews - Content analysis	- $N = 17$; - Mean age = 45; - 82.4% Male; - 70.6% African-American	- All formerly homeless, CM not reported; - All dually-diagnosed.
Neale & Stevenson (2015), UK	To explore the relationships of homeless hostel residents who use drugs and alcohol in order to ascertain the nature and extent of their social and recovery capital.	- Qualitative - Purposive sampling - Semi structured interviews at two timepoints (baseline and 4-6 weeks) - Framework analysis	- $N = 30$ - Mean age = 38; - 70% male; - Ethnicity not reported	- All hostel residents, CM not reported; - 100% SUD: 36.6% heroin and crack cocaine, 16.6%, heroin, crack cocaine & alcohol, 13.3% heroin, 13.3% alcohol and cannabis, 10% alcohol, 6.6% cocaine and MDMA, 10% heroin & alcohol; - 80% self-reported MH problems ranging from mild depression to paranoid schizophrenia.
Farquhar et al. (2014), Portland, OR, USA	To examine how consumers defined and conceptualized success and recovery as they progressed through local housing/ support programmes.	- Qualitative and community-based participatory research - Purposive sampling - Interviews - Thematic analysis	- $N = 16$ - Mean age = 46; - 50% male; 0.5% Trans; - 80% white, 14% African American, 13% American Indian/Alaskan native	- Various housing programmes (alcohol and drug-free, family, transitional and low barrier HF programs), some had CM; - MH not reported.
Cabassa et al. (2013), New York, NY, USA	To explore how individuals with serious mental illness and a history of substance abuse and homelessness envisioned their recovery.	- Photovoice - Purposive sampling - Photo-elicitation interviews and group dialogues - Constant comparative method (grounded theory)	- $N = 16$; - Mean age = 56 ($SD = 12.0$); - 56% male; - 69% African-American, 19% Hispanic, 13% White	- Supported housing (HF and single site supported housing with CM); - 56% SUD; - 31% depression, 31% schizophrenia, 31% bipolar disorder.
Padgett et al. (2008), New York, NY, USA	To examine the nature of social relationships in this population and how social relationships relate to recovery progress over time.	- Qualitative - Purposive sampling - Longitudinal interviews (0,6, 12 mos.) - Cross case analysis	- $N = 41$ - Mean age = 41, (range = 21–60); - 71% male; - 46% African-American, 29% Hispanic, 17% White, 5% Asian American and 2% mixed race	- All in housing programs, CM not specified; - Dually diagnosed: 57% SUD (including crack cocaine, alcohol, powder cocaine, marijuana, and benzodiazepines) - Schizophrenia: 29%, bipolar: 29%, schizoaffective: 24%, major depression: 12%.
Moneyham and Connor (1995), South Eastern USA	To explore the meaning of homelessness from the perspective of previously homeless substance abusers.	- Qualitative (Phenomenology) - Purposive sampling - Semi-structured interviews - Phenomenological analysis	- $N = 8$; - Mean = 40 years; (range = 34 – 50); - 100% male; - 100% African-American	- Formerly homeless in a substance abuse treatment programme, CM not reported; - MH not reported.

* Type of substance use issue reported where specified in the reviewed text.

Recovery Practices and Personal Attributes; and Housing as Foundational for Recovery. Subthemes were also identified and a summary of the themes and subthemes is provided in Fig. 2. Table 4 (supplementary material) provides a more detailed illustration of the study's themes, subthemes and supporting quotes.

Theme 1: two sides of the service coin

Services could be both enabling and disabling for recovery. Caring and supportive relationships with professionals, having access to a wide variety of supports, and freedom of choice created positive recovery experiences. However, for some, settings that infringed on participants' sense of autonomy, such as those with hierarchical structures, tended to constrain positive recovery experiences. Additionally, frustration arose when participants felt subjected to competing demands placed on them by health, housing and other agencies designed to support their needs.

Subtheme 1.1: Services and Supports that Fostered Recovery. Positive relationships with service providers that were perceived as supportive, encouraging, and as fostering hope featured strongly across several studies (Collins et al., 2016; Kerman & Sylvestre, 2020; Moneyham & Connor, 1995; Neale & Stevenson, 2015; Paul et al., 2018). Qualities that participants desired in providers included empathy, person-centredness, humility, acceptance, and respect for service users' autonomy (Collins et al., 2016; Marshall et al., 2022). Positive relationships with providers offered stability in otherwise unstable circumstances, according to Neale and Stevenson (2015, p. 479): "In comparison to relationships with family members, there seemed to be more stability in relationships with professionals over the study period". In several studies (Paul et al., 2018; Marshall et al., 2022; Kerman & Sylvestre, 2020), participants felt better and less alone just knowing that someone was there for them: "it kind of helps you out a little bit just to have in the back of your mind … that somebody else out there, is listening and really cares" (Paul et al., 2018, p. 5). A number of studies (Kerman & Sylvestre, 2020; Collins et al., 2016; Marshall et al., 2022) mentioned that person-centred programmes with principles of mutual respect, a focus on personal strengths, and a harm reduction ethos led to service users feeling as more than just "someone with an AUD" (Collins

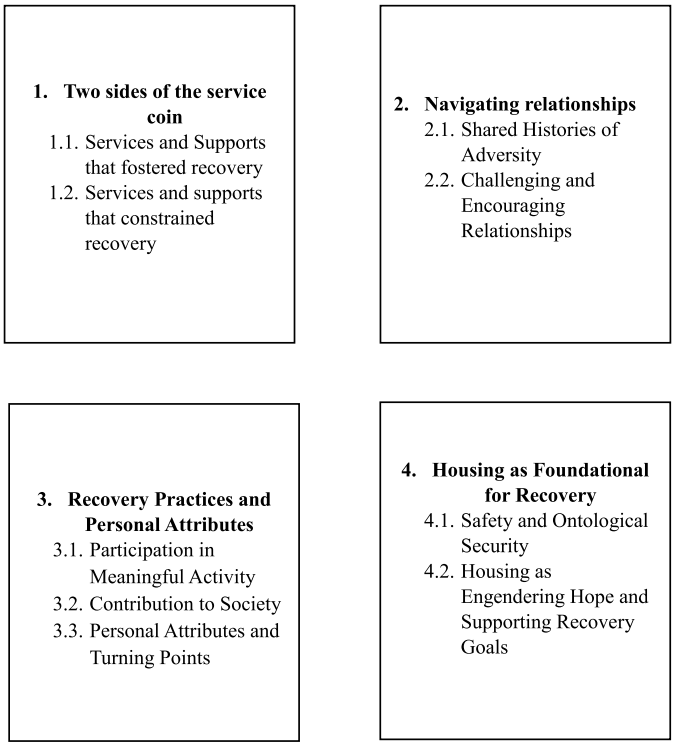


Fig. 2. Summary of themes and subthemes.

et al., 2016, p. 8). The ability to access multiple sources of support related, for example, to employment, mental and physical health, counselling, and support groups such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), was described as enabling in many studies (Kerman & Sylvestre, 2020; Paul et al., 2018; Moneyham & Connor, 1995; Farquhar et al., 2014; Collins et al., 2016).

When homeless service users made the decision to address their circumstances, it was important that a range of accessible supportive structures were in place: "Almost all participants sought housing, income or health support from either one or multiple sources, including family members, friends, professionals (e.g. physicians, case managers, housing workers) and community agencies (e.g. drop in centres, shelters, churches)." (Authors: Paul et al., 2018, p. 193). Pharmaceutical treatments, including medications for psychiatric symptoms and methadone maintenance treatment (MMT), were cited as aiding recovery: "[…] I've been dealing with the methadone maintenance program for quite some time now, and I'm doing real good in there, you know… things starting to look up for me." (Padgett et al., 2022, p. 61). However, others viewed MMT negatively, describing long-term dependence on methadone as "liquid handcuffs" (Kerman & Sylvestre, 2020, p. 391).

Subtheme 1.2: Services and Supports that Constrained Recovery. The rules and hierarchies governing everyday life in drug/alcohol residential treatment settings were depicted as oppressive by participants in five studies (Collins et al., 2016; Kerman & Sylvestre 2020; Neale & Stevenson, 2015; Padgett et al., 2016b; Padgett et al., 2008). In Padgett et al.'s (2008) study, those who entered congregate treatment settings had to adhere to strict curfews and supervision aimed at preventing exposure to "people, places and things" that could trigger relapse. More than half of the participants left these settings and "went AWOL" during the study period. In another study, participants frequently depicted the rules in abstinence-based settings as highly restrictive: "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." (Collins et al., 2016, p. 92).

Fragmented service systems led to frustrations among services users. For example, some did not meet entry requirements for treatment because they had a dual diagnosis: "… rejected by substance abuse treatment programs for taking drugs (including their prescribed psychotropic medications) or for an inability or unwillingness to abide by stringent program rules. Likewise, mental health programs were ill-equipped to handle substance abuse and often rejected clients with dual diagnoses" (authors: Padgett et al., 2016b, p. 66). Other service users felt that competing demands were placed on them from welfare and housing administrative systems: "I don't qualify for Medicaid because I make too much. How can I make too much when I'm not working? ..." (Padgett et al., 2016b, p. 66). Service users also experienced prejudice within both services and the wider community: "You get that feeling, like you're looked down on. Kind of because you're an addict." (Marshall et al., 2022, p. 7).

A lack of preparedness for life in the community was described as hampering recovery (Collins et al., 2016; Padgett et al., 2016b). Others felt abandoned after they transitioned from a shelter to housing: "as soon as you got housed, it's like they [service staff] drop off the face of the earth and they don't want anything to do with you" (Marshall et al., 2022, p. 9). In another study, participants complained about the lack of aftercare following their release from prison, which effectively set them up for failure: "Sometimes I felt sad to leave prison because I knew what I was coming back to …" (Ross-Houle & Porcellato, 2023, p. 179).

Finally and importantly, participants in several studies (Kerman & Sylvestre, 2020, Marshall et al., 2022; Karadzhov, 2023; Neale & Stevenson, 2015) described feeling unsupported within homelessness services. For one participant in Karadzhov, (2023, p. 11) study, the absence of support produced a sense of hopelessness: "[…] No one has taken the time to erm . . . give me an inkling of hope. No one here. [. . .] I don't hold any hope for my recovery". Participants in Neale & Stevenson's (2015, p. 479) study reported that hostel staff could do more to support them: "Because you're homeless … they [think they] are doing us a favour …". High provider turnover was mentioned in two studies as discouraging effective engagement with supports (Collins et al., 2016; Padgett et al., 2008) while in others, overwhelmed service staff led participants to feel that they were not prioritised or adequately informed about their entitlements (Marshall et al., 2022; Kerman & Sylvestre, 2020).

Theme 2: navigating relationships

Relationship complexity was evident in the lives of adults with SUD, particularly when they grew up in turbulent homes where their parents used substances or were coping with poor mental health and/or violence in the home. Where relationships could create challenges for individuals' recovery, they could also provide support and inspiration. Nevertheless, close relationships with family, including parents and children, was consistently cited as important in the lives of recovering adults.

Subtheme 2.1: Shared Histories of Adversity. Childhood neglect, witnessing or being subjected to physical abuse, and exposure to substance use from an early age were described by participants in multiple studies (Neale & Stevenson, 2015; Padgett et al., 2016b; Padgett et al., 2008; Ross-Houle & Porcellato, 2023). Substance use and mental health problems among family members and friends were often reported: "Both of my parents were alcoholics, and it's hard for me to trust people" (Padgett et al., 2008, p. 335); leading to strained relationships in many cases: "Chloe, explained that she did not see her mother as often [...] her step-father had a drink problem and was very abusive when drunk" (Authors: Neale & Stevenson, 2015, p. 478).

Accounts of bereavement featured in a large number of studies, with participants sometimes reporting multiple losses in their close network of family members and friends: "... Like my friend. He died on [name of street] there. He froze to death" (Marshall et al., 2022, p. 6). Reports of drug-related deaths were also commonplace: "[…] most of my friends have died from drug use, AIDS […]" (Padgett et al., 2016b, p. 64). Bereavement took its toll on individuals in already vulnerable circumstances. To illustrate, a participant in one study experienced serious

mental illness: "Then Christmas just gone, my partner passed away. . . And, during that time, I've been sectioned loads of times" (Neale & Stevenson, 2015, p. 479). Others turned to substance use as a coping mechanism: "The death of my friend, he shot himself and when he died I drank pure vodka, I would drink litres per day." (Ross-Houle & Porcellato, 2023, p. 180).

Subtheme 2.2: Challenging and Encouraging Relationships. For participants with family members who used substances or had mental health issues, managing recovery and family relationships was often challenging: "relatives … They ain't nothing but a bunch of trouble … So, that's another reason I haven't been around there for a while …" (Padgett et al., 2022, p. 61). Thus, for many respondents, having healthy boundaries was important for their successful recovery: "… I don't need them coming to visit me, no … I don't need the headache." (Tran Smith et al., 2015, p. 113). Nonetheless, participants in several studies (Collins et al 2016; Neale & Stevenson, 2015; Padgett et al., 2008; Cabassa et al., 2013; Paul et al., 2018) cited family reconnection as a recovery goal while others felt supported by family and were participating in family life: "meeting up for a meal, helping out with work or odd jobs around their houses, or looking after children" (Authors: Neale & Stevenson, 2015, p. 478).

In general, the prospect of family reconnection motivated individuals to strive to improve their circumstances. Children were described as an anchor which, in some cases, motivated participants to stay alive: "If I didn't have children, I would have probably killed myself a long time ago" (Paul et al., 2018, p. 6). The process of having one's children taken into state care was described as extremely painful: "I lost him to adoption. And it hurts every day" (Paul et al., 2018, p. 6), leading some to drink more to cope: "I drink more [thinking about her children] I got my kids taken off me." (Ross-Houle & Porcellato, 2023, p. 8). Family reconnection was consistently cited as a recovery goal, and dealing with separation from children was difficult. Importantly, it was more feasible for those who had housing and supports to be motivated by family reunification to reduce substance use.

In six studies, (Padgett et al., 2022, 2016, 2008; Ross-Houle & Porcellato, 2023; Farquhar et al., 2014; Neale & Stevenson, 2015) participants described romantic relationships – and difficult or problematic relationships, in particular – as a barrier to recovery. Others, however, found their partners to be a valuable source of support as they worked towards their recovery goals: "He's very supportive … I don't think I'd be able to do this [stay away from drugs and alcohol] without him ..." (Neale & Stevenson 2015, p. 481). The 12-steps adage to avoid "people, places and things" was offered by participants in five studies (e.g. Karadzhov, 2023; Padgett et al., 2022, 2016, 2008; Tran Smith et al., 2015). Those who were housed often described setting boundaries or even removing themselves from the company of those they felt could be a bad influence: "[…] they told me [to avoid] "people, places and things." So he's the people … he asks me to smoke but I don't want to do it …" (Tran Smith et al., 2015, p. 113). Having a home helped many participants to set healthy boundaries: "… if anybody's using drugs … they ain't coming in my house." (Padgett et al., 2022, p. 61). Unhoused participants struggled to avoid individuals and environments that could lead them back to substance use: "It is going to be hard to stay away if I am having a really bad day … […] but I know that I can't really be hanging around with her. . . She is going to want to go and score" (Neale & Stevenson, 2015, p. 480).

Both housed and unhoused participants benefitted from mutual support activities: "Sometimes it can lift you up a little bit and realize you are not alone anymore; you're not the only one." (Kerman & Sylvestre, 2020, p. 4). Acts of kindness and companionship were valued: "I owe it all to people that care. You know, not family. I mean complete strangers that I hadn't never seen before cared about me and believed in me enough to give me a chance to prove myself." (Moneyham & Connor, 1995, p. 17). Ties with people in the community were also beneficial to recovery: "[as] long as you have community … don't burn the ties off to your [ethnic] community." (Paul et al., 2018, p. 5).

Theme 3: recovery practices and personal attributes

Across the studies, attention was drawn to practices and personal attributes that supported recovery. Meaningful participation, including giving back to the service community, which in turn motivated service users to maintain their recovery, was important. Personal qualities that individuals attributed to their recovery included perseverance, self-confidence, self-efficacy, self-awareness, self-acceptance, worth ethic, and authenticity. Turning point experiences also influenced or inspired change.

Subtheme 3.1: Participation in Meaningful Activity. Ten studies reported engagement in meaningful activity as helpful to participants' efforts to reduce substance use or to maintaining sobriety: "You have to keep busy, 'cause if you don't stay busy, then you'll get problems … because you're going to go back into the drugs" (Paul et al., 2018, p. 194). Such activities included participation in educational or vocational programmes, employment, volunteering, creative arts, ethnic and religious communities, and recreational activities. Purposeful participation provided people with a reason to be sober and to feel better sober: "I don't touch that (substance) anymore. Because it's not going to help me, it just stressed me out and made my mental problems get worser [sic]." (Padgett et al., 2022, p. 61). Spirituality and spiritual activities featured in five studies (Paul et al., 2018; Kerman & Sylvestre 2020; Flanagan & Briggs, 2016; Cabassa et al., 2013; Padgett et al., 2022). Benefits derived from such practices, including meditation and Bible study, were feeling spiritually strong, having the strength to abstain from drug use, and feeling better able to cope.

However, feelings of apprehension were also a part and parcel of the recovery process, with new challenges often emerging alongside the advancement of various goals: "It started the ball rolling of all those fears you have when you're just coming alive again" (Farquhar et al., 2014, p. 8). Recovery was frequently described as a "work in progress" (Farquhar et al., 2014, p. 6) and having faith in the process was deemed important to sustaining it: "[…] I take it one day at a time. I have faith to continue what I am doing … I have a chance in life today–I really do." (Moneyham & Connor, 1995, p. 18).

Subtheme 3.2: Contribution to Society. A desire to 'contribute to society' was described in several studies (Kerman & Sylvestre, 2020; Farquhar et al., 2014; Cabassa et al., 2013). Contributing to society signified normalcy, community integration and personal achievement. Labour market participation was a way to keep busy, make a contribution, and to gain financial stability and a sense of accomplishment. Returning to education, graduating from vocational programmes, or finding employment enabled participants to (re)gain a sense of self-worth and accomplishment. Where employment was not possible due to physical disability or for retaining certain welfare benefits, individuals instead volunteered or contributed informally to services. Even small contributions conferred a sense of purpose: "It makes you feel like you're somebody" (Kerman & Sylvestre, 2020, p. 5). For others, participation in activities that mobilised their lived experience was empowering, with one participant in Flanagan & Briggs (2016, p. 98) describing it as: "… a different high, but a high. So it's kind of becoming a drug to me, but not over excessive, an enjoyable thing, you know?". In three studies (Karadzhov, 2023; Padgett et al., 2022; Farquhar et al., 2014) participants described gaining control over their financial situation as a recovery goal. To illustrate, sobriety allowed one participant in Padgett et al's (2022, p. 61) study to have disposable income: " […] it feels much better being sober. You know, I keep more money in my pocket …". For others, financial stability symbolised independence and control over one's life: "For Neil, recovery meant […] securing housing stability and financial independence." (Authors: Karadzhov, 2023, p. 12).

Subtheme 3.3: Personal Attributes and Turning Points. Individuals sometimes attributed their progress in recovery to personal qualities such as perseverance, self-confidence, self-efficacy, self-awareness, self-acceptance, worth ethic, and authenticity. Some emphasised self-reliance and decisiveness, "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." (Collins et al., 2016, p. 11), while others emphasised returning to their authentic selves: "I lost myself. A long time ago. This road is hopefully a road that I can come back … Come back to myself …" (Tran Smith et al., 2015, p. 114).

Three studies (Moneyham & Connor, 1995; Collins et al., 2016; Flanagan & Briggs, 2016) described turning points, which refer to "the dynamic process during which a particularly difficult or positive experience, event, or awareness influences changes in someone's life course" (Bellaert et al., 2022, p. 294). Turning points were very often linked to experiences that shocked participants into re-assessing their lives and circumstances: "[…] And I said, "Fuck this shit, man." […] And stopped drinking, stopped doing drugs." (Collins et al,. 2016, p. 94). Examples of turning points included the loss of a close friend, experiences of violence and/or the threat of violence, other forms victimisation, and having a health scare.

Theme 4: housing as foundational for recovery

Twelve studies referred to the enabling role of housing in supporting recovery. Five of these included a mixed sample of both housed and unhoused participants, a further five included housed participants, and two included unhoused participants. Housing took people off the streets or out of shelters, and also conferred ontological security. In this sense, housing promoted better mental health, which in turn supported people's recovery goals.

Subtheme 4.1: Safety and Ontological Security. Housing meant that individuals could escape from life on the street and focus on recovery: "[…] I have a roof over my head and I can do the things I have to do … and I can concentrate on my recovery." (Tran Smith et al., 2015, p. 114). Having a home provided a sense of personal accomplishment and peace and also symbolised new beginnings: "most of all success is just peace of mind, for me. … just acknowledging that it's a safe place and that I need it, is successful for me." (Farquhar et al., 2014, p. 10). Signifiers of ontological security, which refers to the constancy, privacy and routine associated with having a stable environment (Padgett, 2007), were discussed in four studies (Tran Smith et al., 2015; Flanagan & Briggs, 2016, Farquhar et al., 2014, Karadzhov, 2023). Such signifiers included having autonomy over daily tasks, ownership over one's domain, and housing certainty. Having a stable address, feeling motivated to engage in activities, and being able to safely store one's belongings all contributed to feeling autonomous: "I'm basically happy for my independence of being out of the women's shelter … I could lay my money, everything around. I don't have to hide anything." (Tran Smith et al., 2015, p. 112). Security of tenure helped to alleviate feelings of anxiety and depression that would have otherwise been exacerbated by living on the street: " ... living in the street, you're going to probably never stay clean or dry because it's depressing … they can't be successful without housing." (Farquhar et al., 2014, p. 8). Thus, as articulated by this participant, homelessness was viewed as the antithesis to recovery. Karadzhov (2023, p. 294) similarly asserted that: "accounts revealed the deeply anti-recovery nature of homelessness and co-occurring life adversity, which impinged on their abilities to imagine what recovery would be like for them".

4.2: Housing as Engendering Hope and Supporting Recovery Goals. Housing was depicted by participants as key to their recovery: "Well, they supplied housing for me … And that was a major thing because of my homelessness. And it really began to make me feel a little bit more normal … and it began to give me hope …" (Farquhar et al., 2014, p. 6). Having a home led to this participant feeling more 'normal' and hopeful about realising their future goals. Indeed, achieving a sense normality and being perceived by the wider community as normal citizens was often described as an integral part of recovery: "We're among regular people, and we don't feel like we are outcasts" (Collins et al., 2016, p. 94). The importance of housing in bolstering hope and a positive outlook on the future permeated participants' accounts of the meaning of recovery: "That's what hope is all about. Envisioning yourself. When you envision yourself — that's what hope is all about. […] And that's the image you want to bring out, and that's what recovery does." (Karadzhov, 2023, p. 297).

However, individuals who were housed sometimes continued to struggle with financial and personal issues, including poor mental health (Kerman & Sylvestre, 2020; Marshall et al., 2022; Tran Smith et al., 2015). For example, housed individuals often found themselves dealing with ongoing challenges related to inadequate income, social isolation, and poor-quality housing: "when I moved into my place, it was dirty from whoever lived there before. I can't scrub out cupboards. I can't reach up high. I have cockroaches. I can't do anything about it" (Marshall et al., 2022, p. 8). In this sense, both the recovery and housing experiences of many participants were in a state of flux, at times generating anxiety and uncertainty.

Discussion

We aimed to systematically synthesise the qualitative research evidence on the recovery experiences of adult homeless service users with SUD. In this article we presented a qualitative meta-synthesis of findings from 15 studies which included the first-person accounts of 429 participants with SUD experiencing homelessness. The findings demonstrate that, for adults experiencing homelessness, recovery is more than simply a matter of abstaining from drug and/or alcohol use; rather, engagement with appropriate supports, access to adequate and unconditional housing, positive relationships and meaningful engagement are all critical aspects of recovery. Recovery was an active and mutually reinforcing process of engaging in meaningful activity, leveraging personal attributes and supports, and managing relationships, which in turn fostered feelings of optimism, hope, normality and stability. However, participants experienced multiple and sometimes enduring barriers of access to housing stability and broader supports. The demanding nature of recovery meant that, without stable housing and the ontological security it affords, recovery was only partial at best and difficult to realise.

Positive service experiences included supportive and caring relationships with professionals, and the availability of a variety of supports. Positive interactions highlighted by participants included providers' ability to recognise their potential and to see them as more than "an addict". While service users procured various supports independently, it was essential that supports (e.g. employment support, case management, peer counselling) were available and accessible to them, highlighting the critical importance of well-resourced and integrated health, housing and welfare services (e.g. Drake et al., 1997; Nelson et al., 2019) in supporting homeless adults to progress with their recovery.

Treatment dropout rates among adults experiencing homelessness is a problem, and there is evidence that the experience of homelessness increases the risk of relapse (Scott et al., 2005; Zerger, 2002). Thus, unconditional access to housing is necessary if treatment services are to have a positive and sustained impact on individuals' recovery (O'Donnell et al., 2022). Participants in several studies struggled with the hierarchically structured nature of treatment settings and some were excluded from treatment for having mental health disorders. Overall, the findings reinforce the burgeoning evidence (Stanhope et al., 2009; Wusinich et al., 2019) that adults experiencing homelessness also often experience exclusion and disengagement from treatment services, which presents significant barriers to successful recovery. Although not the focus of this systematic review or of the synthesised studies, participants had mixed perspectives of formal treatment (e.g. residential), and of informal addiction supports in the community (e.g. AA). However, perspectives on these supports and their suitability for adults experiencing homelessness requires further attention to bridge the gap between abstinence and person-centred harm reduction approaches to supporting recovery. The findings also highlight the need for what has been described as structurally competent services (Treloar et al., 2021, p. 6) that accommodate the life situations of their clients, acknowledge

the structures that shape interaction, and "observe, imagine and respond to the concerns, capacities, and constraints of the people they purport to serve". The continued development of services that provide personalised and flexible supports with unconditional access to housing can promote stability and may reduce service disengagement among this vulnerable population.

The absence of housing was anti-recovery, and the provision of housing restored basic needs and afforded safety and ontological security, which in turn allowed people to work on their recovery. Ontological security has been examined in respect of recovery trajectories, identity development and the meaning of home for people experiencing homelessness (Mayock, 2023; Padgett, 2007; Patterson et al., 2013). This literature paints a rich picture of the meaning ascribed to home, including the sense of stability and symbols of identity that bolster positive well-being, in contrast to the histories of instability and upheaval that are common in the lives of adults experiencing homelessness. The findings of this review show that without stable housing and supports, the pursuit of recovery is not feasible nor sustainable.

Relationships were described as complex, especially when participants shared histories of adversity with relatives, and where close friends and family were themselves dealing with issues related to mental health, addiction and poverty. Mounting research highlights that childhood adversity is common in the lives of adults with SUD experiencing homelessness (e.g. Bramley & Fitzpatrick, 2018; Mayock & O'Shaughnessy, 2023; McDonagh et al., 2023; Padgett et al., 2012). Trauma-informed care (Hopper et al., 2010), which is critical to supporting individuals with traumatic experiences appropriately, may also be an opportunity to intervene in the cycle of housing instability, poor mental health and re-traumatisation often experienced by adults in chronic homelessness (Goodman et al., 1991; Hopper et al., 2010). Childhood adversity does not always result in experiences of homelessness and SUD but for some, it can interact with other vulnerabilities to compound disadvantage (Padgett et al., 2012; Karadzhov et al., 2020). Thus, where appropriate, the repair of family relationships is an important step for healing childhood trauma and moving forward in life (Kemp, 2019; Walsh, 2002). However, while relationships have the potential to offer support and love, they may also lead participants away from their recovery and (back) towards substance use. Although challenging, findings show that healthy boundaries and relationship management are a part of pursuing recovery, and having independent, stable housing facilitated this.

Children emerged as a highly important anchor from which individuals could persevere with their recovery. The literature on parenthood in the context of homelessness and SUD is modest in size and focuses primarily on mothers (e.g. Barrow & Lawinski, 2009). Other research focuses on parenthood and homelessness (Alschech & Begun, 2020; Barrow & Laborde, 2008; Bradley et al., 2018; Gulcur et al., 2003, p. 201; Shinn et al., 2017), and on addiction and parenthood (Barnett et al., 2021; Chassin et al., 2019; Heimdahl Vepsä, 2020; Kilty & Dej, 2012). However, relatively little is known about the interaction of parenthood, separation from children and recovery in the context of homelessness and SUD. The findings of this review broadly align with the suggestion that children can act as a "positive driving force" (Heimdahl Vepsä, 2020, p. 581) for recovery. Further research is required to understand the relationship between parenthood and recovery, including the ways in which supports can be structured to foster family reconnection.

Implications

The findings of this meta-synthesis indicate that a major barrier experienced by adults in the pursuit of recovery was their lack of preparedness for the community following their release from treatment centres and/or from prison. Individuals who made progress in recovery in these settings returned to shelters or to the street upon release, making it difficult or impossible for them to continue on a path of recovery. Given the ruptures in the systems designed to address the housing and treatment needs of adults experiencing homelessness, polices aimed at addressing homelessness must recognise the risk of placing homeless adults in an institutional circuit. Housing with supports delivered within a harm reduction approach is more effective than re-routing individuals back into the service system after periods of detox and sobriety or abstinence (Collins et al., 2016; Padgett et al., 2016b). Additionally, some participants in reviewed studies were excluded from mental health or addiction treatment for having concurrent mental health and substance use issues, which often characterises individuals experiencing homelessness and SUD (Gutwinski et al., 2021; Hossain et al., 2020). Thus, it is essential that dual diagnosis services are adequately developed and made available to individuals experiencing homelessness and pursuing recovery.

Housing First (HF) is a supported housing programme that employs a harm reduction approach. HF effectively retains adults with complex needs and histories of homelessness in housing (Aubry et al., 2016; Busch-Geertsema, 2013; Loubière et al., 2022), thus removing them from the homelessness services system. Just a few HF programmes were represented in this review (see Paul et al., 2018; Farquhar et al., 2014; Cabassa et al., 2013) and, together with evidence from other qualitative research (e.g. Henwood et al., 2012; Macnaughton et al., 2016; Patterson et al., 2013, 2015), the findings suggest that home provides stability, routine, and a sense of personhood that in turn has a strong positive impact on recovery. Better integration of HF within a mental health system that offers dual diagnosis services, along with the brokering of personalised addiction support, could bolster the facilitative effect of HF for recovery and housing stability for service users with SUD.

Limitations

Of the 15 publications reviewed, six reported the type of SUD that participants had and, of these six, two provided little information apart from distinguishing AUD from SUD. As shown in Table 3, alcohol use disorder and polysubstance use were most strongly represented, reflecting the types of SUD that are most prevalent in homeless populations (Fazel et al., 2008; Gjersing & Bretteville-Jensen, 2018; Han et al., 2022; Nicholls & Urada, 2022). However, different substance use disorders can have different symptoms and also require specific kinds of treatment or interventions. We did not have sufficient information to analyse the data according to SUD type, which may limit the generalisability of the findings to specific SUDs.

Grey literature, theses and dissertations were excluded from this review due to resource and personnel constraints that dictated the prioritisation of peer-reviewed publications. It is possible that additional areas of research and evidence on recovery in the context of homelessness and SUD may have been missed due to the exclusion of grey literature, theses and dissertations.

Conclusion

This review has synthesised the qualitative literature on recovery among adults with SUD experiencing homelessness and generated four main themes: Two Sides of the Service Coin; Navigating Relationships; Recovery Practices and Personal Attributes; and Housing as Foundational for Recovery. These themes represent the lived experiences of homeless services users with SUD, including the ways in which they overcome challenges in the pursuit of recovery. Unconditional supported housing can foster many aspects of recovery; however, it is essential that adequate and wide-ranging supports are available to bolster service users' ability to embark upon their preferred recovery pathway. Unconditional housing, harm reduction and recovery-orientated approaches, and the development of dual diagnosis services are necessary to properly address the needs of adults with SUD experiencing homelessness.

Ethics approval

The authors declare that the work reported herein did not require ethics approval because it did not involve animal or human participation.

CRediT authorship contribution statement

Branagh R. O'Shaughnessy: Writing – review & editing, Writing – original draft, Supervision, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Paula Mayock:** Writing – review & editing, Writing – original draft, Supervision, Funding acquisition, Formal analysis, Conceptualization. **Aimen Kakar:** Writing – review & editing, Formal analysis.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Funding sources

This research received funding from the following sources
This review study was funded by the Irish Research Council Government of Ireland Postdoctoral Fellowship Programme (GOIPD/2022/475).

Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.drugpo.2024.104528.

References

Aldridge, R. W., Story, A., Hwang, S. W., Nordentoft, M., Luchenski, S. A., Hartwell, G., Tweed, E. J., Lewer, D., Vittal Katikireddi, S., & Hayward, A. C. (2018). Morbidity and mortality in homeless individuals, prisoners, sex workers, and individuals with substance use disorders in high-income countries: A systematic review and meta-analysis. *The Lancet, 391*(10117), 241–250. https://doi.org/10.1016/S0140-6736(17)31869-X

Alschech, J., & Begun, S. (2020). Fatherhood among youth experiencing homelessness. *Families in Society: The Journal of Contemporary Social Services, 101*(4), 484–497. https://doi.org/10.1177/1044389419896188

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. https://doi.org/10.1037/h0095655

Aubry, T., Goering, P., Veldhuizen, S., Adair, C. E., Bourque, J., Distasio, J., Latimer, E., Stergiopoulos, V., Somers, J., Streiner, D. L., & Tsemberis, S. (2016). A multiple-city RCT of Housing First with assertive community treatment for homeless Canadians with serious mental illness. *Psychiatric Services, 67*(3), 275–281. https://doi.org/10.1176/appi.ps.201400587

Ayed, N., Akther, S., Bird, V., Priebe, S., & Jones, J. (2020). How is social capital conceptualised in the context of homelessness? A conceptual review using a systematic search. *European Journal of Homelessness, 14*(2), 89–136.

Baggett, T. P., O'Connell, J. J., Singer, D. E., & Rigotti, N. A (2010). The unmet health care needs of homeless adults: A national study. *American Journal of Public Health, 100*(7), 1326–1333. https://doi.org/10.2105/AJPH.2009.180109

Baptista, I., & Marlier, E. (2019). *Fighting homelessness and housing exclusion in Europe: A study of national policies*. European Commission. European Social Policy Network. https://data.europa.eu/doi/10.2767/624509.

Barnett, E. R., Knight, E., Herman, R. J., Amarakaran, K., & Jankowski, M. K. (2021). Difficult binds: A systematic review of facilitators and barriers to treatment among mothers with substance use disorders. *Journal of Substance Abuse Treatment, 126*, Article 108341. https://doi.org/10.1016/j.jsat.2021.108341

Barrow, S. M., & Laborde, N. D. (2008). Invisible mothers: Parenting by homeless women separated from their children. *Gender Issues, 25*(3), 157–172. https://doi.org/10.1007/s12147-008-9058-4

Barrow, S. M., & Lawinski, T. (2009). Contexts of mother–child separations in homeless families. *Analyses of Social Issues and Public Policy, 9*(1), 157–176. https://doi.org/10.1111/j.1530-2415.2009.01171.x

Baum, A. S., & Burnes, D. W. (1993). *A nation in denial: The truth about homelessness*. Routledge.

Bellaert, L., Van Steenberghe, T., De Maeyer, J., Vander Laenen, F., & Vanderplasschen, W. (2022). Turning points toward drug addiction recovery: Contextualizing underlying dynamics of change. *Addiction Research & Theory, 30*(4), 294–303. https://doi.org/10.1080/16066359.2022.2026934

Bradley, C., McGowan, J., & Michelson, D. (2018). How does homelessness affect parenting behaviour? A systematic critical review and thematic synthesis of qualitative research. *Clinical Child and Family Psychology Review, 21*(1), 94–108. https://doi.org/10.1007/s10567-017-0244-3

Bramley, G., & Fitzpatrick, S. (2018). Homelessness in the UK: Who is most at risk? *Housing Studies, 33*(1), 96–116. https://doi.org/10.1080/02673037.2017.1344957

Busch-Geertsema, V. (2013). *Housing First Europe final report*. Housing First Europe.

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. https://doi.org/10.1176/appi.ps.201200503

Campbell, R., Pound, P., Morgan, M., Daker-White, G., Britten, N., Pill, R., Yardley, L., Pope, C., & Donovan, J. (2011). Evaluating meta-ethnography: Systematic analysis and synthesis of qualitative research. *Health Technology Assessment, 15*(43). https://doi.org/10.3310/hta15430

Chassin, L., Hussong, A. M., Rothenberg, W. A., & Sternberg, A. (2019). Parenting and substance use disorder. In M. H. Bornstein (Ed.), *Handbook of Parenting* (3rd ed., pp. 483–516). Routledge. https://doi.org/10.4324/9780429398995-16.

Collins, S. E., Jones, C. B., Hoffmann, G., Nelson, L. A., Hawes, S. M., Grazioli, V. S., Mackelprang, J. L., Holttum, J., Kaese, G., Lenert, J., Herndon, P., & Clifasefi, S. L. (2016). In their own words: Content analysis of pathways to recovery among individuals with the lived experience of homelessness and alcohol use disorders. *International Journal of Drug Policy, 27*, 89–96. https://doi.org/10.1016/j.drugpo.2015.08.003

Coumans, M., & Spreen, M. (2003). Drug use and the role of homelessness in the process of marginalization. *Substance Use & Misuse, 38*(3–6), 311–338.

Critical Appraisal Skills Programme. (2018). *CASP qualitative studies checklist*. https://casp-uk.net/checklists/casp-qualitative-studies-checklist-fillable.pdf.

Davidson, L., & Roe, D. (2007). Recovery from versus recovery in serious mental illness: One strategy for lessening confusion plaguing recovery. *Journal of Mental Health, 16*(4), 459–470. https://doi.org/10.1080/09638230701482394

Deegan, P. E. (1988). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal, 11*(4), 11–19.

Dordick, G. A. (2002). Recovering from homelessness: Determining the "quality of sobriety" in a transitional housing program. *Qualitative Sociology, 25*, 7–32.

Drake, R. E., Yovetich, N. A., Bebout, R. R., Harris, M., & Mchugo, G. J. (1997). Integrated treatment for dually diagnosed homeless adults. *The Journal of Nervous &amp Mental Disease, 185*(5), 298–305. https://doi.org/10.1097/00005053-199705000-00003

El-Guebaly, N. (2012). The meanings of recovery from addiction: Evolution and promises. *Journal of Addiction Medicine, 6*(1), 1–9.

Farkas, M., Gagne, C., Anthony, W., & Chamberlin, J. (2005). Implementing recovery oriented evidence based programs: Identifying the critical dimensions. *Community Mental Health Journal, 41*, 141–158.

Farquhar, S. A., Ryder, M., Henderlong, D., Lowe, R. A., & Amann, T. (2014). Listening to consumer perspectives to inform addictions and housing-related practice and research. *Global Journal of Community Psychology Practice, 5*(1), 1–14. https://doi.org/10.7728/0501201408

Fazel, S., Khosla, V., Doll, H., & Geddes, J. (2008). The prevalence of mental disorders among the homeless in western countries: Systematic review and meta-regression analysis. *PLoS Medicine, 5*(12), e225. https://doi.org/10.1371/journal.pmed.0050225

Flanagan, M. W., & Briggs, H. E. (2016). Substance abuse recovery among homeless adults in Atlanta, Georgia, and a multilevel drug abuse resiliency tool. *Best Practices in Mental Health, 12*(1), 89–109.

Fountain, J., Howes, S., Marsden, J., Taylor, C., & Strang, J. (2003). Drug and alcohol use and the link with homelessness: Results from a survey of homeless people in London. *Addiction Research & Theory, 11*(4), 245–256.

Gaboardi, M., Lenzi, M., Disperati, F., Santinello, M., Vieno, A., Tinland, A., Vargas-Moniz, M., Spinnewijn, F., O'Shaughnessy, B., Wolf, J., Bokszczanin, A., Bernad, R., Beijer, U., Ornelas, J., Shinn, M., & HOME-EU Consortium Study Group. (2019). Goals and principles of providers working with people experiencing homelessness: A comparison between Housing First and traditional staircase services in eight European countries. *International Journal of Environmental Research and Public Health, 16*(9), 1590. https://doi.org/10.3390/ijerph16091590

Gjersing, L., & Bretteville-Jensen, A. L. (2018). Patterns of substance use and mortality risk in a cohort of 'hard-to-reach'polysubstance users. *Addiction, 113*(4), 729–739.

Goodman, L. A., Saxe, L., & Harvey, M. (1991). Homelessness as psychological trauma: Broadening perspectives. *American Psychologist, 46*(11), 1219.

Greenwood, R. M., Stefancic, A., Tsemberis, S., & Busch-Geertsema, V. (2013). Implementations of Housing First in Europe: Successes and challenges in maintaining model fidelity. *American Journal of Psychiatric Rehabilitation, 16*(4), 290–312. https://doi.org/10.1080/15487768.2013.847764

Gulcur, L., Stefancic, A., Shinn, M., Tsemberis, S., & Fischer, S. N. (2003). Housing, hospitalization, and cost outcomes for homeless individuals with psychiatric disabilities participating in continuum of care and Housing First programmes. *Journal of Community & Applied Social Psychology, 13*(2), 171–186. https://doi.org/10.1002/casp.723

Gutwinski, S., Schreiter, S., Deutscher, K., & Fazel, S. (2021). The prevalence of mental disorders among homeless people in high-income countries: An updated systematic review and meta-regression analysis. *PLoS Medicine, 18*(8), Article e1003750. https://doi.org/10.1371/journal.pmed.1003750

Han, B. H., Doran, K. M., & Krawczyk, N. (2022). National trends in substance use treatment admissions for opioid use disorder among adults experiencing homelessness. *Journal of Substance Abuse Treatment, 132*, Article 108504.
Heimdahl Vepsä, K. (2020). Parents' experiences of substance use problems, parenthood, and recovery within the 12-step movement. *Nordic Studies on Alcohol and Drugs, 37*(6), 576–591. https://doi.org/10.1177/1455072520941992
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. https://doi.org/10.1080/15504263.2012.697448
Hopper, E. K., Bassuk, E. L., & Olivet, J. (2010). Shelter from the storm: Trauma-informed care in homelessness services settings. *The Open Health Services and Policy Journal, 3*(1).
Hopper, K., Jost, J., Hay, T., Welber, S., & Haugland, G. (1997). Homelessness, severe mental illness, and the institutional circuit. *Psychiatric Services, 48*(5), 659–665.
Hossain, M. M., Sultana, A., Tasnim, S., Fan, Q., Ma, P., McKyer, E. L. J., & Purohit, N. (2020). Prevalence of mental disorders among people who are homeless: An umbrella review. *International Journal of Social Psychiatry, 66*(6), 528–541. https://doi.org/10.1177/0020764020924689
Johnsen, S., & Teixeira, L. (2010). *Staircases, elevators and cycles of change: Housing First and other housing models for homeless people with complex support needs*. The University of York and Crisis.
Johnson, T. P., & Fendrich, M. (2007). Homelessness and drug use: Evidence from a community sample. *American Journal of Preventive Medicine, 32*(6), S211–S218.
Johnson, T. P., Freels, S. A., Parsons, J. A., & Vangeest, J. B. (1997). Substance abuse and homelessness: Social selection or social adaptation? *Addiction, 92*(4), 437–445.
Karadzhov, D. (2023). " Recovery is fearful to me ...": Conceptualizations, concerns and hopes about personal recovery in adults who are chronically homeless. *Social Work in Mental Health, 21*(3), 285–305. https://doi.org/10.1080/15332985.2022.2155096
Karadzhov, D., Yuan, Y., & Bond, L. (2020). Coping amidst an assemblage of disadvantage: A qualitative metasynthesis of first-person accounts of managing severe mental illness while homeless. *Journal of Psychiatric and Mental Health Nursing, 27*(1), 4–24. https://doi.org/10.1111/jpm.12524
Kemp, R. (2019). Addiction and addiction recovery: A qualitative research viewpoint. *Journal of Psychological Therapies, 4*(2), 167–179. https://doi.org/10.33212/jpt.v4n2.2019.167
Kerman, N., & Sylvestre, J. (2020). Service use and recovery among currently and formerly homeless adults with mental illness. *International Journal of Social Psychiatry, 66*(4), 389–396. https://doi.org/10.1177/0020764020913324
Kilty, J. M., & Dej, E. (2012). Anchoring amongst the waves: Discursive constructions of motherhood and addiction. *Qualitative Sociology Review, 8*(3), 6–23. https://doi.org/10.18778/1733-8077.8.3.01
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.
Loubière, S., Lemoine, C., Boucekine, M., Boyer, L., Girard, V., Tinland, A., Auquier, P., & French Housing First Study Group. (2022). Housing First for homeless people with severe mental illness: Extended 4-year follow-up and analysis of recovery and housing stability from the randomized Un Chez Soi d'Abord trial. *Epidemiology and Psychiatric Sciences, 31*, e14.
Lyon-Callo, V. (2000). Medicalizing homelessness: The production of self-blame and self-governing within homeless shelters. *Medical Anthropology Quarterly, 14*(3), 328–345.
Macnaughton, E., Townley, G., Nelson, G., Caplan, R., Macleod, T., Polvere, L., Isaak, C., Kirst, M., McAll, C., Nolin, D., Patterson, M., Piat, M., & Goering, P. (2016). How does Housing First catalyze recovery?: Qualitative findings from a Canadian multi-site randomized controlled trial. *American Journal of Psychiatric Rehabilitation, 19*(2), 136–159. https://doi.org/10.1080/15487768.2016.1162759
Marshall, C. A., Gewurtz, R., Ross, C., Becker, A., Cooke, A., Roy, L., Barbic, S., Lysaght, R., & Kirsh, B. (2022). Beyond securing a tenancy: Using the capabilities approach to identify the daily living needs of individuals during and following homelessness. *Journal of Social Distress and the Homeless*, 1–15. https://doi.org/10.1080/10530789.2022.2070098
Mayock, P. (2023). (Re)assembling the self: Homeless young people's identity journeys and the search for ontological security. *Child Care in Practice, 29*(3), 297–318. https://doi.org/10.1080/13575279.2023.2199191
Mayock, P., & O'Shaughnessy, B (2023). Homelessness and substance use. In J. Bretherton, & N. Pleace (Eds.), *The Routledge handbook of homelessness* (1st ed., pp. 244–255). Routledge. https://doi.org/10.4324/9781351113113-25.
McDonagh, D., De Vries, J., & Cominskey, C. (2023). The role of adverse childhood experiences on people in opiate agonist treatment: The importance of feeling unloved. *European Addiction Research, 29*(5), 313–322. https://doi.org/10.1159/000532005
McNaughton, C. C. (2008). Transitions through homelessness, substance use, and the effect of material marginalization and psychological trauma. *Drugs: Education, Prevention and Policy, 15*(2), 177–188.
McVicar, D., Moschion, J., & Van Ours, J. C. (2015). From substance use to homelessness or vice versa? *Social Science & Medicine, 136–137*, 89–98. https://doi.org/10.1016/j.socscimed.2015.05.005
Moneyham, L., & Connor, A. (1995). The road in and out of homelessness: Perceptions of recovering substance abusers. *Journal of the Association of Nurses in AIDS Care, 6*(5), 11–19. https://doi.org/10.1016/S1055-3290(05)80018-4
National Alliance to End Homelessness. (2024). *State of homelessness: 2023 edition*. https://endhomelessness.org/homelessness-in-america/homelessness-statistics/state-of-homelessness/.
Neale, J. (2001). Homelessness amongst drug users: A double jeopardy explored. *International Journal of Drug Policy, 12*(4), 353–369. https://doi.org/10.1016/S0955-3959(01)00097-4
Neale, J., & Stevenson, C. (2015). Social and recovery capital amongst homeless hostel residents who use drugs and alcohol. *International Journal of Drug Policy, 26*(5), 475–483. https://doi.org/10.1016/j.drugpo.2014.09.012
Nelson, G., Worton, S. K., Macnaughton, E., Tsemberis, S., MacLeod, T., Hasford, J., Goering, P., Stergiopoulos, V., Aubry, T., & Distasio, J. (2019). Systems change in the context of an initiative to scale up Housing First in Canada. *Journal of Community Psychology, 47*(1), 7–20. https://doi.org/10.1002/jcop.22095
Nicholls, M. J., & Urada, L. A. (2022). Homelessness and polysubstance use: A qualitative study on recovery and treatment access solutions around an urban library in Southern California, USA. *Health & Social Care in the Community, 30*(1), e175–e183. https://doi.org/10.1111/hsc.13424
Noblit, G. W., & Hare, R. D. (1988). *Meta-ethnography: Synthesizing qualitative studies*. Sage (Vol. 11).
O'Donnell, R., Hatzikiriakidis, K., Savaglio, M., Vicary, D., Fleming, J., & Skouteris, H. (2022). The extent to which non-conditional housing programs improve housing and well-being outcomes: A systematic review. *Housing, Care and Support, 25*(1), 46–60. https://doi.org/10.1108/HCS-09-2021-0025
OECD. (2021). *Homeless population*. OECD - Social policy division - Directorate of employment. *Labour and Social Affairs*. https://www.oecd.org/els/family/HC3-1-Homeless-population.pdf.
Padgett, D., Gurdak, K., & Bond, L. (2022). The "high cost of low living": Substance use recovery among older formerly homeless adults. *Substance Abuse, 43*(1), 56–63. https://doi.org/10.1080/08897077.2020.1734713
Padgett, D., Henwood, B. F., & Tsemberis, S. J. (2016a). *Housing First: Ending homelessness, transforming systems, and changing lives*. USA: Oxford University Press.
Padgett, D. K. (2007). There's no place like (a) home: Ontological security among persons with serious mental illness in the United States. *Social Science & Medicine, 64*(9), 1925–1936. https://doi.org/10.1016/j.socscimed.2007.02.011
Padgett, D. K., Henwood, B., Abrams, C., & Drake, R. E. (2008). Social relationships among persons who have experienced serious mental illness, substance abuse, and homelessness: Implications for recovery. *American Journal of Orthopsychiatry, 78*(3), 333–339. https://doi.org/10.1037/a0014155
Padgett, D. K., Henwood, B. F., & Tsemberis, S. J. (2015). Housing first internationally: Canada, Europe, and Australia. In D. K. Padgett, B. F. Henwood, & S. J. Tsemberis (Eds.), *Housing First: Ending homelessness, Transforming systems, and changing lives* (pp. 133–166). Oxford University Press. https://doi.org/10.1093/acprof:oso/9780199989805.003.0008.
Padgett, D. K., Smith, B. T., Henwood, B. F., & Tiderington, E. (2012). Life course adversity in the lives of formerly homeless persons with serious mental illness: Context and meaning. *American Journal of Orthopsychiatry, 82*(3), 421–430.
Padgett, D. K., Tiderington, E., Tran Smith, B., Derejko, K.-S., & Henwood, B. F. (2016b). Complex recovery: Understanding the lives of formerly homeless adults with complex needs. *Journal of Social Distress and the Homeless, 25*(2), 60–70. https://doi.org/10.1080/10530789.2016.1173817
Parsell, C., & Parsell, M. (2012). Homelessness as a choice. *Housing, Theory and Society, 29*(4), 420–434. https://doi.org/10.1080/14036096.2012.667834
Patterson, M. L., Currie, L., Rezansoff, S., & Somers, J. M. (2015). Exiting homelessness: Perceived changes, barriers, and facilitators among formerly homeless adults with mental disorders. *Psychiatric Rehabilitation Journal, 38*(1), 81–87. https://doi.org/10.1037/prj0000101
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), Article e003442. https://doi.org/10.1136/bmjopen-2013-003442
Paul, S., Corneau, S., Boozary, T., & Stergiopoulos, V. (2018). Coping and resilience among ethnoracial individuals experiencing homelessness and mental illness. *International Journal of Social Psychiatry, 64*(2), 189–197. https://doi.org/10.1177/0020764017748986
Percy, W., Kostere, K., & Kostere, S. (2015). Generic qualitative research in psychology. *The Qualitative Report*. https://doi.org/10.46743/2160-3715/2015.2097
Pleace, N., & Bretherton, J. (2012). Will paradigm drift stop Housing First from ending homelessness? *Categorising and critically assessing the Housing First movement from a social policy perspective*. In *Social Policy in an Unequal World: Joint annual conference of the East Asian Social Policy Research Network and the UK Social Policy Association*.
Ralph, R. O. (2000). Recovery. *Psychiatric Rehabilitation Skills, 4*(3), 480–517.
Rogers, E. S., Farkas, M., & Anthony, W. A. (2005). In C. E. Stout & R. A. Hayes (Eds.), *Recovery from severe mental illnesses and evidence-based practice research.* (pp. 199–219). John Wiley & Sons, Inc.
Ridgway, P. (2001). ReStorying psychiatric disability: Learning from first person recovery narratives. *Psychiatric Rehabilitation Journal, 24*(4), 335–343. https://doi.org/10.1037/h0095071
Ross-Houle, K., & Porcellato, L. (2023). Recovery capital in the context of homelessness, high levels of alcohol consumption, and adverse significant life events. *Drugs: Education, Prevention and Policy, 30*(2), 173–184. https://doi.org/10.1080/09687637.2021.2014402
Sahlin, I. (2005). The staircase of transition: Survival through failure. *Innovation: The European Journal of Social Science Research, 18*(2), 115–136. https://doi.org/10.1080/13511610500096400
Scott, C. K., Foss, M. A., & Dennis, M. L. (2005). Pathways in the relapse—Treatment—Recovery cycle over 3 years. *Journal of Substance Abuse Treatment, 28*(2), S63–S72. https://doi.org/10.1016/j.jsat.2004.09.006
Shinn, M., Brown, S. R., & Gubits, D. (2017). Can Housing and service interventions reduce family separations for families who experience homelessness? *American*

Journal of Community Psychology, 60(1–2), 79–90. https://doi.org/10.1002/ajcp.12111

Spaniol, L., Gagne, C., & Koehler, M. (2003). The recovery framework in rehabilitation and mental health. In D. P. Moxley & J. R. Finch (Eds.), Sourcebook of Rehabilitation and Mental Health Practice (pp. 37–50). Springer US. https://doi.org/10.1007/0-306-47893-5_4.

Stanhope, V., Henwood, B. F., & Padgett, D. K. (2009). Understanding service disengagement from the perspective of case managers. *Psychiatric Services, 60*(4), 459–464.

Substance Abuse and Mental Health Services Administration. (2023). *Mental Health and Substance Use Disorders*. https://www.samhsa.gov/find-help/disorders.

Tran Smith, B., Padgett, D. K., Choy-Brown, M., & Henwood, B. F (2015). Rebuilding lives and identities: The role of place in recovery among persons with complex needs. *Health & Place, 33*, 109–117. https://doi.org/10.1016/j.healthplace.2015.03.002

Treloar, C., Schroeder, S., Lafferty, L., Marshall, A., Drysdale, K., Higgs, P., Baldry, E., Stoove, M., & Dietze, P. (2021). Structural competency in the post-prison period for people who inject drugs: A qualitative case study. *International Journal of Drug Policy, 95*, Article 103261.

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. https://doi.org/10.1002/(SICI)1520-6629(199903)27:2<225::AID-JCOP9>3.0.CO;2-Y10.1002/.

Tsemberis, S. (2010). Housing First: Ending homelessness, promoting recovery and reducing costs. In I. Gould Ellen & B. O'Flaherty (Eds.), *How to house the homeless* (pp. 37–56). Russell Sage Foundation.

Tsemberis, S., & Asmussen, S. (1999). From streets to homes: The pathways to housing consumer preference supported housing model. *Alcoholism Treatment Quarterly, 17*(1–2), 113–131.

Tsemberis, S., & Eisenberg, R. F. (2000). Pathways to housing: Supported housing for street-dwelling homeless individuals with psychiatric disabilities. *Psychiatric Services, 51*(4), 487–493.

United States Interagency Council on Homelessness. (2022). *ALL IN: The federal strategic plan to prevent and end homelessness*. United States Interagency Council on Homelessness.

Vangeest, J. B., & Johnson, T. P. (2002). Substance abuse and homelessness: Direct or indirect effects? *Annals of Epidemiology, 12*(7), 455–461.

Walsh, F. (2002). A family resilience framework: Innovative practice applications. *Family Relations, 51*(2), 130–137. https://doi.org/10.1111/j.1741-3729.2002.00130.x

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, 13*, 635–649.

White, W. L. (2007). Addiction recovery: Its definition and conceptual boundaries. *Journal of Substance Abuse Treatment, 33*(3), 229–241.

Wong, Y.-L. I., Park, J. M., & Nemon, H. (2006). Homeless service delivery in the context of continuum of care. *Administration in Social Work, 30*(1), 67–94. https://doi.org/10.1300/J147v30n01_05

Wusinich, C., Bond, L., Nathanson, A., & Padgett, D. K. (2019). If you're gonna help me, help me": Barriers to housing among unsheltered homeless adults. *Evaluation and Program Planning, 76*, Article 101673. https://doi.org/10.1016/j.evalprogplan.2019.101673

Zerger, S. (2002). *Substance abuse treatment: What works for homeless people. A Review of the Literature* (pp. 1–62). Nashville, TN: National Health Care for the Homeless Council.