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Complex Recovery: Understanding the Lives of Formerly Homeless Adults with Complex Needs

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Abstract

Objective—This report examines mental health recovery in a population neglected in the literature—formerly homeless adults with serious mental illness and co-occurring substance abuse. The term ‘complex recovery’ is used to examine the onset and impact of various types of adversity over the life course.

Method—Burawoy’s extended case method was conducted on in-depth interviews with 74 formerly homeless adults living in housing programs in New York City. Data included verbatim transcripts, interviewer feedback forms, and case summaries.

Results—Seven themes emerged: the longstanding influence of poverty, childhood hardship, social support and network depletion, substance abuse and recovery, unequal impact of gender differences, experiences of incarceration and fragmented service system. Structural as well as individual factors were found to comprise complex recovery.

Conclusions—Complex recovery, which situates mental health recovery amidst homelessness and other forms of adversity, has implications for policies and practices designed to assist this vulnerable population.

Keywords

serious mental illness; homelessness; substance abuse; mental health recovery; structural factors

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The authors declare that there is no conflict of interest.
INTRODUCTION

The paradigm of recovery has transformed mental health services in the United States and other countries (Anthony, 1993; Mental Health Commission of Canada, 2009; Slade, Amering, & Oades, 2008). First-person accounts (Deegan, 1996; Ridgway, 2001; Saks, 2008) paired with strong empirical evidence (Harding, 2003; Hopper, Harrison & Janca, 2007) have laid the groundwork for a re-envisioning of the potential for a recovered life with and in spite of mental illnesses such as schizophrenia and bipolar disorder. The recovery movement was and remains a direct challenge to traditional approaches relying on hospitalization and medication as the appropriate response to a presumption of enduring disability.

Policymakers, providers and consumer advocates have pursued multiple approaches to promulgating recovery-oriented policies and practices (Davidson, O'Connell, Tondora, Lawless, & Evans, 2005; Davidson & White, 2007; Mancini, Hardiman, & Lawson, 2005; Marshall, Oades, & Crowe, 2009). However, the burgeoning body of research on mental health recovery has generally neglected the effects of deep and abiding poverty, in particular homelessness. Admittedly, it is a daunting challenge to examine the complex but patterned interactions of individual factors set within larger structural barriers (Krieger, 2000). Among those whose lives have been adversely affected by poverty and homelessness, persons with serious mental illness must confront the additional challenges of stigma and social exclusion (Barker, 2003; Zugazaga, 2004). Negative social attributions include assumptions of personal disability, social and cognitive deficits, and violent or irrational behavior (Cozzarelli, Wilkinson & Tagler, 2001; Kendall, 2005; Link, Phelan, Stueve, Moore, Bresnahan & Struening, 1995; Phelan, Link, Moore & Stueve, 1997). Structural barriers include a lack of affordable housing as well job training (Padgett, Henwood & Tsemberis, 2016).

These individuals enter their recovery trajectories with deficits and strengths that remain poorly understood. Research on recovery with a broad sample of mental health consumers is needed (Happell, 2008; Ridgway, 2001) as “it is not clear if the experiences of consumer-professionals are characteristic of the broader population of people with schizophrenia or if they represent a distinct good-outcome subgroup” (Bellack, 2006, p. 433). The promise of recovery raises hopes but also heightens the fear of failure amidst rising expectations (Corrigan, 2014). The United States, a primary site for recovery research, is where individualistic values are given priority and recovery is construed as personal responsibility (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011). Similarly, the emphasis in some recovery programs on returning to before-illness (pre-morbid) functioning presumes there is a prior life desirable enough to restore.

What is required for a recovered life when the obstacles extend before and beyond the onset of serious mental illness? We address this question by examining the multi-dimensional meaning of recovery in a population often neglected in the recovery literature--formerly homeless adults with serious mental illness and co-occurring substance abuse. Using in-depth data from 74 interviews drawn from two qualitative studies, we seek to ‘go earlier’ in
examining childhood experiences as well as to ‘go broader’ to include structural factors that contribute to or inhibit recovery. We address the following research questions:

1) What influences the onset and course of mental illness, homelessness and substance abuse?

2) How do multiple and overlapping problems interact over the life course?

3) How are these problems addressed by existing services?

4) What structural factors affect participants’ lives that might affect recovery?

While the elements of a recovered life are manifold and their ultimate determination lies beyond the scope of this report, we hope that a deeper understanding can be achieved.

**Complex Recovery: The Contribution of Cumulative Adversity**

We propose the concept of complex recovery to capture the kaleidoscope of disadvantage and life adversity that besets formerly homeless individuals and daunts a service system designed to meet their needs. As such, this concept befits the term ‘complex needs’, the latter a relatively recent addition to the lexicon used to connotate multiple co-occurring problems in an individual's life (Atherton & McNaughton Nicholls, 2008). When viewed as the product of cumulative adversity, complex recovery is the dynamic process of overcoming multiple forms of adversity as one pursues a ‘recovered life’.

The term ‘recovery’ as used here goes beyond its popularized reference to overcoming substance abuse or its more recent application to serious mental illness to include homelessness and other forms of life adversity such as child abuse and sexual trauma. Complex recovery is inter-connected and synergistic in nature; it involves more than the additive effects of multiple problems. As a consequence, addressing complex recovery challenges researchers whose methods are better suited to testing individual variables across large samples rather than examining complex and changing interactions across the life course (Diez-Roux, 1998).

In developing measures of mental health recovery (Andresen, Oades, & Caputi, 2003; Campbell-Orde, Chamberlin, Carpenter, 2005; Noordsy, Torrey, Mueser, Mead, O'Keefe, & Fox, 2002), researchers typically rely on what is accessible and measurable such as symptoms and daily functioning. Less tangible aspects elude concretization (Meehan, King, Beavis, & Robinson, 2008), e.g., hope and a sense of self-fulfillment (Deegan, 1996; Corrigan, 2014). Similar to serious mental illness, addiction recovery follows an unpredictable trajectory, its existence largely documented through measures of alcohol or drug use (Sobell & Sobell, 1992).

While individual-based measures have been developed for both types of recovery as well as other problems (including trauma, homelessness, poor health), less is known about how these problems interact as well as the role of extra-individual contexts and structural factors. Proximal contextual factors such as family, friends and the local service environment can play a role both positive and negative (Whitley & Drake, 2010). Distal or upstream factors and their effects are more challenging to capture yet potentially powerful influences on complex recovery. These oppressive structural effects, described as pathogenic by Smith,
Chambers & Bratini (2009), exert an influence that eludes the individualistic scope of most service provision.

For service providers attuned to structural obstacles, mental health recovery tends to be refracted through the lens of stigma and social exclusion (Corrigan, 2004; Link & Phelan, 2001). Negative attitudes towards persons experiencing serious mental illness and substance abuse are likely to be compounded when homelessness is factored in. However, the influence of structural barriers earlier in life as well as during adulthood often lies outside the purview of a researcher’s measures or a practitioner’s services.

A life course perspective offers optimal means for such inquiry (Ben-Shlomo & Kuh, 2002) and qualitative methods give the advantage of prioritizing consumers’ voices and experiences (Padgett, 2012). In this study, we use ‘complex recovery’ and ‘cumulative adversity’ as sensitizing concepts (Strauss & Corbin, 1990) to guide analyses of in-depth interviews of formerly homeless persons with serious mental illness and co-occurring substance abuse.

**METHODS**

The adoption of Burawoy’s extended case method (1998) enables the researcher to examine an extant theory or construct to search for anomalies and contribute to a more inclusive and valid definition. In doing so, one may proceed from directly observable or measurable phenomena to examine larger economic and political contexts. Following Burawoy (1998), we examine individual cases in order to reflect on (and expand) the meaning of recovery.

**Sampling and Data Collection**

The data for this report were collected as part of two Federally-funded qualitative studies conducted in 2004-2005 (Study A) and 2010-2011 (Study B) in New York City. As designed, the interviews were conducted to capture the experiences of formerly homeless adults living in varied program settings ranging from transitional supportive housing to permanent supportive apartments, all serving formerly homeless persons with serious mental illness. Inclusion criteria included: over age 18, English-language fluency, DSM-IV diagnosis of serious mental illness, and history of homelessness and substance use.

Study A (n=39) used maximum variation sampling in which senior program staff were asked to nominate clients with both positive and negative levels of recovery (criteria relied on staff judgments of mental health status and daily functioning). Study B (n=35) was focused on examining recovery in ‘higher functioning’ individuals from this population. In addition to the above criteria, Study B used purposive sampling to identify individuals who had Global Assessment of Functioning (GAF) (Jones, Thornicroft, Coffey & Dunn, 1995) scores above 65, housing stability, absence of current (but history of) substance use disorder, and one or more signs of mental health recovery such as having a job and/or stable partner. Participants in both studies were paid a US$30 incentive per interview plus a roundtrip Metrocard valued at US$4.50. All study protocols were approved by the authors’ institutional human subjects committee.
In both studies, in-depth interviews were carried out by graduate student research staff trained in qualitative methods and having backgrounds in research with this population. The interview guide included casting-a-wide-net questions and focused probes for mental health and psychiatric treatment experiences, substance use and recovery and homeless episodes. The overall goal of the interviews was to understand from the participants’ perspectives how they were currently doing, how that status was achieved and what life experiences preceded it, both positive and negative. Although interviewers did not directly inquire about traumatic events, they were trained to sensitively probe if and when such events were mentioned.

In both studies, interviewers were required to fill out a post-hoc Interviewer Feedback Form (IFF) describing the surroundings of the interview (if conducted in the participant's residence) and non-verbal behavior to contextualize what was said. The first author provided ongoing feedback and supervision and weekly team meetings were held for debriefing to minimize bias. Interviews, lasting anywhere from 45 minutes to 2 hours, were transcribed verbatim and entered into ATLAS.ti software for data management and analysis.

**Data Analysis**

Case study analyses (Patton, 2002) were conducted by analyzing the following: verbatim transcripts; interviewer feedback forms (IFFs), and case summaries in narrative and matrix formats. Narrative case summaries were constructed by the participant’s interviewer and consisted of a sequential report of life events (both positive and negative). Matrix summaries used the ‘domain’ approach in spreadsheet format such that each participant's life events were classified (family relationships, mental illness, substance abuse, work history) and briefly summarized. This enabled cross-case as well as within-case (life course) comparisons.

Participant demographics were obtained through self-report at the conclusion of the interview. In cases where participants did not self-report socio-economic background, two research staff independently read the case files and rated each study participant as growing up in either low income/working class or middle class and higher backgrounds. The former was defined as the family being on public assistance or having one or both parents sporadically employed or working in low-wage jobs. The latter was defined as having parents (one or both) working in professional positions and having a college education or higher. Consensus discussions were used to arrive at the final ratings.

In keeping with Burawoy’s extended case method (1998), we looked outside the usual definitional parameters for early life circumstances and extra-individual factors that could expand our understanding of the meaning of recovery. Each case file was read multiple times to identify the salient domains of recovery derived from the literature as well as new barriers or incentives that emerged from the interviews. Analytic memos were developed to assist in the cross-case analyses and thematic development.

Strategies for rigor pursued during the data analysis included auditing of analytic decisions, peer debriefing within the team and negative case analysis (Padgett, 2012). As an example of the latter, a popular assumption that persons with serious mental illness abuse substances to ‘self-medicate’ their psychotic symptoms was echoed in some interviews but a search for
negative cases—individuals whose substance abuse pre-dated their mental illness or declined after the psychiatric diagnosis—led to a more fine-tuned understanding of co-occurring substance abuse.

RESULTS

Demographic Characteristics

As shown in Table 1, the two study samples are similar in average age and SES background. The groups are different in ethnic/racial and gender composition although African-Americans are the largest subgroup in both samples. As shown, the overwhelming majority of participants came from low income or working class backgrounds; about one-half reported having one or more episodes of incarceration.

Cross-Cutting Themes

The Longstanding Influence of Poverty—As shown in Table 1, the descent into homelessness for most was set against a longstanding familiarity with economic deprivation. Individuals from middle-class families (n=16) did not necessarily have ‘easy’ childhoods (family conflict was a common occurrence) but they did not encounter economic problems until later in life after they left home or were institutionalized. For example, SP8 (study participant plus identification number) received a college degree in biochemistry and worked as a computer technician before his bipolar disorder worsened and he began to abuse cocaine and lost his housing. SP34 immigrated to the United States from an Asian country, a young woman with a college degree who grew up in an affluent family. She struggled with psychosis for years but was able to maintain a job at a bank and raise a daughter who is currently enrolled in college. The stress of working led to unemployment for prolonged periods and she eventually became homeless.

These examples stand in contrast to the experiences of the majority. Many had a working parent who struggled to support the family, but the combination of unemployment and large extended families meant persistent deprivation. “It was rough. Because there was so many of us... either we didn’t have shoes, or we didn’t have clothes. And you had to be really doing bad... before the family could afford buying you another pair of shoes.” (SP29)

As this participant reported,

She [SP’s mother] just had so much going on...her and my father was getting a divorce and she was trying to work and she was trying to make it on food stamps ... my sisters took care of me and my brother... took care of me for a while but then he went into the Navy so he wasn't there. (SP27)

Childhood Hardship—For many participants, a childhood characterized by deprivation and neglect was compounded by exposure to neighborhood violence. SP11 recalled his childhood, “Oh, man, it was rough. There was a lot of drugs, there was a lot of shooting and killing and robbin’ in Harlem. There was a lot of crackheads, a lot of prostitution. Diseases, AIDS. All that shit.” Participants also reported stressful home environments that included...
verbal and physical abuse, frequently exacerbated by use of alcohol or drugs. SP4 recalled witnessing her father's physical abuse towards her mother,

...If someone said to him, ‘Your wife is beautiful,’ he would beat her. Again, he was drinking... I don't mean just a smackin' around,...I mean putting her in the hospital....I remember being this little, couldn't even see over the bed, going to see my mother in the hospital ...back then I would hide a lot in the closet or anything to not hear this.

Others reported experiencing abuse directly. SP26 and his mother endured cycles of abuse and contrition at the hands of his father, “He used to beat me and my mother, I mean bad, and then the next day, “Oh, I'm sorry, I swear to God I won't do it again.” One day he'd love us, the next day he hated us.”

Social Support and Network Depletion—Estrangement and rejection were among the reasons given for the social isolation that characterized participants’ lives. Parents, if not prematurely deceased or estranged from the participant’s life, often had problems of their own and other children or grandchildren to assist. Participants’ children—most were adults by the time of the study interview—had led turbulent lives with the participant or, more often, with other family members or in foster care.

Participants’ life stories contained accounts of untimely deaths due to drug overdoses, violent confrontations, fatal accidents, and medical problems including AIDS, cancer, and heart disease. Family members were often ‘in the same boat’, i.e., coping with serious mental illness themselves. Speaking of his medical problems and eviction, one participant noted, “I still gotta go through life making it seem like everything is alright because I don't want to depress people with my own worries ‘cause nobody can really help because everybody is going through the same thing.” (SP9)

One of the most striking examples of this complexity came from SP25, a veteran, who began his interview by stating:

Well right now I'm going through a lot of depressive drama because I'm handling a lot of family problems that's causing more stress on top of my depression and PTSD. On my son's side, he just lost his mom in July, and right before that we lost her middle sister and before that ....we lost her baby sister... and we getting ready to have a couple of more deaths in the family. We have an uncle that's got terminal cancer ...And on top of that then we have another sister-in-law she has emphysema....she's just 50 ... her husband was told a few times they didn't think she'd make it. And on top of that, my youngest son, he's been sentenced to 25 to life for manslaughter. And [in the 1980s] my whole family passed away, first my mom, my father, and the same time my mom's in the hospital dying my brother's in the hospital, he died of HIV.

It is difficult to over-estimate the extent of transience and loss in social relationships over the life course. SP1, recovering from drug addiction and bipolar disorder, reflected on his lack of friends,
Oh god, I have very few, I have my one remaining friend from my childhood who is
dying of ALS, a neuromuscular disease...most of my friends have died from drug
use, AIDS...they're in jail for life, I mean just tough neighborhood, housing
projects, all that fun stuff.

**Substance Abuse and Recovery: The Significance of People, Places and
Things**—The 12-step motto urging those in recovery to avoid any 'people, places and
things' that might trigger a relapse has special meaning when one's surrounding environment
is more likely to contain such problematic influences. Participants reported early exposure to
substance abuse, an exposure that continued into adulthood. SP38 was introduced to drug
use by his father,

... I used to use heroin, cocaine, marijuana, pills, so I indulged in a lot of drugs. It
was a family thing because my dad let us use drugs at an early age. According to
him it was fine as long as we didn't use no needles... he let me smoke pot at the age
of 8. ... he used to give it to us. He thought it was okay...

All of the participants resided in low-income neighborhoods where their respective programs
had access to affordable housing. Some were placed in the same neighborhoods where they
had grown up or where their problems had been most intense. With drugs easily available,
income could be generated from selling them on the street. When asked where he went after
being kicked out of his family's apartment, SP39 stated,

In my friend's house. Sleep in a car. If I had some weed, I could go to his house.
He'd say two bags a weed to stay the night. So, I'm hustlin', trying to make $15 just
for three bags.

Participants talked about the ease of access to substances through proximity to other users in
their social service programs. SP 29 noted that some residents in his housing program
continued to use substances even when forbidden by program rules,

As soon as they get their money, they going to buy them a bag of herb and some
beer, know what I mean. I knocked on one of the guys’ doors a couple of days ago
and the herb [smell] just hit me! And I said ‘You better air this out man! ... if they
come by you're going to jail.’

**The Unequal Impact of Gender Differences**—In a previous report from Study A
(Author, 2006), formerly homeless women were portrayed as disparaged more than their
male counterparts for exhibiting similar behaviors. In this analysis, we found women
experiencing similar disadvantages, but with additional findings on how men are affected by
the ‘code of the street’ (Anderson, 2000). The ‘code’, a reflection of poverty and alienation,
sets norms for masculine behavior that include violent aggression as pre-emptive self-
defense and sexual freedom over stable relationships. Men paid a price in having to contend
with violent confrontations and risking injuries and arrests, but the ‘code’ also endowed
them with more freedom of movement and the ability to engage in income-generating
activities.
Even in the presence of serious mental illness, men benefited from this greater latitude of acceptable behaviors compared to their female counterparts who were condemned as unfit mothers, unfeminine and sexually licentious. In addition, women lacked the opportunities that men had to participate in the underground economy (dealing drugs, street peddling, off-the-books construction work, street musician). Having fewer defenses when homeless, women had to contend with repeated exposure to sexual assault, compounding the potential for trauma. SP7 offered this account from her years of crack addiction,

I've been raped about five or six times. I just lay there and let the person do what they gotta do. And once they get up and leave, I go to the bathroom and wash up.... and cry and tell myself I'm not going to let this happen again. Well, obviously, it did...and it got worse each time. Sometimes they just tie me up and beat me with a belt...But I knew I was getting myself in these positions by trusting men.

For women, these gender-related tensions were sometimes moderated by the presence of a trusted male friend or relative. For men, women were a source of support (especially mothers and sisters), but partner relationships could be a problem. As SP 25 reported, “The third time I was in rehab I ran into this female we messed around, drinking and drugs, that set me off. The rehab is right across the street from the hotel we was at”. Or as SP6 explained,

They put me into a program ... a treatment center for men. One of the reasons why I never successfully completed a treatment program is I'm easily distracted by women, and this [program] was all men, so I had no choice but to pay attention and it literally worked for me.

Experiences of Incarceration—While some participants had felony convictions that sent them to prison, most had jail terms for minor crimes such as drug possession, loitering, or trespassing. As SP18 reported, she had had many run-ins with law enforcement in Florida where she had sought escape from the winter.

’Cause it's warm all year round, I'd be better off. I could sleep on the beach and stuff like that. But that's not true ‘cause when I slept on the beach I'd get picked up and be put in jail for the night for loitering.

SP26’s drug problems led to repeated arrests and time incarcerated,

... I've been in every correctional faculty [sic] in New York City...except the federal prison.... chronic addiction and selling and using drugs. ... I have three felonies for selling drugs to undercover agents... But every place I've been, no matter where I went or what I done, or how much time I done, as soon as I got out I used drugs.

These longer prison terms also brought attrition and estrangement in family relationships, “Like I said since I been incarcerated I don't have no family. My mom and pops passed since I been incarcerated. On my pops side, I lost contact. ... I'm my own family. I'm my own man here.” (SP 37)

A Fragmented Service System—in addressing addiction and mental illness, participants reported encountering numerous ‘wrong doors’ or ‘closed doors’ when seeking
help, 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.

I would ... go from the hospital to these residences.... And they got all the power. You don't want to say too much....And you know you gonna have to live under all these rules. And so they took me to one place in the Bronx, and...they didn't accept me, and I'm like, phew (exhale), back to the drawing board. And so they took me out to another place and it didn't work there either. So it finally came to [name of program] - they accepted me. (SP13)

Additionally, complicating barriers within the entitlement system exacerbated the effects of existing problems. SP9 sustained a severe skull fracture and brain injury from a run-in with a local gang. Previously laid off from his job as a security guard, he reported being unable to obtain help with his medical or mental health problems due to restrictions on entitlement qualification, precipitating a descent into homelessness,

... it's [brain injury] a serious disability that's hidden. People don't know because you can't see it, 'cause it's all mental (crying). I can try so hard ... but I don't qualify for Medicaid because I make too much. How can I make too much when I'm not working? My unemployment is too much. So then I gotta deal with the housing eviction.

**Individual case studies of complex recovery**—To illustrate cumulative adversity individually, Figures 1 and 2 shows the life trajectories of a male participant (SP29), a 60-year-old African American man, and a female participant (SP7, a 52-year-old African-American woman). SP29's life experiences began with childhood poverty living within a family with 10 children. He began using cocaine and heroin at age 16 and was incarcerated on several occasions including a long prison stint that ended in 2004. Diagnosed with schizophrenia at age 25 and still on medication at the time of the interview, SP29 was homeless on and off until entering his program. SP7 was sexually abused in childhood and impregnated by her father at age 18. Abandoned to distant relatives by her mother, she spent much of her adulthood in and out of psychiatric hospitals and struggling with an addiction to crack cocaine.

**DISCUSSION**

The findings from this study help to elucidate factors that affect complex recovery by focusing on adversities that overlap and contribute to cumulative effects over time. Childhood hardship was found to be greater among low-income families. For some participants, family dysfunction pre-dated the onset of serious mental illness and exacerbated the illness itself. Poverty in adulthood (true for all study participants given the studies’ inclusion criteria) was linked to lower socio-economic status in childhood with few exceptions. The depletion of social networks, a consequence of poverty-related morbidity and mortality, increased social exclusion associated with mental illness and substance abuse.
And illegal drug use and homelessness were often linked to arrests and incarceration, furthering social isolation.

When traumatic events are added to the life course—sexual abuse, debilitating injuries, assaults on the street or in prison—their effects can overshadow the psychiatric diagnosis that so often defines these individuals in the service system. Individuals in this report possessed multiple identities related to having survived mental illness, substance abuse, and homelessness. Undergirding and preceding these ‘survivor’ identities are demographic characteristics such as race and gender that bring their own challenges and, for some, relative advantage. Being male, for example, confers certain advantages in our study population. Being African American confers certain disadvantages in U.S. society (Alexander & West, 2012). Taken together, such identities evince a degree of intersectionality (Crenshaw, 1991) that has further relevance for complex recovery. This counters a tendency toward individualistic attributions for mental illness and poverty that hinders understanding of the dynamic and inter-locking nature of lives as lived (Bullock, 1999; Singer, Ryff, Carr & Magee, 1998).

In this context, having a serious mental illness can be one of many problems in life and not necessarily the most debilitating one. This was apparent in participant interviews, as individuals often spoke at greater length about their struggles with addiction and health problems than they did about their experience of mental illness. Studies have shown that persons with serious mental illness are at greater risk of drug and alcohol abuse and have more physical health problems and higher mortality than the general population (Druss, Zhao, Von Esenwein, Morrato, & Marcus, 2011). In this context, the co-occurrence of substance use and physical health problems with mental illness may contribute to masking psychiatric symptoms and/or amplifying their effects. For example, providers may mistake symptoms of brain trauma for drug-induced or psychiatric symptoms (Corrigan & Deutschle, 2008).

Meanwhile, service systems are typically funded and staffed to address one presenting problem at a time—to pull out a single thread entangled in others—whether it is mental suffering, physical illness, substance abuse or a lack of shelter. Homeless mentally ill persons too often find themselves traversing the ‘institutional circuit’ of hospital emergency rooms, clinics, detox centers, shelters and jails (Hopper, Jost & Hay, 1997). Outside of the need for appropriate treatment and services, the ‘normal’ aspects of adult life—employment, parenting, higher education, leisure activities—elude members of this population as the findings from this report indicate.

Recovery from and in mental illness is invariably a challenge for each person, but complex recovery expands understanding of this phenomenon to include structural factors as well. Thus far, there has been limited research about how structural factors influence individual journeys of recovery (Henwood & Whitley, 2013). The majority of participants in this study shared in the same exposure to adversity as other residents growing up in areas of ‘concentrated disadvantage’ (Sampson, Raudenbush, & Earls, 1997) with high rates of poverty, single parenthood and violence. For example, a longitudinal study of 224 inner city young adults in Philadelphia found that by age seven a total of 81 percent had seen someone...
arrested, 74 percent had heard gunshots, 35 percent had seen someone get shot, and 19 percent had seen a dead body outside (Fitzgerald, 2013). In the United States, African American men are six times more likely to be incarcerated than white men (Pettit, 2012) a disproportion stemming from racial inequalities in the criminal justice system (Alexander & West, 2012). Put another way, individuals in pursuit of complex recovery share many problems in common with their counterparts in poverty-stricken urban areas. The cumulative nature of their problems is likely greater in magnitude but not in kind.

For policymakers, structural problems are a challenge to address but this task has been made potentially easier by health care reforms promising greater service integration for vulnerable populations (Doran, Misa & Shah, 2013). ‘No wrong door’ initiatives are a response to such service fragmentation (Substance Abuse and Mental Health Services Administration, 2002) and have met with considerable success in treating co-occurring mental illness and substance abuse (Drake & Wallach, 2000). Integrating services is an important step, but realizing the promise of complex recovery also requires a broader understanding of structural factors including stigma, social exclusion and endemic poverty (Hopper, 2007; Shinn, 2015). For practitioners, social science perspectives such as intersectionality theory (Crenshaw, 1991) can be helpful in framing how individual lives are affected by multiple interacting influences. Mental health providers can also benefit from incorporating a greater emphasis on the effects of poverty and social exclusion (Smith, 2005). This may include giving more time to assessing adverse childhood experiences as well as current symptoms and problems.

In line with the goals of Burawoy’s extended case method, we believe that an awareness of complex recovery contributes to broader, more inclusive theories of recovery. Broad based anti-poverty initiatives promote recovery by decreasing inequality, and culturally-sensitive programs are needed to decrease stigma and enhance the ability of individuals to have fulfilling lives in the community (Smith, 2005; Thornicroft, 2006).

**Strengths and Limitations**

This report relied upon case study analyses of interviews with a relatively large sample of individuals with complex problems including serious mental illness, substance abuse and homelessness. While the rapport of in-depth interviewing helps reduce the likelihood of biased self-reports, we acknowledge that under-reporting (due to memory lapse or omission) is plausible—which reinforces our message of the profound effects of the adversity that was mentioned. We also note that participants in Study B represented higher functioning members of the population of interest by virtue of Study B’s overarching aims. This bias was also likely to produce under- rather than over-reporting of the extent of adversity.

Strengths of this study include the use of strategies for rigor including negative case analysis, auditing of analytic decisions and peer debriefing (Padgett, 2012). While our research took place in New York City, the demographic characteristics of the samples mirror the populations of their counterparts in other large urban areas. By focusing on negative events over the life course, we are mindful that this report omits accounts of resilience and survivorship that can shed light on the positive dimensions of complex recovery. To this end, we are currently engaged in a longitudinal study of a cohort of formerly homeless adults with mental and substance use disorders to assess sequencing and impact of positive and
negative events in their trajectories of recovery. We acknowledge that extant research methods place constraints on investigating the life course with its sequencing and intensity of adverse events as well as adaptive responses.

CONCLUSION

Awareness of the complex needs of homeless persons has brought greater attention to the co-existence of mental illness with additional serious problems such as substance abuse and lifelong adversity. In this report, we draw attention to the significance of complex recovery where individuals must contend with these problems as interacting and synergistic in influence. For a significant number of individuals, the notion of ‘recovery’ must be expanded to include past traumas, current problems and future aspirations. Moreover, the phenomenon of complex recovery alerts providers and policymakers to the influence of structural as well as individual problems, most related to enduring poverty and its consequences. The considerable promise of mental health recovery can be realized if and when its complexities are fully addressed.

Acknowledgments

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References

Author. 2006.


Figure 1.
SP29-Life Trajectory
Figure 2.
SP7- Life Trajectory
## Table 1

Demographic Characteristics

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<th>Study A</th>
<th>Study B</th>
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<td><strong>Mean Age (SD)</strong></td>
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