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A Comprehensive Approach to Substance Abuse and Homelessness

For many individuals, substance abuse and homelessness are inextricably intertwined. Indeed, substance use is often both a precipitating factor and a consequence of being homeless.[1] *Further, individuals who are homeless rarely have substance use disorders alone—many have serious mental illnesses, acute and chronic physical health problems, and histories of trauma. They require safe and appropriate housing, multiple interventions, and client-centered care, as the following series of articles attest.*

Researchers estimate that as many as half of all people who are homeless have diagnosable substance use disorders at some point in their lives. Alcohol abuse is more common, occurring in almost half of all homeless, single adults; drug abuse occurs in approximately one-third of this group. Increasingly, individuals who are homeless and have substance use disorders are younger and include women, minorities, poly-drug users, and individuals with co-occurring mental disorders.[2]

Homeless individuals with substance use disorders have multiple and complex needs (see page 2). Research conducted between 1988 and 1993 by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA) revealed that individuals with substance use disorders who are homeless need 1) services that address their tangible needs for housing, income, and employment; 2) access to flexible, low-demand interventions; and 3) long-term, continuous treatment and support.[2]

Common Themes in Effective Substance Abuse Programs[3]

Comprehensive Services - Offering a rich blend of services that address the client's safety, health, social, and material needs, through formal and informal relationships with other service organizations.

Integrated Services - Use of multidisciplinary clinical teams to provide simultaneous, well-coordinated treatment of co-occurring conditions at the same service site, with an emphasis on housing as an essential component of treatment.

Client-centered Care - An individualized plan of care based on the client's needs, wishes, capacities, and readiness for treatment, rather than on the program's predetermined benchmarks for treatment outcomes.

Uniquely Qualified Staff - Caregivers with compassion, empathy, patience, flexibility, and a sense of humor who are able to handle difficult situations rationally and calmly and who reflect the diversity of their clients.

Access to Housing - A stable living situation, especially early in the treatment process, that is not necessarily contingent upon sobriety.

More recently, the National Health Care for the Homeless Council conducted a study of programs recognized for providing effective substance abuse treatment for homeless people. Council staff **Ken Kraybill, MSW,** and **Suzanne Zerger, MA,** visited six of 20 programs nominated by administrators and clinicians in the field. Though each program is unique in its approach (see program highlights below), some common themes emerged (see box at left). For more information, see *Providing Treatment for Homeless People with Substance Use Disorders: Case Studies of Six Programs*, available on the Council Web site (*www.nhchc.org/Publications*).

DIVERSE TREATMENT APPROACHES Albuquerque Health Care for the Homeless, Inc., provides a continuum of services from outreach to drop-in, residential recovery for women and men, and sober transitional housing. The program is unique in its ability to embrace seemingly contradictory substance abuse treatment methods. For example, the Harm Reduction Outreach Program provides sterile syringes to injection drug users (syringe exchange has been legal in New Mexico since 1998), and Tierra del Sol, the women's residential recovery program, employs harm reduction techniques (see related story on harm reduction in this issue). In contrast, Casa Los Arboles, a modified social recovery program for men, is abstinence-based. However, staff are quick to point out that services at Albuquerque are client-centered, and that means being able to offer those services that are most likely to meet the needs and preferences of individuals.

CO-OCCURRING SERIOUS MENTAL ILLNESS The Chicago Health Outreach (CHO) Pathways Home program offers an integrated continuum of assertive outreach, outpatient, and residential services for homeless individuals with co-occurring mental and substance use disorders. Pathways Home, which opened in 2001, is a program of CHO, established in 1985 as an HCH demonstration project. Client-centered care is the cornerstone of services at Pathways Home, which relies heavily on both harm reduction techniques and motivational interviewing to help move clients toward positive change (see story on motivational interviewing in this issue). Helping individuals obtain appropriate housing is a high priority treatment intervention.

ALTERNATIVE TREATMENT SERVICES Portland Alternative Health Center (PAHC), a program of Central City Concern in Portland, Oregon, is a multidisciplinary, integrated health clinic licensed as a drug and alcohol treatment program. The clinic serves homeless and low-income people with multiple diagnoses. PAHC is an abstinence-based program, with acupuncture and Chinese herbal medicines as the preferred methods for detoxification. Acupuncture has been found to decrease physiological stress, reduce craving, diminish depression and physical pain, and promote relaxation.[3] PAHC also offers primary care, mental health care, and aclohol- and drug-free housing. PAHC's Mentor Program provides a recovering staff person to guide a newly recovering individual through the difficult initial 4 to 6 weeks of sobriety.

Characteristics of Homeless People with Substance Use Disorders

- An estimated 50 percent of homeless adults with serious mental illnesses have a co-occurring substance use disorder. Individuals with co-occurring disorders have more problems, need more help, and are more likely to remain homeless than other groups of people.[5]
- Homeless people with mental and substance use disorders often have significant acute and chronic medical conditions, including diabetes, liver disease, upper respiratory infections, serious dental health problems, tuberculosis, and AIDS. Homeless individuals with alcohol disorders are in especially poor health.[6]
- People with substance use disorders who are homeless are more likely to have arrest histories, to have been arrested in the past year, and to report felony drug convictions.[7] Fifty percent of all arrests of homeless people relate to drinking in public spaces.[2]
- Homeless people with substance use disorders, especially those with co-occurring mental disorders, are at risk for losing their housing due to eviction, arrest, and incarceration. Once homeless, they are unlikely to succeed in treatment without access to safe, sober housing.[8]
- Fewer than one-quarter of individuals who need treatment for alcoholism or the use of illicit drugs receives it.[2] Those with the least resources face the most significant barriers to care.
- There is often a discrepancy between what homeless individuals want and what providers believe they need. Homeless individuals may urgently want a job, housing, and help with housing expenses.[9] Only 9 percent of homeless respondents to a national survey mentioned alcohol and drug treatment as something they needed "right now."

CRISIS CENTER The Chemical Dependency Crisis Center (CDCC) is a program of the Bowery Residents' Committee, a community-based organization that serves homeless and low-income people in New York City. CDCC is a residential detoxification program providing short-term services for up to 24 recovering individuals. CDCC operates a highly structured, abstinence-based model that offers multiple group sessions daily. These group sessions include many approaches and topic areas. The center has an open admissions policy, serving those with mental illnesses, HIV/AIDS, and sexual minorities, among others. In addition to detox services, CDCC operates as a crisis center and offers medical respite to those individuals who are not sick enough to be hospitalized but are too ill to be out on the streets.

HOMELESS YOUTH Larkin Street Youth Services is a community-based organization that provides a continuum of services for homeless and runaway youth in San Francisco. Larkin Street began as a drop-in center and now serves approximately 2,000 young people between the ages of 12 and 23 each year. Larkin Street's 18 programs provide a comprehensive continuum of services from street outreach to permanent housing. About 90 percent of youth served have a history of alcohol or drug use, and 82 percent have been physically or sexually abused.[3] However, more than 80 percent of the young people who participate in Larkin Street's case management services permanently exit street life each year. The program emphasizes outreach, housing, and harm reduction/motivational interviewing techniques.

HOMELESS FAMILIES The Worcester Homeless Families Program, based in the Family Health Center of Worcester,

Massachusetts, has provided comprehensive, integrated services to homeless families since 1988. Mental health and substance abuse treatment, parenting, advocacy, and child-focused services are integrated with primary health care. Each family is served by a multidisciplinary team that includes a family advocate, mental health clinician, and primary care provider. Services at the Worcester program are strengths-based and trauma-sensitive, since the vast majority of homeless women have experienced physical and/or sexual abuse.[3] The program takes advantage of the non-stigmatizing nature of primary health care to engage families in a range of mental health, substance abuse, and trauma-related services (see related story in this issue).

Harm Reduction Strategies Meet People Where They Are

Diane McCague is Harm Reduction Coordinator at Albuquerque Health Care for the Homeless, Inc. She considers her work to be about treating drug users with respect and support, something they don't often get. It's about keeping them, and their sex partners, alive and safe. Ultimately, it's about keeping open the lines of communication. "When they do need help, they'll come to us," McCague says, "because we're not going to say, 'I told you so.'"

McCague believes her approach to drug addiction is pragmatic. If nagging an addict to quit worked, she says, "nobody would use drugs." When a friend tried repeatedly to get her to use less salt on her food, McCague relates, "I didn't want to eat with her anymore. It never occurred to me to put less salt on my food."

McCague teaches drug users how to shoot up more safely. She exchanges used syringes for clean ones (to help stem the spread of HIV and hepatitis C, among other infectious diseases) and hands out alcohol pads; tourniquets (stretchy ones are less harmful than shoestrings or belts, she notes); sterile water (to prevent people from using the water in puddles, rivers, and toilets); antibiotic ointment and vitamin E to treat wounds; and pure ascorbic acid (vitamin C) to break down rocks of crack cocaine (because it is safer to use than lemon juice or vinegar, she says).

ESTABLISHING RELATIONSHIPS Working with homeless people who use drugs is about establishing and maintaining relationships, says **Ed Stellon, MS,** Director of Pathways Home in Chicago, which embraces harm reduction techniques. Focusing too soon on treatment may undermine the therapeutic relationship from the outset, warns Stellon. "Clients are likely to feel that you're not listening, that you're trying to control them, or that they couldn't possibly attempt treatment and fail because they don't want to disappoint you."

Stellon speaks about the need to redefine success for homeless people with substance use disorders, something **Melinda Hillock, MSW, LICSW**, calls "taking baby steps." Hillock is Clinical Social Worker at the UMass Memorial Hospital outpatient clinic in Worcester, Massachusetts where she works with people who have HIV and AIDS. For the 6'2", 106-lb man she treats who is wasting from AIDS, it's a success that he comes in every week for breakfast, even though he is still smoking pot.

ABSTINENCE AS HARM REDUCTION On the face of it, harm reduction sounds innocuous enough. Stellon defines harm reduction as a set of "tangible public health strategies to work with people who are not ready to make a big change." Abstinence is not diametrically opposed to harm reduction, Stellon believes. "It's one of the best harm reduction strategies."[10]

Still, proponents of an abstinence-only model of treatment—embodied, for example, in the 12-steps of Alcoholics Anonymous—fear that allowing an alcoholic or addict to continue to use, even in reduced amounts, enables their addiction. There is not a lot of research to date on the overall effectiveness of harm reduction techniques, but research on needle exchange programs indicates that they have not encouraged additional abuse.[11]

MEETING BASIC NEEDS Harm reduction advocates believe it makes little sense to ask an addict to give up drugs and alcohol before you address the underlying causes of their distress. Indeed, a lot of what happens under the rubric of harm reduction for homeless people with substance use disorders involves meeting their immediate subsistence needs.

"When they are rested, fed, and cleaned up, they are in better shape to make decisions about their life," McCague says. This approach is backed by research, which indicates that people are more likely to accept treatment once their basic needs have been met.[12]

A safety-first approach is critical for homeless adolescents, according to **Eliza Gibson, LCSW,** Manager of Mental Health and Substance Abuse Services for Larkin Street Youth Services in San Francisco. "I'd much rather have a kid who is high on heroin sleeping in the shelter than in the park," she says. When an adolescent is safe and the staff has earned his or her trust, together they can begin to work on some of the larger issues that underlie substance abuse. The skills of motivational interviewing can move an adolescent in the direction of change, Gibson says.

Proponents of both harm reduction and abstinence are alike in their respect for the individual and the choices he or she makes. "They [clients] have to make the decision whether or not to use," notes **David Eisen, MSW,** a licensed acupuncturist and doctor of oriental medicine who is Director of the abstinence-based Portland Alternative Health Center in Portland, Oregon. "All we can do is offer them the tools."

Motivational Interviewing Moves People in the Direction of Change

If you've ever had trouble trying to eat less, exercise more, or quit smoking, you know that motivation for change waxes and wanes. You have to be willing to make a change that you recognize is important, feel able to make the change happen (i.e., have a sense of self-efficacy), and be ready to make the change at a particular point in time. "One can be willing and able to make a change, but not ready to do so," note William R. Miller and Stephen Rollnick, authors of the definitive text on motivational interviewing, *Motivational Interviewing: Preparing People for Change*.[13]

Developed for use in substance abuse treatment, motivational interviewing is defined as "a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence."[14] According to Miller, "Motivational interviewing is a respectful, collaborative way of being with people" that helps them elicit their own motivation for change. It runs counter to more confrontational techniques and has been proven effective in a number of medical, public health, and criminal justice settings.[13]

Ken Kraybill likes to quote author Madeline Hunter, who said, "They say you can lead a horse to water, but you can't make him drink. But I say you can salt the oats."[16] In motivational interviewing, Kraybill says, "It's our role as the clinician to salt the oats to make people thirsty for change."

Kraybill believes the following five assumptions are critical to understanding motivational interviewing:

- Motivation is a state, not a trait. Clinicians can influence a person's motivation for change.
- Resistance is not a force to be overcome.
- Ambivalence is a positive thing, because it means people are wrestling with change.
- The client is an ally, not an adversary.
- Recovery and change are intrinsic to the human experience.

One of the major challenges for the clinician working with homeless people is to help them regain hope. Most have given up on hope as a self-protective survival mechanism, Kraybill notes, but a person isn't likely to change unless he or she believes that such change is possible. Setting small, realistic goals for people, such as keeping regular medical appointments, can bolster their confidence. In addition, the clinician's own expectations about a person's ability to change have an important effect on the outcome.[13]

There are some specific principles and skills of motivational interviewing (see box) that are easy to learn but difficult to put into practice, Kraybill says. The clinician has to move away from being an advice giver and a teacher and learn to walk side by side with his or her clients. "It's easier to be judgmental," notes Ed Stellon.

Kraybill believes that motivational interviewing frees both the client and the clinician to focus on the process of recovery rather than on predetermined outcomes. "Best of all, you can see that it works," he says.

FOUR PRINCIPLES OF MOTIVATIONAL INTERVIEWING[13]

- **Express empathy.** Accepting people as they are frees them to change. Acceptance of the individual is the not same as agreement with or approval of his or her behavior.
- **Develop discrepancy.** When a behavior is seen as conflicting with important personal goals, change is more likely to occur.
- **Roll with resistance.** Arguing is counterproductive; reluctance and ambivalence are natural and understandable.
- **Support self-efficacy**. A person's belief in the possibility of change can be an important motivator.

OARS: THE BASIC SKILLS OF MOTIVATIONAL INTERVIEWING[16]

- **Open-ended questions.** Examples include, "How can I help you?" "What are the positive things and what are the negative things about your behavior?" "What do you want to do next?"
- **Affirmations.** These should be genuine statements that recognize clients' strengths and build confidence in their ability to change.
- **Reflective listening.** Defined as "a particular, active form of listening in which the counselor serves as a kind of mirror, reflecting back and clarifying for the person the meaning that he or she is expressing."[15] Reflective listening can involve rephrasing, paraphrasing, or discussing feelings.
- **Summarizing.** Reflect back to clients their ambivalence and accentuate any statements they make that indicate a willingness to change.

Primary Care Helps People Reclaim Their Lives

Ansell Horn, FNP, runs the day-to-day operations of the Bowery Residents' Committee (BRC) respite program in New York City. He provides far more than conventional medical care. "You can't just treat a medical condition without dealing with all the other issues our patients confront," Horn says.

Primary care providers who work with homeless people treat medical problems directly related to substance abuse, such as HIV/AIDS and hepatitis C. However, Horn points out that because many homeless people lack regular medical care, he and physician **Mira Batra, MD,** often uncover medical problems—ranging from urinary tract infections to cancer—that have not been attended to or diagnosed. Many patients also have co-occurring mental disorders, and all need housing and a range of social services. Both Horn and Dr. Batra are associated with the Community Medicine Department of St. Vincent's Hospital in Manhattan.

CASE STUDY

Luis Sanchez* came to the Bowery Resident's Committee (BRC) detox on March 3, 2003. He denied any medical problems. He developed a cough and was placed on respite. A chest x-ray was arranged and blood sent to a lab. His white count was 1.4. We discussed HIV testing. Mr. Sanchez said that he had recently tested negative for HIV. Subsequently, he got sicker and was admitted to St. Vincent's Hospital for PCP, a common pneumonia in people with AIDS. After a week he returned to detox. Mr. Sanchez admitted he had tested positive for HIV in prison 10 years earlier and confided that he had recovered from numerous bouts of PCP. Primary care was arranged at St. Vincent's Department of Community Medicine's Ryan White Clinic. Mr. Sanchez stayed on respite at BRC for 1 1/2 months. He was placed in housing by the Department of AIDS Services while waiting for a bed in a long-term substance abuse treatment center. "BRC's done a great job for me," Mr. Sanchez says. "My intention was always to get high. Right now, I don't have a desire to get high. Now I want to get my health stable, my recovery, and maybe, just enjoy what little life I do have with my family."

**Mr. Sanchez has given written permission for his name and his story to be used. Submitted by Ansell Horn, FNP, Bowery Residents' Committee.*

The respite care program at BRC opens the door for patients to long-term services, including ongoing medical care at St. Vincent's Hospital and housing run by the BRC, some of it for people with co-occurring disorders. The availability of such services is critical to helping people recover.

"Frequently we get people in detox when they're ready, but it may not be the same day," says **Erik Garcia, MD,** Medical Director of the Homeless Outreach and Advocacy Project (HOAP) in Worcester, Massachusetts. "Sometimes the best opportunity is right here, right now." Massachusetts has defunded detox beds over the past 6 months in a cost-saving move, Dr. Garcia reports.

MEETING THE NEEDS OF WOMEN The provision of primary care to pregnant and parenting women who have substance use disorders offers an important opportunity to engage them in mental health, substance abuse, and trauma-related services, according to **Linda Weinreb, MD,** founder of the Worcester Homeless Families Program.

"When a mother brings her child in for medical care, she is doing something good, and we can begin a relationship based on her strengths," Dr. Weinreb says. Most homeless mothers who abuse substances are wracked with shame and guilt, but providers can reframe their survival skills in a positive light, notes **Maureen Rule, MA, LPC,** Program Manager of Tierra del Sol, the women's residential treatment program at Albuquerque Health Care for the Homeless, Inc.

Because most homeless women have been victims of violence, their substance abuse may be viewed as an "adaptive and reasonable response to serious trauma," Dr. Weinreb says. Behaviors that providers view as "resistant" can often be reframed as an effective coping stategy. "We have to understand women's behavior and their choices based on their experiences," Dr. Weinreb says.

TREATING PAIN One of the most significant challenges in providing medical or dental care for homeless people with substance abuse disorders is helping them manage pain appropriately. **Judith L. Allen, DMD,** often conducts extensive surgery on her patients at the McMicken Dental Center of the HCH Dental Project in Cincinnati, where she is the Clinical Director. Still, she sometimes has to battle with a patient's substance abuse treatment counselor about post-operative pain medication.

"Post-operative pain medication won't throw a person back into substance abuse if we manage it wisely," Dr. Allen says. "On the contrary, not treating their pain puts them at risk of using again."
At HOAP, Dr. Garcia draws up written contracts with the patients he treats for acute pain. While in treatment, his patients must agree not to receive narcotic pain medicine from any other physician, and their "lost or stolen" medicine will be not replaced. "Medications tend not to get lost when the patients know this up front," Dr. Garcia says.

TIME-CONSUMING/LABOR-INTENSIVE WORK Horn acknowledges that the type of medical care he practices with his homeless patients who abuse substances is "time-consuming, labor-intensive work." It requires patience, persistence, and teamwork, but Horn says the results are worth the effort. "We help people reclaim their lives."

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