

Module 10D:

Alcohol Use Disorders in Homeless Populations



PARTICIPANT HANDOUT

Introduction

Homelessness became an apparent pressing social issue in the United States during the 1980s and 1990s because of the frighteningly large number of homeless individuals and families appearing in public and in social work intervention programs (First, Rife, & Toomey, 1995). It is impossible to present accurate data concerning the scope of the problem because:

- there is little consensus concerning how to define and quantify this condition (narrowly or broadly; counting family units or numbers of individuals)
- many communities do not choose to look for and count their homeless members
- many homeless individuals and families do not choose to be found and counted

Homelessness in America during the 1950s and early 1960s almost exclusively involved single men over the age of 50. Homeless populations are now characterized by much greater diversity (Burt, 1992; First, et al., 1995).

Thirty-eight percent of homeless individuals have a mental health concern. Nearly one-half of homeless men (47%) and 16% of homeless women also experience alcohol use disorders (Johnson, 1995). Homeless individuals who abuse alcohol and other drugs are quite susceptible to liver disease, gastrointestinal ailments, tuberculosis, seizures and other neurological disorders, hypertension, cardio-pulmonary diseases/disorders, and HIV/AIDS infection (Johnson, 1995). Furthermore, the combined chances of alcohol, drug, and mental health problems anytime in a homeless person's life are estimated at 30% (Burt, Aron, Douglas, Valente, Lee, & Iwen, 1999). Because homeless populations are often hidden from view and therefore difficult to study, research on the homeless with alcohol disorders is not as abundant as it is with many other groups.

Learning Objectives

By the end of this module, learners should be able to:

A. Understand-

1. the factors important in the lives of homelessness individuals
2. the culture of the homeless
3. the homeless in a cultural context

B. Recognize the ways in which the problems of homelessness and alcohol use disorders interact and the prevalence of these co-occurring processes

C. Become familiar with modifications of alcohol treatment approaches that enhance effectiveness with homeless populations

Background

One significant barrier to the systematic study of homelessness is the lack of a coherent definition of terms. Rossi (1987) suggests that homeless means, "not having customary and regular access to a conventional dwelling" (p. 10). The United States Department of Housing and Urban Development (HUD, 1984) has defined homelessness as "living in public or private emergency shelters; or in the streets, parks, subways, bus terminals, railroad stations, airports, under bridges or aqueducts, abandoned buildings without utilities, cars, tracks, or any of public or private space that is not designated for shelters" (pp. 7-8).

These definitions, however, ignore the population of "hidden homeless" and precariously housed persons and families who develop unexpected, unconventional, and unrecognized solutions to meeting their needs, such as doubling up or camping out with friends and relatives (Johnson, 1995). In reference to homeless individuals, the term "squatting" indicates someone who is living in places not meant for human habitation. The precariously or marginally housed person is one who is at a very high risk of becoming homeless, and includes individuals who are vulnerable because they do not have legal lease arrangements.

Understanding homelessness is further complicated by its seasonal nature in many regions, and by its episodic versus chronic variations. Furthermore, the concept of "homeless" has varying meanings in different national and cultural contexts. Globally, homelessness may be conceptualized as the opposite of adequate housing. Adequate housing protects against the elements (temperature extremes, precipitation, sun damage, etc.), has access to potable water sources, provides for sanitation (removal of human and animal waste products, sewage), protects from intruders, and provides freedom from sudden removal or having no security of tenure (Conroy, 1987). The United Nations' generic term for lacking shelter is "sans domicile fixe" (SDF), or "without fixed address." Table 1 presents a variety of cultural conceptualizations of homelessness around the world.

Table 1. Conceptualizations of Homelessness

Homeless Concept	Word/Phrase	Country/Culture
Lack of shelter	roofless sin techo (without roof)	India Latin America
Cut off from a household or other people	clochard (tramp) pennebruder (prison brothers) furosha (floating people) puliukko (elderly male alcoholic) itinérants (itinerants)	France Germany Japan Finland Quebec, Canada
Homeless or street children	gamino (gamin) pixote (from the movie Pixote) khate (rag picker)	Colombia Brazil Nepal
Squatter settlements, spontaneous settlements	bidonvilles (tin cities) pueblos jóvenes (young towns) kampung (village)	Francophone Africa Lima, Peru Indonesia

Developing nations often view their population who lives out-of-doors as a result of massive rural-to-urban migration, with the public or private housing sector not being able to accommodate the numbers of people. Squatter or spontaneous settlements are often made from found materials and emerge on land owned by someone else. The pueblos jóvenes of Lima, Peru, are towns that emerge without an infrastructure to support the population. In the industrialized world, homelessness is viewed as: 1) a result of personal problems, such as chronic alcoholism, drug abuse or mental illness (especially following the era of deinstitutionalization), or 2) the results of gentrification, which lowers the affordable income housing stock, with a concomitant move from an industrialized to a service economy and a decrease in financial assistance-in the U.S., "Welfare Reform" (Glasser, 1994). Generally, if being itinerant is a part of the culture, the population is not considered to be homeless (e.g., the Travellers of Ireland). However, this distinction becomes unclear in cases where individuals spend years living between shelter programs and claim this as their lifestyle.

The association between alcohol and homelessness has historical roots and stereotyping. Until very recently, the word "puliukko" has been used in Finland interchangeably to describe both homeless and alcoholic. In Japan, the yosebas (single men, many of whom are alcoholic) are afforded inexpensive housing while they work in the construction industry but are found living out-of-doors during periods of unemployment. In the United States, "skid row" has historically been the area of a city where single men and women with alcohol problems live transiently in inexpensive hotels or on the streets (Glasser, 1994).

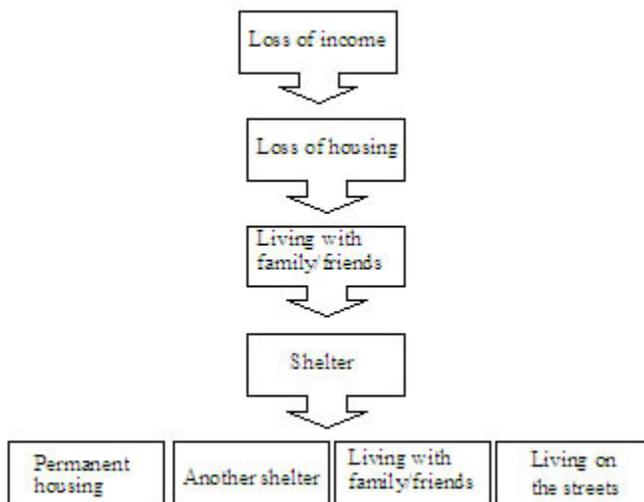
Pathways To Homelessness

The ecological model allows us to view homelessness as a result of the interplay between (Toro et al., 1991; Morse, 1992):

- personal problems (e.g., alcohol abuse, illicit drug use, and/or mental illness)
- structural problems of the scarcity of affordable housing (e.g., through urban renewal, gentrification, or some other cause of removing affordable housing units from circulation)
- economic restructuring to a low wage service economy
- reduction in financial assistance

The ecological model integrates issues of individual vulnerabilities within the broadest cultural and societal landscapes. It recognizes that as housing niches for the poor have been lost, those who were most vulnerable, including those with alcohol-related problems, suffered a loss of permanent housing. It also recognizes that vulnerability to homelessness arises with a loss of support systems (family, charity, and government) required for individuals and families to survive in a complex society (First, et al., 1995). Institutional systems may also be a source of homelessness when individuals are released without a sufficient guarantee of residential security (e.g., deinstitutionalization, prison release).

A "typical" pathway to homelessness is the loss of any source of income. In the United States, structural transformation of the economy and inflationary erosion of welfare support during the 1970s and 1980s had a particularly severe impact on poorly educated, unskilled, young, minority men and women (Berlin & McAllister, 1994). An individual's loss of income may also be due to a variety of personal problems, including alcohol use disorders.



Associated with a loss of income is the loss of secure housing (one's own place or one that is shared). This is usually followed by a period of residing with family or friends until those arrangements become strained or policy violations develop (e.g., eviction threats from a landlord). The individual is then forced into shelter programs. Shelter living does not allow for more than a few, easily transported, personal possessions. After a relatively

brief stay in a particular shelter (sometimes thirty to sixty days), the individual typically moves into more permanent housing, moves to another shelter, tries staying with friends and family again, or is forced to live on the street.

Living on the street can include sleeping in parked cars, abandoned buildings, public parks, and bus/train terminals. The homeless individual becomes especially difficult to reach and the chances of obtaining housing or treatment appear to diminish. One of the few studies that tried to follow the homeless trajectory found that, as homelessness among youth in Wales continued, opportunities to return home lessened (Liddiard & Hutson, 1991). Ethnographic research indicates that homeless individuals take pride in their independence from society's structures and in their ability to survive by ingenious means. For example, some homeless individuals have been observed to "act crazy" as a means of self-protection on the streets (Hopper, 1991; Koegel, 1992).

There is a paradox in that the "low-demand, no questions asked" services delivered in places such as shelters, soup kitchens and day centers, attract high numbers of homeless people, yet have few professional staff (Fournier & Kovess, 1993; Glasser, 1988). However, professional treatment programs that require the person to leave the homeless milieu, even those designed specifically for the homeless, have large attrition rates before and during treatment. For example, a 58% attrition rate occurred between screening and entering treatment among New York City chemically addicted, mentally ill shelter residents who had been interested in entering a treatment center (Nuttbrock, Rahav, Rivera, Ng-Mak, & Link, 1998). Another issue is the use of alcohol and cigarettes as elements of an underground economy of reciprocity among homeless individuals. The challenge is to design programs that at least begin the treatment process within the settings in which the homeless already live or spend much of their time.

The Relationship of Alcohol and Homelessness

The relationship of alcohol and drug use to homelessness is interactive and iterative in that it is both a cause and an effect of homelessness (Johnson & Cnaan, 1995). It is difficult for an individual with limited financial resources to remain in stable housing. When significant proportions of those financial resources are spent on alcohol or other substances, maintaining stable housing becomes even more difficult. However, it is difficult for an individual to focus on substance abuse treatment when basic survival needs for food and shelter are precariously and unreliably met. The stress and danger associated with homelessness also may feed back into the cycle of relying on alcohol or other substances as a coping strategy. Homelessness may result from poorly planned discharge from residential treatment, institutionalization, hospitalization, or incarceration related to substance involvement. There is also evidence that alcohol use among the homeless may provide some secondary benefits. James Spradley (1970), an anthropologist working in Seattle during the 1960's, found that the intermittently employed men living on skid row used alcohol as a source of camaraderie. Here alcohol was an adaptation to life on the streets, as well as a cause of becoming a "vagabond."

Traditional treatment options are not generally effective with the homeless population (Johnson & Cnaan, 1995). Providers do not seek out homeless alcohol abusers, and may be reluctant to treat homeless persons because of unpredictable behavior, high-risk medical problems, and extensive demands/needs (Lubran, 1990). Alcohol and addiction treatment programs historically provided very little in the way of progressive levels in community-based care and support for homeless clients, and state agencies have historically provided funding for very few services (Johnson & Cnaan, 1995). Notable breakthroughs are attributed to the NIAAA and NIAAA/NIDA (National Institute on Drug Abuse) collaboration funding of demonstration projects for homeless persons with alcohol and drug problems.

Alcohol and drug abuse/dependence are the most pervasive health problems among the homeless in the U.S. Table 2 presents some estimates of the rate of alcohol abuse and dependence among various homeless populations. For example, the NIAAA sponsored a nation-wide study, the National Longitudinal Alcohol Epidemiologic Survey (NLAES), of 42,862 homeless people. Results indicated that 7.4% of the subjects met the American Psychiatric Association's DSM-IV criteria for alcohol abuse or dependence (APA, 2000).

Table 2 - Estimated Prevalence of Alcohol Problems in Homeless Populations

Study Details	Rate of Alcohol Problems	Authors
U.S., random sample, comparison group	7.41% met DSM - IV criteria	NIAAA-NLAES (1992)
U.S., homeless men, women, mothers	58-68% men 30% women 10% mothers	Fisher & Breakey (1991)
U.S., individuals using homeless services	38% current 46% past year 62% life	Urban Institute (1999)
California, homeless youth	48.4% alcohol users or dependent	Robertson, et al. (2000)
NYC; soup kitchen; 5+ drinks per day	43% men, 19 women	Magura et al. (2000)
Rhode Island, sheltered homeless	29.3% lifetime abuse or dependence	Glasser & Zywiak (2001)

The methods of defining alcohol-related problems vary between studies, and are influenced by the study setting. For example, in Glasser and Zywiak's (2001) research, some subjects were interviewed in shelters that were supposed to be alcohol and drug free, so there was some client inhibition when describing their alcohol use. The Rhode Island site described in Table 2 was an "abstinence shelter" model, therefore data show relatively low rates. Nevertheless, the table illustrates that alcohol problems in homeless populations are many times the rate estimated for the U.S. general population.

In addition to substance abuse and mental health problems, homeless individuals are at greater risk for HIV infection (Rahav, Nuttbrock, Rivera, & Link, 1998) and tuberculosis (Wright & Weber, 1987). Of great concern are the homeless who are non-compliant with TB treatment (Caminero, Pavon, Rodriguez de Castro, Julia, Cayla, & Cabrera, 1996). In a recent study of men using Toronto homeless shelters, mortality rates were 8.3 times that of the general male population among the 18 to 24 year old age group; 3.7 times greater for the 25 to 44 year old group; and 2.3 times more for the 45 to 64 year old group (Hwang, 2000). A study of street youth in Montreal (Roy, Haley, Lemire, Boivin, Leclerc, & Vincelette, 1999) found a prevalence rate of 9.2% for markers of Hepatitis B infection, 12 to 23 times higher than findings observed in Ontario in the general population aged 14 to 30 years old (Glasgow, Schabas, Williams, Wallace, & Nalezty, 1997). These findings have significant implications for public health and social work practice with homeless individuals who have alcohol use disorders.

Homeless individuals are at greater risk for substance abuse, mental health problems, and HIV infection and tuberculosis.

Treatment of Substance Abuse Problems Among the Homeless

There appears to be no definitive treatment strategy for alcohol-related intervention with homeless individuals. However, common elements of successful interventions include:

- the integration of substance abuse and mental health services
- easy access to entering the program and avoiding disruption in making transitions (e.g., from detoxification to longer term residence)
- the provision of intensive case management
- the type of programs provided (e.g., recreational programs)
- special emphasis on the provision of housing at the conclusion of treatment
- retention of homeless individuals in substance abuse programs by listening to their critiques of other treatment programs, and making programmatic adjustments (Orwin, Garrison-Mogren, Jacobs, & Sonnefeld, 1999).

Several treatment modalities have been or are currently being tested for efficacy with homeless populations experiencing alcohol use disorders. These include outreach, Motivational Interviewing (MI), intensive case management, stabilization programs, therapeutic communities within shelters, and transitional and supportive housing for the formerly homeless. Confronting treatment barriers is also an important strategy.

Outreach

Outreach is a first step for making contact with people living out-of-doors. The outreach worker, who may be traveling on foot or by vehicle, offers the homeless individual social contact, food, referrals, and advocacy. An interesting example of outreach work and its subsequent evaluation was the Park Homeless Outreach Project in New York City (Ukeles Associates, 1995). Teams of workers became acquainted with the homeless men, women, and couples who occupied three Manhattan parks (including one which also housed Gracie Mansion, the Mayor's official residence). During the two-year project, the outreach teams made contact with almost every homeless park dweller (N=283). The teams succeeded in connecting 89 of these individuals with services, including detoxification, alcohol and drug treatment, entitlement programs, and temporary shelters. They placed 24 clients into permanent or transitional housing.

The project was less successful in linking individuals to permanent housing; after six months, only three of the twenty-four park dwellers placed in housing were known to be still sleeping indoors. Nevertheless, many lessons were learned from this outreach project. For example, it was important for an individual outreach worker to concentrate on a very specific geographic location in the park before trusting relationships could develop. The worker needed to have regular hours in the park, but also had to be flexible and come to the park as needed. Cellular phones helped the outreach workers link the client directly and immediately with service providers when they were ready to move forward. Once the clients were housed, it was important for the outreach worker to stay in touch with them, and find new housing if the first placement did not work out.

Motivational Interviewing

Many homeless individuals with alcohol problems spend much of their day meeting basic survival needs in the laissez-faire, low demand agencies of soup kitchens, day centers, and shelters. These environments provide ideal locations and critical opportunities to utilize interventions designed to increase an individual's motivation to change. Motivational Interviewing (MI) is a relatively new therapeutic approach (Miller & Rollnick, 1991) for reducing or eliminating alcohol consumption and other addictive behaviors across a number of diverse populations. This approach could be adapted for use with the homeless, but it should be noted that its use has not been subjected to adequate empirical testing with this population. The five basic principles of motivational interviewing are: (1) expressing empathy, (2) developing discrepancy, (3) avoiding argumentation, (4) rolling with resistance, and (5) supporting self-efficacy (Miller, Zweben, DiClemente, & Rychtarik, 1992). Clients are helped through MI to move from the stages of precontemplation to contemplation, and then to determination, action, and maintenance (Prochaska & DiClemente, 1982).

Principles of Motivational Interviewing

- Express empathy
- Develop discrepancy
- Avoid argumentation
- Roll with resistance
- Support self-efficacy

Developing discrepancy refers to the therapeutic aim of increasing clients' ambivalence regarding their current behaviors and the extent to which they would like to avoid negative consequences in the future. For example, many homeless individuals express great love and affection for their children. Most cannot live with their children, because of their lifestyle.

This painful discrepancy between the personal goal of maintaining close contact and the reality of the situation can increase the individual's motivation to change. Another discrepancy is the homeless individual's love of freedom to come and go at will, but their lives become very circumscribed as a function of interaction with shelters, services, and their communities.

Supporting self-efficacy is an important social work function. Homeless individuals often feel powerless and invisible. Many express the sentiment that there is no way out of the situation and that people who have tried to help have not succeeded. MI helps individuals set realistic, achievable goals, which in turn strengthens their belief and confidence in their own ability to change. MI with the homeless should incorporate flexibility concerning issues that the individual thinks are most important. Although a lack of suitable, stable housing, the abuse of alcohol or other substances, or mental health problems may seem to be the most critical needs to an outsider, the priorities of the homeless individual may be quite different. In one of the few published assessments of homeless persons'

needs, Acosta and Toro (2000) found that safety, education, transportation, medical/dental needs, and job training/placement were rated as more important than housing, mental health, and substance abuse treatment in a probability sample of 301 homeless adults. An important principle in any intervention with homeless individuals involves beginning with issues most salient to the client- "beginning where the client is."

Intensive Case Management

In 1990, the NIAAA, in consultation with NIDA, funded fourteen demonstration projects for alcohol and drug abuse treatment for the homeless. Thirteen of the projects provided intensive case management services to meet the primary goals of (Perl & Jacobs, 1992):

- Reducing the participants' consumption of alcohol and other drugs
- Increasing the participants' level of residential stability
- Enhancing the participants' economic and/or employment status

The projects were allowed wide latitude in terms of the type of case management delivered, where it was delivered (i.e. shelter, street, office), the intensity and dosage of contact, the type of staff delivering the treatment (e.g., people in recovery, professionals), and if the case management was delivered as a team or individually.

The guiding definition of case management was: an array of activities that are coordinated and delivered to clients on a regular basis, wherever they may be found, in order to assure that service needs are met. The important activities of case management include, but are not limited to, assessment, continuous service planning, advocacy, benefits acquisition, service linkage, and monitoring (Perl & Jacobs, 1992).

The case management model can be particularly useful for life in shelters and on the streets, where services are fragmented and the homeless individual has to be continually on the move. In particular, substance abuse treatment and psychological help must be combined with helping the client meet survival needs: food, stable housing, and employment and/or receipt of financial benefits (Stahler, 1995). Integral to the case management approach is the development of the trusting relationship that is at the core of helping the homeless individual utilize the services that may be available (McMillan & Cheney, 1992).

When case management has been tested within the ideal conditions of research where there is typically a high quantity and quality of services, it has been shown to be efficacious. However, outside of these ideal study conditions, there are often not enough case managers to serve each client. Homeless individuals must often take the initiative of seeking out the case manager, checking in frequently to learn the status of their cases (for example, the availability of a bed in detoxification unit, a bed in a transitional housing unit, or progress on legal matters). Case management intensity is often related to the level of funding for treatment programs for the homeless; this level is often directly related to the degree of advocacy for this stigmatized population.

A serious issue in case management is worker burn out. A study of case management in Montreal analyzed three years of client contact logs. The case

management was delivered to twenty-five homeless or marginally housed women who had completed a detoxification program and a rehabilitation program (Mercier & Racine, 1995). The case management services were supposed to reach the women in soup kitchens, day centers, on the street, or wherever they might be present. However, the researchers observed an increasing reliance by the case managers on telephone contacts and office visits, and an overall trend toward decreasing frequency of contacts. The authors hypothesized that case managers became very discouraged by the third year of the project, and tried to gain more control in their work by not leaving the office setting. They suggested that case management services need organized and thorough mechanisms for addressing the issues of worker burn out and discouragement.

Stabilization Programs/Therapeutic Communities

Two approaches tried with homeless substance abusers involve modifying emergency shelter areas into safe and substance-free environments. The philosophy in both the stabilization program and the therapeutic community is to offer an alternative to homeless individuals who are ready to work on alcohol/drug problems. The critical aspect is that these alternatives do not require the homeless individual to leave the shelter setting, which the client may not be ready to do.

Stabilization :

Create substance-free zones within shelter environments

Therapeutic Community :

Others in recovery become major support network, create therapeutic milieu

Stabilization programs inside shelters offer substance-free zones for individuals who have completed detoxification, but still have no place to live. In a study of such programs within two Boston shelters, Argeriou and McCarty (1993) found the rates of success to be 63.5%. This rate was comparable to that of post-detoxification in traditional substance abuse programs. Clients who completed stabilization programs decreased their substance use and experienced longer lag times to relapse compared to clients who did not complete the stabilization. The utilization of shelters for substance abuse stabilization represents a cost-effective way to provide services to the homeless population. Shelters represent "windows of opportunity" to engage the homeless client in substance abuse treatment. These stabilization programs are still in existence ten years after the initiation of the project (Argeriou, 2000).

The therapeutic community (TC) approach is a well-known residential treatment strategy wherein the community of other individuals in recovery becomes the major support network. The classic TC relies on intensive group sessions, with members often confronting each other concerning their need to change in order to live in the "outside world," substance free. The TC approach has been modified to meet the needs of homeless, mentally ill, substance abusers. The modifications include more individualized, more flexible, and less intense intervention than is typically found in standard TC programs (Swan 1997). The Center for Therapeutic Community Research studied 342 homeless persons who entered the modified TC program. These clients were found to have successful outcomes in terms of reduced drug use and criminal behavior and an increased ability to find and retain jobs (Sacks and De Leon, 1997).

Transitional/Supportive Housing

By the mid-1980s, a pattern was developing in the U.S., in which some homeless individuals experienced repeated episodes of shelter living. Many of these individuals were unable to make a successful transition from shelter to apartment living, and needed a lot more support to maintain permanent housing. Through funding from the Department of Housing and Urban Development (HUD), non-governmental community organizations developed housing strategies to support the homeless in their quest for secure housing. These strategies included transitional housing, generally consisting of housing with two years of services; and supportive housing, which is housing with the provision of services for an open-ended period of time. Transitional and supportive housing may be provided in one physical space (e.g., apartments built in former factories, such as Montreal's "Ma Chambre," or "My Sister's Place" in Hartford), or it may be provided in scattered apartments in publicly or privately owned buildings. A key aspect is that services are brought in to individuals or families who have access to affordable transitional/supportive housing. In many communities, the provision of transitional and supportive housing is much preferred over building more emergency/ temporary shelters, which are often viewed with fear and suspicion.

Transitional Housing

- Approximately two years of services with housing for successful transition from shelter to permanence

Supportive Housing

*- Bring services into homes
social work intervention
referral recreation
- Appropriate expectations for involvement and participation tenant organizations*

An example of transitional housing is the Thames River Family Program in Norwich, Connecticut (Glasser, 1994). Formerly homeless women and their children move into one of the 24 apartments in a new building on the grounds of a former hospital. The families have 24-hour a day security, recreational programs for the children, and many on-site classes and support groups. During their two years of residence, the women live drug, alcohol, and violence free, and they attend classes, job training, and/or work. Another transitional housing program that has been in existence for over 100 years is Open Hearth, in Hartford, Connecticut (Glasser & Zywiak, 2000). The program has 79 beds for men who want to complete the Open Hearth alcohol and drug rehabilitation program. Open Hearth also has a 25-bed shelter, in which many of the men have stayed before deciding to enter treatment. The shelter and transitional services are under one roof, which facilitates movement of the men from shelter living to rehabilitation.

In Montreal, supportive housing is provided through the housing federation, FOHM (La Fédération des OSBL [Organismes Sans But Lucratif] d'Habitation de Montréal). This endeavor provides up to 1,000 tenants with ongoing help in the form of social work intervention, referral to health and social service agencies, support for tenant organizations, and recreational activities to ensure that high-risk tenants (e.g., the chronically mentally ill and those with alcohol disorders) will be successful in keeping their housing. The housing is affordable, defined in Canada as being no more than 30% of a person's income. A key component of supportive housing is the role of the onsite concierge, whose services are integral to the stability of the tenants' lives (FOHM, 1997). Research conducted by a team from the University of Quebec in Montreal, who closely interviewed a sample of thirty-three FOHM tenants, concluded that there were significant improvements in the tenants' overall quality of life, and that the tenants expressed a high degree of satisfaction with their housing. The researchers conclude: "It is now easier for these marginalized people to develop friendships because they feel more on the same level as the other tenants and are no longer looked on as 'the fool on the block...'" (FOHM, 1997, p. 14).

Confronting Barriers to Services for the Homeless

Individual and system-wide advocacy may include:

- Accompanying the individual to appointments
- Convincing treatment programs to accept the individual
- Improved diagnosis could extend the scope of services
- Address issues such as lack of health care coverage for indigent individuals without program benefits
- Work with coalitions and collaborative efforts to influence politics and policy (e.g., state-wide coalitions for homeless)

A social worker beginning to work with homeless individuals very quickly confronts barriers to services that are inherent in the homeless person's world. For example, individuals in need of access to financial assistance (e.g., SSI) may not have their birth certificate. Other important papers may have been lost during frequent transitions between shelters and the street. A client may be difficult to locate due to multiple moves between shelters that are a part of many communities' policies toward the homeless. If a person wants to enter a treatment program, he or she may not have insurance coverage, and there may be very few beds set aside for indigent individuals. Compounding these problems is a generalized dislike of homeless individuals, who may be dirty and are generally blamed for their homeless state. Working with homeless individuals requires fortitude and commitment.

In addition to advocating for homeless individuals on a case-by-case basis, social workers can join coalitions for the homeless or other advocacy groups. These types of activities can effect system changes that benefit many homeless individuals. For example, shelters in some cities close for the summer. Although other shelters may absorb a certain number of homeless persons, many individuals will begin what becomes a lifetime pattern of living out-of-doors. Similarly, in some cities, a permanent address is necessary to receive benefits. Coalitions that consist of both homeless individuals and service providers can join forces to advocate for change in these systems.

Summary

In summary, treatment services for homeless persons with alcohol use disorders range from the outreach offers of engagement in a human relationship (e.g., the Park Homeless Outreach Project in New York City (Arete Corporation, 1995)), to the more formalized treatment programs inside shelters. The help may be in the form of case management or motivational interviewing. These techniques may be delivered in agencies such as soup kitchens, shelters, and day programs, where the homeless meet their basic survival needs.

A significant step toward improving services is better screening for alcohol use problems among homeless populations. The staff of agencies serving homeless individuals should attempt screening efforts, at the very least,, even though the staff may not be able to conduct full diagnostic interviews. The AUDIT-12, which screens for both alcohol and drug abuse, was developed for homeless and other poor populations. It is currently being pilot tested in various cities (Campbell, Barrett, Cisler, Solliday-McRoy, & Melchert, 2001).

AUDIT-12

Circle the answer that BEST DESCRIBES your drinking and drug use for the LAST YEAR.

1) How often do you have a drink containing alcohol?

(0) Never (1) Monthly or less (2) Weekly or less (3) Two or three times a week (4) Daily or almost daily

2) How many drinks* containing alcohol do you have on a typical day when you are drinking?

*(number of STANDARD DRINKS: 12 oz. beer, 5 oz. wine, 1-1.5 oz. liquor)

(0) none (1) 1 OR 2 (2) 3 OR 4 (3) 5 OR 6 (4) 7 to 9 (5) 10 or more

3) How often do you have five (5) or more drinks on one occasion?

(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

4) How often do you use other substances (cocaine, marijuana, pills, etc) to get high or change your mood?

(0) Never (1) Less than monthly (2) Weekly or less (3) Two or three times a week (4) Daily or almost daily

5) How often do you use two or more substances (including alcohol) on the same occasion?

(0) Never (1) Less than monthly (2) Weekly or less (3) Two or three times a week (4) Daily or almost daily

A/D involvement_____

In the last year, HOW OFTEN have these events happened to you?

6) How often have you found that you were unable to stop drinking or using drugs once you started?

(0) Never (1) Less than monthly (2) Weekly or less (3) Two or three times a week (4) Daily or almost daily

7) How often have you failed to do what was normally expected from you because of drinking or drug using?

(0) Never (1) Less than monthly (2) Weekly or less (3) Two or three times a week (4) Daily or almost daily

8) How often have you needed a drink or other drug, or to get high first thing in the

morning to get yourself going after a night of heavy drinking or drug using?

(0) Never (1) Less than monthly (2) Weekly or less (3) Two or three times a week

(4) Daily or almost daily

Dependence_____

9) How often have you had a feeling of guilt or remorse after drinking or drug using?

(0) Never (1) Less than monthly (2) Weekly or less (3) Two or three times a week
(4) Daily or almost daily

10) How often have you been unable to remember what happened the night before because of drinking or using?

(0) Never (1) Less than monthly (2) Weekly or less (3) Two or three times a week
(4) Daily or almost daily

11) Have you or someone else been injured because of your drinking or drug using?

(0) Never (1) Less than monthly (2) Weekly or less (3) Two or three times a week
(4) Daily or almost daily

12) Has a relative or friend or doctor or other health worker been concerned about your drinking/drug-using, or suggested that you stop using, cut down or get treatment?

(0) No (2) Yes, but not in the last year (4) Yes, during the last year.

Harm_____

Total score_____

Alcohol and drug recovery programs may also be wedded to transitional or supportive housing, which offer the individual a way out of homelessness. To be effective, any and all services delivered to homeless individuals must be guided by the individual's own goals and priorities. This means that intervention goals must be flexible, adaptive, and include improved screening, assessment, and diagnosis, along with harm reduction approaches and provision of respite or safe zones. Program development must also take into account the perspectives, culture, experiences, and wishes of the homeless population. Homeless individuals should be involved in the development and revision of the services they use.

CLASSROOM ACTIVITIES

1. Volunteer for 2-3 shifts at a local homeless program (shelter, soup kitchen, transitional housing). Discuss what you learned about the residents of such a program-what is important to them, how do alcohol/substances affect their functioning and circumstances, what stereotypes are inaccurate?
2. Role-play a homeless person in an alcohol treatment motivational interviewing session. Try it with: (1) a single homeless man living in shelter, (2) a single homeless woman being discharged from a medical facility after frostbite, and (3) a homeless mother living with her children in the family car.
3. Invite the director of a local homeless program to your class to discuss the ways that alcohol use disorders present themselves in this population, how the program responds to it, and the hopes/barriers related to providing alcohol treatment to the users of the services.
4. Review and discuss the attached appendix (annotated bibliography).

Discussion Issues

1. What are the ways in which (agency, local, state, federal) policies support/interfere with the delivery of alcohol treatment services to homeless individuals? How do the policies and/or practice guidelines (e.g., certification requirements, Code of Ethics, payment plans, etc.) support/interfere with your ability to deliver a continuum of services to homeless individuals with, or at risk of, alcohol use disorders?
2. What are the important research critique questions to keep in mind when you read reports of research with homeless persons (i.e., those related to the type of research questions asked, research design, instruments used, sampling strategies, and interpretation of results)?
3. What are the implications of different language/labels related to the homeless population, especially those with alcohol use disorders? (Brainstorm a list of terms first, then critique their implications for social work practice with this population.)
4. Discuss the ways in which social workers can ensure that homeless persons have a "voice" in the development and implementation of the programs that serve them.

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APPENDIX A

Treatment of Alcohol Use Disorders in the Homeless Population: An Annotated Bibliography

The Prevalence of Alcohol Use Disorders among the Homeless

Assessing the extent of homelessness within a population is very challenging, since many homeless individuals and families are hidden from view. It is also difficult to assess the extent of alcohol and drug use related problems among this population. The following are some of the most often-cited works that attempt to count the homeless and to assess the extent of their alcohol and drug use related problems.

Bassuk, Ellen L. et al. (1998). Prevalence of mental health and substance use disorders among homeless and low-income housed mothers. *American Journal of Psychiatry*, 155, 11, 1561-1564. The authors found a high prevalence of lifetime substance abuse (41% and 35%), lifetime post traumatic stress syndrome (36% and 34%), and lifetime major depressive disorders (45% and 43%) among homeless and housed low income mothers. These high rates are attributed to multiple stressors of poverty, whether the mothers are housed or homeless.

Baxter, Ellen, & Hopper, Kim. (1981). *Private lives/public spaces: homeless adults on the streets of New York City.* New York: Community Service Society. Although this book does not specifically estimate the numbers of homeless people in New York City, it is one of the first and most influential studies of homelessness in recent decades. Kim Hopper's field notes, which documented many of the homeless' beliefs that the streets were safer than the shelters, were summoned by the courts, and became evidence in a successful effort to improve the City's shelters. In subsequent work, Baxter and Hopper trace the demolition of single room occupancy hotels as a major reason for the cause of the rise of homelessness since the 1970's in the U.S.

Cohen, Alex, & Koegel, Paul. (1996). The influence of alcohol and drug use on the subsistence adaptation of homeless mentally ill persons. *Journal of Drug Issues*, 26, 219-243. The authors report on the Adaptation of the Homeless Mentally Ill research study in which 50 homeless mentally ill individuals in Los Angeles were followed ethnographically for three years. Approximately half of these individuals used drugs, alcohol, or both. There was great variation in the patterns of use. Some of the individuals organized their lives around the consumption of alcohol and drugs, while others experienced wide swings between acute use and restraint, and others were able to moderate their consumption. These patterns of use and abuse are important in designing treatment for the homeless mentally ill substance user.

Fischer, Pamela J., & Breakey, William. (1991). The epidemiology of alcohol, drug, and mental disorders among homeless persons. *American Psychologist*, 46, 1115-1128. In a review of nine studies of primarily shelter and street-dwelling homeless individuals, the authors found lifetime alcohol use disorders from 28% - 68%, with rates of 58% - 68% for homeless men, 30% for homeless single women, and 10% for mothers in homeless families.

Glasser, Irene. (1996). The 1990 Decennial Census and patterns of homelessness in a small New England city. In : Dehavenon, Anna Lou (Ed.). *There's no place like home: anthropological perspectives on housing and homelessness in the United States* (pp. 19-33). Westport, CT: Bergin & Garvey. The United States has been counting its population since 1780. Many undercounted groups include migrants, illegal immigrants, Gypsies, and the homeless. This report is on a yearlong study of homeless people in a small city. Many of the homeless suffered from chronic substance abuse or mental illness. The largest group of homeless people was the doubled up population (those who resided with another household on a temporary basis). Being doubled up was also the most common precursor to other types of homelessness.

Link, Bruce G., et al. (1994). Lifetime and five-year prevalence of homelessness in the United States. *American Journal of Public Health*, 84, 1907-1912. This telephone survey was the first to look at literal (sleeping in shelters and out-of-doors) and non-literal (staying temporarily with family or friends) homelessness throughout the U.S. The authors found that 7.4% of the 1507 interviewed had been literally homeless during their lifetime. This is much higher than a point-in-time census would indicate. Since the study was based on a telephone survey, it is probably an underestimate of the rate of homelessness.

Magura, S., Nwakeze, P. C., Rosenblum, A., & Joseph, H. (2000). Substance misuse and related infectious diseases in a soup kitchen population. *Substance Use & Misuse*, 35, 551-3. This article reports the results of a survey of alcohol and drug use among 219 New York City soup kitchen guests, not all of whom were homeless. The rate of drinking five or more drinks per day was 19% for women and 43% for men. An interesting finding was a large discrepancy between self-reported use of crack and opiates compared with hair analysis. For women, self-report for crack use was 51% in contrast to 80% crack use based on hair analysis. For men, the rates were 35% by self-report and 73% by hair analysis.

Robertson, M., Koegel, P., & Ferguson, L. (1989). Alcohol use and abuse among homeless adolescents in Hollywood. *Contemporary Drug Problems*, 16, 415-452. This study of homeless youth in Hollywood, found that 48.4% of the youth could be diagnosed as either alcohol users or alcohol dependent at some point in their lives. Even the non-abusers were at high risk of becoming problem drinkers. Most of the youth had not received any alcohol treatment and most were preoccupied with survival needs of food, shelter, and clothing. The researchers

advocate that treatment for alcohol and drugs be offered with material help. An interesting observation was that alcohol users were less likely to utilize shelters than nonusers, probably due at least in part to the restrictive policies of the shelters. This is a cause for concern -- not using shelters puts the alcohol-using homeless youth out of the reach of help and in greater danger of victimization.

Rossi, P.H., Wright, J.D., Fisher, J. A., & Willis, G. (1987). The urban homeless: estimating composition and size. *Science*, (March), 1336-1341. This classic article distinguishes between the literally homeless (those sleeping in shelters or out-of-doors) and the precariously or marginally housed (those who have tenuous claims to a conventional dwelling, such as those doubling up with another family). Most of the homeless research cited in this bibliography refers to the literally homeless.

Urban Institute. (1999). Homelessness: programs and the people they serve. Summary report of the National Survey of Homeless Assistance Providers and Clients. Washington, D.C. : Urban Institute. This U.S. study of 4,207 randomly selected clients of homeless-serving agencies assessed self-reported alcohol problems. Reports indicated rates of 38% within the past month, 46% within the past year, and 62% within the individual's lifetime. The lifetime reported use of drugs was 58% and the lifetime reported existence of mental health problems was 57%. The lifetime reported combination of alcohol, drug, and mental health problems was 30%.

Health Care for the Homeless

Delivering health care to the homeless is particularly challenging. There are public health challenges to effectively delivering care for diseases such as tuberculosis, where the sleeping conditions facilitate its transmission and the lack of stability make treatment difficult.

Caminero, JA, et al. (1996). Evaluation of a directly observed six month fully intermittent treatment regimen for tuberculosis in patients suspected of poor compliance. *Thorax*, 51, 1130-1133. This study reports on the success of directly observed, twice-weekly drug therapy for previously non-compliant TB patients in Gran Canaria, Spain. The patients were homeless, chronic alcoholics, IV drug abusers, HIV positive, and had previously abandoned a daily anti-tuberculosis regimen. There were only three relapses of TB for 102 patients followed for one year and 88 followed for two years. The authors believe that directly observed therapy could be applied to high-risk patients in other industrialized countries with good success.

Gelberg, Lillian, et al. (1997). Competing priorities as a barrier to medical care among homeless adults in Los Angeles. *American Journal of Public Health*, 87, 217-220. This project studied 1563 sheltered and non-sheltered adults and their access to health care. The effort to meet basic survival needs of food, shelter,

and safety was a barrier to receiving regular 'discretionary' (non-emergency) health care. Thus, these people may delay treatment during early stages of disease, and forego preventative care. The authors recommend locating health care at food giving agencies, since many people come there on a regular basis.

Gilders, Ian. (1997). Violence in the community-a study of violence and aggression in homelessness and mental health day services. Journal of Community and Applied Social Psychology, 7, 377-387. Drop-in centers and daytime shelters are excellent sites for attracting homeless substance abusers into outreach and early intervention services. However, these "low demand" centers are occasionally the site of violent behavior by their clients. This article reports on an analysis of the aggression patterns of 30 clients involved in violent incidents at day centers in England. The study found that a past history of violence was most closely associated with an incident of aggression, followed by substance use and an age of under 35 years. Interestingly, mental illness was not significantly associated with violence. The authors suggest some general guidelines for the prevention of violence in these types of day centers.

Rahav, Michael, et al. (1998). HIV infection risks among homeless, mentally ill, chemical misusing men. Substance Use and Misuse, 33, 1407-1426. This article explored the relative importance of homelessness and depression in increasing risky behaviors of unsafe sex and unsafe IV drug use among homeless, mentally ill, chemically misusing men. Prolonged homelessness was correlated with risky sexual activities including having sex with strangers and/or with IV drug users. Depression was most related to unsafe IV drug use behavior. The authors see reducing homelessness as an urgent condition for reducing HIV infection.

Wright, James D. & Weber, Eleanor. (1987). Homelessness and health. Washington D.C.: McGraw-Hill Healthcare Information Center. This paper reports on Health Care for the Homeless, a landmark study involving 34,035 homeless clients in 19 U.S. sites. The findings laid the foundation for the development of subsequent health care for homeless projects. A large section reports on alcohol and drug use-related disorders.

Treatment

What treatment strategies have been found to be most effective for the homeless alcoholic? Although there does not appear to be a definitive treatment strategy, there are common elements to successful treatments. These include: integration of substance abuse and mental health services, easy access to entering the program, intensive case management, recreational programs, no disruption in transitioning to other programs such as from detoxification to longer term residence, and, very importantly, the provision of housing at the end of the substance abuse treatment.

Assessing Treatment Needs

Acosta, Olga & Toro. Paul A. (2000). Let's ask the homeless people themselves: a needs assessment based on a probability sample of adults. *American Journal of Community Psychology*, 28, 343-366. This is one of the few large-scale needs assessments with the homeless. In a probability sample of 301 homeless adults, safety, education, transportation, medical/dental needs and job training/ placement were rated more importantly than housing, mental health and substance abuse treatment. Beginning with the homeless individual's priorities is an important first step in any intervention.

Outreach and Engagement

Conley, Dalton Clark. (1996). Getting it together: social and institutional obstacles to getting off the streets. *Sociological Forum*, 11, 25-40. The author, working out of a law clinic located in a large New York city soup kitchen, explored why so few of the on-the-street homeless were taking advantage of a state-funded shared housing grant. Institutional obstacles (e.g., unreliable welfare payments) and personal obstacles (e.g., substance abuse) were found to contribute to a high level of mistrust of government programs.

Fournier, Louise, et al. (1993). Reaching the most destitute of the homeless: when success turns to failure. *Contemporary Drug Problems*, 415-431. From 1988 until it was closed in 1991, *Dernier Recours Montréal* (Last Resort Montreal) was a well attended 24 hour, seven days a week drop in center for the homeless in downtown Montreal. People came at all hours to rest, drink coffee, see a counselor, and get out of the cold. However, area businesses were outraged at the constant presence of the homeless. This study found that almost 50% of the DRM users suffered from a psychiatric disorder and almost one-third had a dual diagnosis (mental disorder and substance abuse). The authors noted that although DRM was very successful in attracting the clientele the center wished to serve, the lack of program and structure did nothing to improve the lives of most clients.

Ukeles Associates Inc. (1995). Evaluation of the Park Homeless Outreach Project report to the New York Community Trust. New York City: Ukeles Associates Inc. This evaluation assessed the effectiveness of utilizing outreach workers for the homeless men, women, and couples who occupied three Manhattan parks. During the two-year project, the outreach teams had contact with 283 different individuals. They connected 89 to services including alcohol and drug treatment, detoxification, entitlement programs, and temporary shelters. The outreach teams made contact with almost every homeless park dweller. Lessons learned included the importance for an individual outreach worker to concentrate on a very specific geographic location in the park, to have regular hours in the park, and to be able to be flexible and come to the park as needed. Cellular phones helped the outreach workers link the client directly and immediately with service providers when they were ready to move forward. Once

the clients were housed, it was important for the outreach worker to stay in touch, and to find new housing if the first placement did not work out.

Motivational Interviewing (brief treatment)

Miller, W. R. and Rollnick, S. (1991). Motivational interviewing: preparing people to change addictive behavior. New York: Guilford Press. This classic work describes the technique of motivational interviewing (MI), a treatment approach that can reduce or eliminate alcohol consumption and other addictive behaviors in a number of diverse populations. It could well be adapted for the homeless. The five basic principles of MI are expressing empathy, developing discrepancy, avoiding argumentation, rolling with resistance, and supporting self-efficacy. In MI, clients are helped to move through the stages change: pre-contemplation, to contemplation and then to determination, action, and maintenance.

U.S. Department of Health and Human Services. (1999). Enhancing motivation for change in substance abuse treatment. Treatment improvement protocol series #35. Bethesda, MD: Center for Substance Abuse Treatment, DHHS Publication No. (SMA) 99-3354. This guide to best practices is designed to increase understanding of the role of motivation in substance abuse treatment. The guide offers many examples of effective strategies to increase a client's motivation to utilize substance abuse treatment.

Intensive Case Management

Cox, Gary B., et al. (1998). Outcome of a controlled trial of the effectiveness of intensive case management for chronic public inebriates. *Journal of Studies in Alcohol*, 59, 523-532. This excellent study recruited 298 chronically homeless alcoholics from a detoxification unit, and randomly assigned them to intensive case management or to a control group. Follow-up interviews every six months for two years indicted better outcomes for the case management group on three measures: total income from public assistance; stable housing; and decreased drinking. Although the results were not as dramatic as the authors anticipated, the CM model appeared to be very positive for the treatment of the homeless alcoholic.

Drake, Robert E. et al. (1997). Integrated treatment for dually diagnosed homeless adults. *The Journal of Nervous and Mental Disease*, 185, 298-305. This study compared the course of substance abuse, psychiatric symptoms, and housing stability of 217 homeless, dually diagnosed persons in Washington, DC. The homeless received either integrated treatment delivered by a community agency, or standard care from community services. Though not randomly assigned, much of the analysis looked at group differences. Both groups, surprisingly, received approximately the same amount of services, but the integrated treatment was delivered by more professionals, and was coordinated by a case manager. The authors' analysis revealed that it was the integration of

services, rather than the professionalism, which was of most help. This major study illustrates that the fragmentation of services for the homeless is a major barrier to treatment.

Orwin, RG, Garrison-Mogren, R., Jacobs, M. L., & Sonnefeld, L. J. (1999). Retention of homeless clients in substance abuse treatment. Findings from the National Institute on Alcohol Abuse and Alcoholism Cooperative Agreement Program. *Journal of Substance Abuse Treatment*, 17, 45-66. Retention of the homeless individual in a substance abuse program is a huge challenge, since this individual has probably already "dropped out" of many programs. In reviewing the findings of some of the major treatment studies, the authors conclude that being flexible enough to listen to the individual's and group's critique of any treatment program for the homeless, and then making adjustments, increases retention.

Perl, Harold I., & Jacobs, Mary Lou. (1992). Case management models for homeless persons with alcohol and other drug problems: an overview of the NIAAA Research Demonstration. *Progress and Issues in Case Management*, NIDA research monograph series #127 (pp. 208-222). Bethesda, MD: National Institute on Drug Abuse. In 1990, the NIAAA, in consultation with NIDA, funded 14 demonstration projects for alcohol and drug abuse treatment for the homeless. Thirteen of the projects provided intensive case management services to meet three primary goals: reduce consumption of alcohol and other drugs; increase participants' level of residential stability; and enhance their economic and/or employment status. Case management was defined as: an array of activities that are coordinated and delivered to clients on a regular basis, wherever they may be found, in order to assure that service needs are met. Important activities of case management are assessment, continuous service planning, advocacy, benefits acquisition, service linkage, and case monitoring.

Stahler, Gerald J. (1995). Social interventions for homeless substance abusers: evaluating treatment outcomes. In: Stahler, Gerald J., & Stimmel, Barry (Eds.). *The effectiveness of social interventions for homeless substance abusers* (pp. xiii-xxiv). New York: Haworth Medical Press. The case management model is particularly useful for life in shelters and on the streets. Services are fragmented and the homeless individual, because of his tenuous relationship to a place to sleep, has to be continually on the move. Many projects with the homeless indicate that substance abuse treatment and psychological help must be combined with assisting the client to meet basic survival needs of food, stable housing, employment, and/or receipt of financial benefits. The case manager is most often at the core of integrating these services.

Shelter Stabilization and Therapeutic Communities within Shelters

Argeriou, Milton, & McCarty, Dennis. (1993). The use of shelters as substance abuse stabilization sites. *The Journal of Mental Health Administration*, 20, 126-

137. This article describes a stabilization program inside two shelters in Boston that have been in existence for ten years. The program offers homeless individuals who have gone through detoxification, but still have no place to live, a substance-free portion of a shelter. Clients who completed the stabilization program decreased their substance use and relapsed later than clients who did not complete the program. The utilization of shelters for substance abuse stabilization represents a cost-effective way to provide services, and shelters represent a "window of opportunity" to engage the homeless client in substance abuse treatment.

Nuttbrock, Larry A., et al. (1998). Outcomes of homeless mentally ill chemical abusers in community residences and a therapeutic community. *Psychiatric Services*, 49, 68-76. This study randomly assigned 694 homeless, mentally ill, chemical abusers to a community residence and to a therapeutic community. Both programs were enhanced to provide mental health and substance abuse treatment. Surprisingly, clients assigned to the "high demand" therapeutic community had better outcomes for both psychiatric symptoms and substance use. Depressed clients also reacted well to the emotional support provided by the therapeutic community.

Transitional and Supportive Housing

Conrad, Kendon J., et al. (1998). Case managed residential care for homeless addicted veterans: results of a true experiment. *Medical Care*, 36, 40-53. This randomized controlled trial was conducted for five years with 358 homeless male veterans addicted to alcohol and/or drugs. Approximately one quarter also had a psychiatric diagnosis. One group was randomized to case managed residential care (CMRC), which included up to six months of residential care and intensive case management for another six months. The CMRC group did better on the medical, alcohol, employment, and housing measure than the control group, which received a 21-day hospital program and subsequent follow-up to the community. However, the differences between the two groups greatly diminished after one year.

Susser, Ezra, et al. (1997). Preventing recurrent homelessness among mentally ill men: a 'Critical Time' Intervention after discharge from a shelter. *American Journal of Public Health*, 87, 256-262. This research study lends support to the value of transitional services between shelter living and living in the community. The Critical Time Intervention provided the individual leaving the shelter with a worker who helped the individual build durable ties and supports in the community. The project involved a randomized trial of 96 homeless men with severe mental illness, half of whom also had substance abuse problems. Results indicated that over the 18-month follow-up period, there was a significant improvement by those who had received the CTI versus those who had received standard care.

Cross-National Comparisons of Homelessness

The definitions, understandings of causation, and philosophies of treatment of homelessness differ throughout the world. Below are several works that discuss homelessness among two or more cultures.

Glasser, Irene. (1994). Homelessness in global perspective. New York: G.K. Hall Reference, A Division of MacMillan, Inc. This is one of the few international comparisons of homelessness. In the industrialized world, margins of society. For example, until very recently, the Finnish word for homeless was alcoholism has traditionally been most strongly associated with lack of shelter and living at the puliukko, which means old (ukko) and alcoholic (puli, from the word pulituuri, meaning varnish/lacquer). In the third world, homelessness is most often associated with rural to urban migration and the existence of children on the street.

Glasser, Irene, Fournier, Louise, & Costopoulos, Andre'. (1999). Homelessness in Quebec City, Quebec, and Hartford, Connecticut: a cross-national and cross-cultural analysis. *Urban Anthropology and Studies of Cultural Systems and World Economic Development*, 28, 141-164. When Quebec City, Quebec, and Hartford, Connecticut, were compared by rates and nature of homelessness, it was found that Quebec had a lesser rate of homelessness, and had few or no families who were homeless. In contrast, Hartford had a significant and growing number of homeless families. The authors, using their own primary research in their respective cities, suggested several hypotheses that might explain these differences. The authors also discussed the derivation of the term itinérant, which appears to refer to the legacy in Quebec of the former farm worker who moved to the city, found only occasional work as a laborer, and drank. The term itinérant (in contrast to sans-abri, which is closer to the English homeless) is the preferred term used by advocacy groups for the homeless in Quebec.

Helvie, Carl O., & Knunstmann, Wilfried (Eds.). (1999). Homelessness in the United States, Europe, and Russia. Westport, CT: Bergin and Garvey. This collection compares homelessness in seven countries, reviewing definitions, ideas of causation, health care (including substance use), and social policies and services for the homeless. A local expert wrote each of the country contributions, with helpful charts compiled by the editors for ease of comparison.

Ethnographic Descriptions of the Culture of the Homeless

The following works are written by ethnographers who have spent extended periods of time studying communities of homeless people in order to tailor services effectively to the culture of the homeless.

Glasser, Irene. (1988). More than bread: ethnography of a soup kitchen. Tuscaloosa, AL: University of Alabama Press. What happens when 100 or more very poor people, many of whom are substance abusers not in treatment, come together daily to eat and socialize in a barrier-free setting? This book explores the culture created in the dining room of a soup kitchen in the 1980's, where alcohol and drug users, people with chronic mental illness, and others in poverty came together. The irony is that these often minimally-staffed, non-governmental services were accepted and utilized by the very poor, while at the same time, many were shunning more professionalized treatment.

Glasser, Irene, & Bridgman, Rae. (1999). Braving the street: anthropological perspectives on homelessness. New York and Oxford: Berghahn Books. This book reviews most of the ethnographic work from the U.S. and Canada on homeless individuals and families. A summary of projects that seek to prevent homelessness, or house the homeless, and take the culture of the homeless community into consideration is included.

Liebow, Elliot. (1993). Tell them who I am: the lives of homeless women. New York: Penguin Books. Elliot Liebow, an excellent urban anthropologist, spent most of his career with the National Institute of Mental Health. He was the author of Tally's Corner (Little, Brown Co., 1967) which influenced generations of students and professionals in the fields of sociology and anthropology. When diagnosed with cancer in the 1980's, he decided to work in homeless shelters when he felt well. This labor of love resulted in Tell Them Who I Am, an excellent ethnographic description and analysis of a group of homeless women in Washington, D.C. Liebow also utilized reflexive anthropology, since he had some of his key informants comment on his text. These commentaries are published as footnotes throughout the book.

Spradley, James. (1970). You owe yourself a drunk: an ethnography of urban nomads. Boston: Little, Brown. This is a classic ethnography in which Spradley sought to answer the question of why the alcoholics on skid row in Seattle, Washington, spent 30 days in jail and almost immediately went back to drinking. Spradley applied his skills as a linguistic anthropologist to appreciate the great fund of knowledge required for surviving on the street. Since he did this research, inexpensive single-room-occupancy hotels (SRO's) in which most of the men lived, have become scarce, and many of the men from the study would now be living in shelters, which offer less privacy and permanency than the SRO's of previous times.

Waterston, Alisse. (1999). Love, sorrow, and rage: destitute women in a Manhattan residence. Philadelphia: Temple University Press. This is the intimate story of residents from the Woodehouse, a program for women who have been homeless and who have chronic mental problems. Many also have severe substance abuse problems. This book offers the women's own voices, as Waterston develops an informal and mutual relationship with them. She cooks up

stews in the kitchens, accompanies them to doctor appointments, and is shown the best sleeping spots in the subway system. Most of the women know that they have psychological problems, but generally hate the side effects of their psychotropic medications. They are also wary of becoming involved with mental health professionals because they "will be in the computer" and fear becoming hospitalized or incarcerated. Although this supportive housing program is a welcome respite from the streets, some of the women during the course of the study return to their homeless milieu.

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