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# Qualitatively and quantitatively evaluating harm-reduction goal setting among chronically homeless individuals with alcohol dependence

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## HIGHLIGHTS

- Abstinence-based goals are not always considered desirable or attainable.
- We evaluated participant-generated treatment goals.
- Participants named clinically meaningful goals related to drinking, quality of life and health.
- Drinking and problem reduction—not abstinence—were the most common drinking goals.
- Participants generated increasing numbers of goals over the course of the study.

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## ABSTRACT

*Introduction:* Most treatment programs for alcohol dependence have prioritized alcohol abstinence as the primary treatment goal. However, abstinence-based goals are not always considered desirable or attainable by more severely affected populations, such as chronically homeless people with alcohol dependence. Because these individuals comprise a multimorbid and high-utilizing population, they are in need of more focused research attention that elucidates their preferred treatment goals. The aim of this secondary study was therefore to qualitatively and quantitatively document participant-generated treatment goals

*Methods:* Participants were currently or formerly chronically homeless individuals ($N = 31$) with alcohol dependence who participated in a pilot of extended-release naltrexone and harm-reduction counseling. Throughout the treatment period, study interventionists elicited participants' goals and recorded them on an open-ended grid. In subsequent weeks, progress towards and achievement of goals was obtained via self-report and recorded by study interventionists. Conventional content analysis was performed to classify participant-generated treatment goals

*Results:* Representation of the three top categories remained stable over the course of treatment. In the order of their frequency, they included drinking-related goals, quality-of-life goals and health-related goals. Within the category of drinking-related goals, participants consistently endorsed reducing drinking and alcohol-related consequences ahead of abstinence-based goals. Quantitative analyses indicated participants generated an increasing number of goals over the course of treatment. Proportions of goals achieved and progressed towards kept pace with this increase

*Conclusions:* Findings confirmed hypotheses that chronically homeless people with alcohol dependence can independently generate and achieve treatment goals towards alcohol harm reduction and quality-of-life improvement.



## 1. Introduction

### 1.1. Goals and the alcohol treatment literature

Goal setting has long been considered a key aspect of alcohol treatment. To date, most available alcohol treatment programs and providers have prioritized abstinence as the primary treatment goal. The

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prioritization of abstinence-based goals is likely connected to the conceptualization of substance dependence more generally as a "chronic, relapsing brain disease" (Leshner, 1997; National Institute on Drug Abuse, 2008). Proponents of this medical or disease model posit that substance dependence should be treated using interventions designed to help people achieve and maintain abstinence (National Institute on Drug Abuse, 2008). The corollary is that, were they not to insist upon abstinence-based goals, providers might "enable" or facilitate continued alcohol dependence and related harm (Denning & Little, 2011).

Echoing providers' preferences, surveys have indicated that abstinence is considered a desirable goal by a large minority to a majority of alcohol-dependent, treatment-seeking individuals (46%–84%) (Al-Otaiba, Worden, McCrady, & Epstein, 2008; Heather, Adamson, Raistrick, & Slegg, 2010; Hodgins, Leigh, Milne, & Gerrish, 1997; McKeganey, Morris, Neale, & Robertson, 2004; Öjehagen & Berglund, 1989). Moreover, there is some evidence that individuals in treatment tend to conform to treatment-providers' goals over time (Joosten, De Weert-Van Oene, Sensky, Van Der Staak, & De Jong, 2011) and increasingly endorse abstinence-based goals (Hodgins et al., 1997). Finally, studies have indicated that participants with abstinence-based goals at baseline evince improved treatment outcomes as measured by, for example, abstinent days, time to first drink and relapse to heavy drinking (Adamson, Heather, Morton, & Raistrick, 2010; Bujarski, O'Malley, Lunny, & Ray, 2013; Hodgins et al., 1997; Mowbray et al., 2013).

This nearly exclusive focus on provider-driven treatment goals, however, leads to a falsely dichotomous conceptualization of recovery. Under this model, alcohol dependent individuals either achieve success by conforming to provider-driven, use-reduction or abstinence-based goals, or they experience treatment failure by not adhering to these goals. Both theory and empirical data suggest that repeated failed treatment attempts erode self-efficacy and self-control for later behavior change (Marlatt & Donovan, 2005; Muraven & Baumeister, 2000). Given the chance, however, alcohol dependent individuals are capable of generating their own treatment goals, which may be connected to but may extend beyond their alcohol use (e.g., improving relationships, engaging in meaningful activities, achieving health-related goals). Such user-driven goals, which may help reduce alcohol-related harm and improve quality of life (Collins et al., 2014), may be more relevant to and realistic for alcohol-dependent individuals who are not yet ready, willing or able to cut down or stop.

The literature to date is also limited by its inclusion of primarily treatment-seeking individuals. Treatment enrollment, which involves time and financial commitment and may be attached to other salient incentives (e.g., maintaining child custody, diversion from criminal justice system), is likely associated with a higher level of either internal or external motivation for provider-driven abstinence-based goals (Wolfe, Kay-Lambkin, Bowman, & Childs, 2013). Further, treatment-related variables, such as treatment attendance, may be subject to social desirability bias (Zemore, 2012). Thus, those who engage in abstinence-based treatment are more likely aligned with providers and their abstinence-based treatment goals than those who do not.

Recent research, however, has indicated that the vast majority of individuals with alcohol problems do not seek treatment. The 2012 National Household Survey on Drug Use and Health indicated that an estimated 20.6 million people in the US needed but did not receive alcohol or drug treatment, and over a quarter of these respondents reported the primary reason was their lack of interest in abstinence (SAMHSA, 2014). These findings are even less promising among marginalized and more severely affected populations, including chronically homeless people with alcohol dependence. Studies show that few homeless people with alcohol dependence voluntarily start treatment (15–28%) (Rosenheck et al., 1998; Wenzel et al., 2001), and even fewer complete it (2.5–33%) (Orwin, Garrison-Mogren, Jacobs, & Sonnefeld, 1999). An NIAAA review showed that treatment engagement in this population decreased as program demands—particularly abstinence—increased (Orwin et al., 1999). Considering that homeless individuals are disproportionately affected by alcohol dependence (Fazel, Khosla, Doll, & Geddes, 2008), which can lead to disproportionate use of publicly funded services (Larimer et al., 2009), this population is in need of more focused research attention.

### 1.2. Study aims and hypotheses

The above findings point to a few gaps in the literature. To date, there has been little consideration of the goals of alcohol dependent individuals who are not actively seeking abstinence-based treatment. Because they make up a majority among those with alcohol dependence, however, it is important to understand the needs of individuals who are not optimally served by existing abstinence-based treatments and are not interested in abstinence or use-reduction goal setting. From a public health perspective, it is also important to focus on individuals with multimorbidities and resulting high utilization of publicly funded services to begin to address their problems with more patient-centered approaches tailored to fit their needs.

A recent pharmacobehavioral study aimed to address this research gap (Collins et al., 2014). This single-arm, 12-week pilot ($N = 31$) combined harm-reduction counseling and an opioid receptor antagonist, extended-release naltrexone (XR-NTX; market name VIVITROL), to elicit goals from chronically homeless, alcohol-dependent individuals and help them work towards their goals. The ultimate aim of harm-reduction interventions is to help substance users reduce alcohol-related harm and improve quality of life without requiring abstinence or use reduction (Collins et al., 2011). This study indicated that the treatment was feasible and acceptable to participants. A steady decline in alcohol craving, use and problems was also observed (Collins et al., 2014).

The aim of the present, secondary study was therefore to qualitatively and quantitatively document goals elicited from chronically homeless people with alcohol dependence who participated in the above-cited parent study. We first used conventional content analysis to classify and assess the frequency of participants' goals. Second, we used inferential statistics to determine whether participants' volume of goal generation and achievement or progress made towards these goals changed over the course of the study. Regarding the content analysis, it was hypothesized that participants would be able to generate their own goals and that these goals would encompass more than abstinence and drinking reduction. It was further hypothesized that participants would generate a significantly greater number of goals and would show significantly greater goal achievement and progress over the course of the parent study.

## 2. Materials and methods

### 2.1. Design

The data in this secondary analysis were collected during a single-arm pilot study assessing initial feasibility, acceptability, and alcohol outcomes following a combined pharmacobehavioral intervention involving extended-release naltrexone and harm-reduction counseling (Collins et al., 2014).

### 2.2. Participants

Participants ($N = 31$; 12.9% women) were currently or formerly (i.e., now living in permanent supportive housing) chronically homeless individuals with alcohol dependence (according to the DSM-IV-TR) who had participated in the parent study (see Table 1 for baseline demographic data), which was a single-arm study assessing initial feasibility and alcohol outcomes following receipt of extended-release naltrexone and harm-reduction counseling (Collins et al., 2014). All participants in the parent study were included in the present analysis.