International Journal of Drug Policy 23 (2012) 111–119

Contents lists available at ScienceDirect

International Journal of Drug Policy

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

Research paper

Where harm reduction meets housing first: Exploring alcohol's role in a project-based housing first setting

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ARTICLE INFO

Article history:
Received 11 May 2011
Received in revised form 7 July 2011
Accepted 11 July 2011

Keywords:
Alcohol use
Alcohol dependence
Alcohol abuse
Homelessness
Housing first
Harm reduction

ABSTRACT

Background: Housing first (HF) programmes provide low-barrier, nonabstinence-based, immediate, supportive and permanent housing to chronically homeless people who often have co-occurring substance-use and/or psychiatric disorders. Project-based HF programmes offer housing in the form of individual units within a larger housing project. Recent studies conducted at a specific project-based HF programme that serves chronically homeless individuals with alcohol problems found housing provision was associated with reduced publicly funded service utilisation, decreased alcohol use, and sizable cost offsets. No studies to date, however, have qualitatively explored the role of alcohol use in the lives of residents in project-based HF.

Methods: We collected data in a project-based HF setting via naturalistic observation of verbal exchanges between staff and residents, field notes taken during staff rounds, and audio recorded staff focus groups and resident interview sessions. Qualitative data were managed and coded using a constant comparative process consistent with grounded theory methodology. The goal of the analysis was to generate a conceptual/thematic description of alcohol's role in residents' lives.

Results: Findings suggest it is important to take into account residents' motivations for alcohol use, which may include perceived positive and negative consequences. Further, a harm reduction approach was reported to facilitate housing attainment and maintenance. Residents and staff reported that traditional, abstinence-based approaches are neither desirable nor effective for this specific population. Finally, elements of the moral model of alcohol dependence continue to pervade both residents' views of themselves and the community's perceptions of them.

Conclusions: Findings suggest it is necessary to set aside traditional models of alcohol use and approaches to better understand, align with, and address this population's needs. In doing so, we might gain further insights into how to enhance the existing project-based HF approach by applying more tailored, alcohol-specific, harm reduction interventions.

Introduction

Chronically homeless individuals often have co-occurring alcohol-use disorders, which lead to increased risk for various related problems (Turnbull, Muckle, & Masters, 2007; Wright & Tompkins, 2006), including alcohol-related deaths (Hawke, Davis, & Erlenbusch, 2007; O'Connell, 2005; Public Health – Seattle and King County, 2004). Research has also shown that this population encounters various barriers to engagement in supportive services (Young, Grusky, Jordan, & Belin, 2000) and that traditional treatment options are generally ineffective (Zerger, 2002). One reason why traditional infrastructures may not engage this population is that the primary focus on abstinence from alcohol eclipses other important factors such as individuals' overall quality of life and the larger context of their alcohol use and its role in their lives (Denning, 2000).

Where housing first meets harm reduction

Housing first (HF) differs from traditional housing approaches by providing low-barrier (i.e., no specific exclusion criteria), nonabstinence-based (i.e., not requiring abstinence from substance use), immediate and permanent supportive housing to chronically homeless individuals (Stefancic & Tsemberis, 2007; Tsemberis &

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doi:10.1016/j.drugpo.2011.07.010

Eisenberg, 2000). To date, two HF approaches have been empirically tested in the literature. The *scattered-site HF* approach for homeless populations with primary psychiatric disorders has been in use since the early 1990s (Tsemberis & Eisenberg, 2000). In this approach, residents are offered a choice of individual housing units located throughout the larger community and can access supportive services delivered via an assertive community treatment (ACT) model. The scattered-site HF model is associated with increased housing retention (Tsemberis & Eisenberg, 2000), lower associated costs (Stefancic & Tsemberis, 2007), and greater perceived consumer choice (Tsemberis, Gulcur, & Nakae, 2004).

In the current evaluation, we will be focusing on a newer application of the HF model, *project-based HF*. This approach also involves the provision of low-barrier, nonabstinence-based, immediate, and permanent supportive housing to chronically homeless individuals; however, residents are provided with individual units (e.g., private studio apartments or semi-private cubicles) within a single housing project. In this approach, residents can elect to receive on-site case-management and other supportive services. Recent studies have tested the effectiveness of project-based HF in improving outcomes for chronically homeless individuals with alcohol problems, and have shown it to be associated with increased housing stability, reduced utilisation of publicly funded services and associated costs, and reductions in alcohol-use and alcohol-related problems (Collins et al., in press; Larimer et al., 2009; Pearson, Montgomery, & Locke, 2009).

One factor hypothesized to contribute to the effectiveness of project-based HF – particularly amongst chronically homeless individuals with alcohol problems – is the low-barrier, nonabstinence-based aspect of the approach. By removing alcohol abstinence or treatment attendance as prerequisites for attaining and maintaining housing, project-based HF may be a more accessible and feasible housing model for chronically homeless people with alcohol problems who are unwilling and/or unable to stop using alcohol (Tsemberis et al., 2004). This nonabstinence-based aspect of the project-based HF model makes it compatible with a broader set of harm-reduction approaches.

As applied to alcohol use, harm reduction refers to a set of pragmatic strategies that minimise alcohol-related, negative consequences for the affected individual and society at large (Marlatt, 1998). Harm reduction focuses on "accepting clients where they're at" and deemphasises pathologising or placing moral value on alcohol use (Denning, 2000; Marlatt, 1996). Harm reduction approaches support the realisation of client-driven goals – which can but are not required to include abstinence – and recognise "any positive change" towards reducing harm and improving quality of life as steps in the right direction (Harm Reduction Coalition, 2009; Zerger, 2002). A handful of studies have documented the effectiveness of the harm-reduction oriented HF model for chronically homeless individuals with alcohol problems. Although it typically does not require abstinence or use reduction, initial findings have shown that harm-reduction oriented HF is not associated with significant increases in substance use (Pearson et al., 2009; Tsemberis et al., 2004), and can even be associated with significant substance-use reductions (Collins et al., in press; Larimer et al., 2009; Padgett, Stanhope, Henwood, & Stefancic, 2010).

Understanding the status quo: The continuum model of housing and the medical and moral models of alcohol dependence

Despite promising initial findings for HF and harm-reduction approaches in this population, the "continuum model" of housing represents the mainstay of housing provision in the US (Locke, Khadduri, & O'Hara, 2007). This model typically requires individuals to fulfil certain requirements, such as abstinence achievement and treatment attendance, before they may transition from a shelter to transitional housing to permanent housing. These aspects of the continuum model of housing are complementary to the medical model of alcohol treatment, which holds that alcohol dependence is a "chronic, relapsing brain disease" (Leshner, 1997; National Institute on Drug Abuse, 2008), and is optimally treated with abstinence-based housing, treatment and services.

The medical model of alcohol use is drawn upon to inform the aetiology, diagnosis and treatment of alcohol dependence. In contrast to many diseases, however, the defining symptoms of alcohol dependence also happen to reflect a human behaviour (i.e., alcohol use). Because human behaviours are observable and are primarily assumed to be operant, rational and voluntary, they are open to moral judgement based on social norms and values (Hyman, 2007; Pollack, 2010). Further, alcohol-use behaviour is conceptualised to be alternately divorced from one's control (i.e., a chronic relapsing disease) and a matter of rallying one's motivation and volition to change (i.e., "Keep coming back. It works if you work it."; May, 2001). Thus, although they have been described as theoretically distinct, it is difficult to fully extricate the medical model from the moral model of alcohol dependence in practice (Institute of Medicine (IOM), 1990; Moyers & Miller, 1993).

The moral model purports that alcohol dependence reflects and sustains "defects of character" that drive affected individuals to engage in "bad" behaviour (e.g., commit crimes, lie to treatment providers, relapse to substance use) (Alcoholics Anonymous, 1984, 2008). Thus, once an individual is diagnosed with alcohol dependence, and if necessary, initial medical treatment is provided (e.g., medical detoxification), most mainstream, abstinence-based housing, treatment and service provision relies on aspects of the moral model to guide individuals in recovery. Regarding housing more specifically, the medical and moral models support the continuum model of housing, which involves punishment for undesirable behaviour (e.g., removal from housing) and reward for desirable behaviour (e.g., movement through the housing continuum to more permanent housing; Allen, 2003). For many chronically homeless individuals with alcohol problems, repeated contact with traditional medical model approaches may be less successful, and may result in a revolving door of gaol, medical detoxification, mandated abstinence-based treatment and failed attempts to navigate continuum-based housing (Kertesz, Horton, Friedmann, Saitz, & Samet, 2003; Richman & Neumann, 1984; Shaner et al., 1995).

Exploring the role of alcohol in a project-based HF setting

Given the barriers associated with continuum housing settings (i.e., treatment requirements and substance-use abstinence), chronically homeless individuals with alcohol problems often struggle to attain and maintain adequate housing (Burlingham, Peake-Andrasik, Larimer, Marlatt, & Spigner, 2010; Padgett, Henwood, Abrams, & Davis, 2008; Rowe, 1999). The project-based HF approach offers a harm-reduction alternative to the medical/moral model emphasised in the more established continuum model of housing, and it has been shown to be associated with improved service utilisation, public costs and alcohol-use outcomes (Collins et al., in press; Larimer et al., 2009; Pearson et al., 2009). Given the newness of this approach, however, there are no qualitative evaluations to date exploring alcohol use amongst individuals in this specific type of setting. Such an exploration might highlight points for future enhancement of project-based HF programmes for this particular population. The aim of this evaluation was therefore to explore the role of alcohol use in the lives of chronically homeless individuals with alcohol problems living in a harm-reduction oriented, project-based HF setting.