

**Housing for People with Alcohol and Drug Addictions:  
An Annotated Bibliography**

Submitted to  
The City of Vancouver, Housing Centre

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## Table of Contents

<b>Executive Summary</b>	
<b>1. Overview</b>	1
1.1 Purpose	1
1.2 Method	1
<b>2. Review of the Literature</b>	2
2.1 The role of housing	2
2.2 Housing approaches and issues	4
<b>3. Empirical Studies</b>	8
3.1 Impact of housing on drug use	8
3.2 Housing for dually diagnosed individuals	9
3.3 Outpatient detoxification program with supported housing	11
<b>4. Examples of Approaches</b>	11
<b>5. Summary and Conclusions</b>	26
<b>Bibliography</b>	30

## **Executive Summary**

### **Overview**

This report was prepared for the City of Vancouver to assist in their development of Segal Place, a social housing project at 55 East Hastings. The City is interested in studies of the effect of offering housing as an intervention for people with issues relating to the use of substances, including alcohol and drugs.

This report provides an annotated bibliography of 32 studies that consider the role of housing for people with alcohol and drug use issues. Topics that are addressed include:

- The relationship between alcohol and drug services and housing for homeless or at-risk individuals;
- Different types of approaches/housing models such as supported housing, a continuum approach, housing where the use of drugs and alcohol is permitted, and alcohol and drug-free housing; and
- Components of a comprehensive strategy to address the needs of individuals with issues related to the use of alcohol and drugs.

A variety of different projects for homeless individuals with alcohol and drug use issues are also summarized.

Much of the literature reviewed in this report relates to housing for homeless people with substance use issues.

### **The role of housing**

There is consensus in the literature that “housing is the cornerstone of care” for homeless persons. Studies of a variety of projects in the U.S. have concluded that one cannot begin to address the alcohol and drug problems of homeless persons unless they are provided with appropriate housing. For example:

- One of the lessons learned from a study of nine community based grant projects in the U.S. targeted to homeless individuals with alcohol and other drug problems is that the shelter, sustenance, and security needs of the clients should be met first, and the treatment needs addressed second (Orwin, n.d.).
- A review of 14 demonstration projects in the U.S. found that it is extremely difficult to help chemically dependent homeless individuals unless they are provided with a secure, comfortable and supervised place to live. It was also found that the provision of housing, food, health care and other services may be a hook for attracting and maintaining clients in treatment. In cases where homeless individuals are not ready for residential treatment services, case management may provide the required support and assistance with basic life necessities (e.g. food and shelter) that will enable them eventually to work towards sobriety (Conrad, 1993).

- A study of 171 clients who participated in community-based drug treatment programs in Los Angeles found that meeting the need for housing services had a significant impact on reducing drug use. Among those who received help with locating housing, there was a 50% reduction in drug use, compared to a 23% reduction among those who did not receive help with locating housing, and a 41% reduction among those who did not declare a need for housing services (Hser, 1998).
- Several programs demonstrate a need for longer term or permanent housing for individuals who complete treatment programs. A lack of such housing is a major barrier to continued recovery (Conrad, 1993).
- A study of 517 patients enrolled in a Veterans Affairs outpatient detoxification program demonstrated that the provision of supported housing can contribute to successful outcomes (e.g. continuing and completing further treatment (Wiseman, 1997).

### **Housing models for dually diagnosed individuals**

The literature addresses the question of what type of housing can work best for dually diagnosed individuals who have both severe mental illness and substance use disorders. Two prevailing models have emerged to address the needs of persons with mental illness. The more traditional program utilizes a “level of care” or “continuum” approach, where the varying needs of clients are addressed by offering several housing settings, each with different levels of service and supervision and restrictiveness. This model often relies on staffed, group living arrangements. Clients “advance” to more independent alternatives as they master the appropriate skills required to move on. The other approach, supported housing, enables individuals to remain in their residence and access community-based services. It is the intensity of supported services that changes according to the needs of the client.

The supported housing model has received mixed reviews for people with dual disorders. While some authors see merit in both approaches as being part of a comprehensive housing response, there are indications that dually diagnosed individuals may require additional supports or services than those generally provided in supported housing. At this time, there are no conclusive studies on this point. However, a U.S. study is underway to evaluate the effectiveness of the two models (Rickards 1999).

### **Wet and dry housing**

The literature discusses the need for a variety of housing options to meet the diverse needs of individuals with alcohol and drug issues, and to meet the changing needs of individuals over time. Some authors express the opinion that wet housing (where the use of drugs and alcohol is tolerated) has societal and individual benefits for people who are not interested in changing their substance use. This form of housing can reduce morbidity and may permit the development of trusting relationships so that residents can be persuaded to participate in treatment. They believe that a continuum of housing should include shelters and other safe havens that are very tolerant of use. On the other hand, the authors note that some clinicians believe wet housing enables substance use and is counter-therapeutic. They believe that some clients may be motivated to stop using drugs if maintaining their housing depends on this.

The literature includes strong support for alcohol and drug-free (ADF) living alternatives for individuals who are committed to abstinence. Studies indicate that affordable ADF housing can

support the efforts of homeless and very low-income individuals to maintain sobriety following initial successful treatment and recovery programs.

### **Examples of approaches**

The following are some key findings from the programs described in the literature:

- There is a need for communities to be able to offer a comprehensive package of services that could include:
  - community service patrols
  - outreach
  - 24-hour crisis/drop-in centres
  - sobering-up stations/diagnostic screening centres
  - safe havens/(entry level shelters where use is permitted)
  - detoxification centres
  - post-detoxification stabilization services,
  - residential recovery facilities
  - transitional housing
  - low demand (wet) housing
  - supported housing
  - permanent housing (some of which is alcohol and drug-free)
  - outpatient programs
- Walk-in counselling programs and sobering-up stations can serve as an entry point for individuals to begin to think about treatment. They also provide an opportunity for case managers to recruit individuals and help them connect with existing services (examples 1 and 2, Anchorage and Louisville).
- Individuals who complete detoxification require additional residential services or care to maintain sobriety (examples 3 and 8, Boston and New Orleans).
- Individuals who leave recovery homes (after 90 days) may need additional assistance for successful re-entry into the inner-city environment (example 4, Los Angeles).
- Case managers can play an important role in advocating for clients and helping them to secure housing (example 6, Minneapolis).
- Providing intensive case management services to homeless individuals can reduce the harmful effects associated with chronic substance use. Preliminary results of a study in Seattle suggested that clients who received these services increased their incomes, spent fewer nights on the streets and in shelters, spent more nights in their own housing, and had slightly fewer detox admissions (example 10, Seattle).
- Enhanced treatment programs that also include drug-free work therapy and program-managed drug-free housing may be more effective than traditional treatment programs in reducing alcohol and other drug use and homelessness. The authors hypothesize that “shelter care without

effective substance abuse treatment is doomed to providing crisis first aid rather than substantive intervention. Similarly, substance abuse treatment without available housing and therapeutic work experiences is likely to be equally ineffective (example 12, Birmingham).

- A supported housing program in New York is providing independent apartments and support services or treatment to formerly homeless, dually diagnosed individuals that are often described as “treatment resistant” or not “housing ready” by other housing programs (example 13, New York).
- Street outreach can be key in opening the door to needed housing and services for homeless individuals with severe mental illness and/or substance disorders living on the street (example 14, Philadelphia).

## **Conclusions**

The literature demonstrates the importance of housing in providing alcohol and other drug treatment and recovery services to homeless and homeless at-risk individuals. There is a need for communities to be able to provide access to a comprehensive package of services and types of housing including entry level shelters where alcohol and drug use is permitted, post-detoxification stabilization services, residential recovery facilities, transitional housing, low demand (wet) housing, supported housing, and permanent housing, some of which is alcohol and drug-free.

There are questions about how best to meet the needs of dually diagnosed individuals. Further research is necessary to determine effective housing and support/treatment models for this population.

Although it is clear that housing is a necessary pre-condition for addressing the needs of individuals with issues related to the use of alcohol and drugs, the provision of housing alone is not a guarantee that people will be able to maintain sobriety or achieve housing stability. In many cases, some form of support or treatment will be necessary. The nature and level of services needed will vary with each individual.



# Housing for People with Alcohol and Drug Addictions: An Annotated Bibliography

## 1. Overview

This report was prepared for the City of Vancouver to assist in their development of Segal Place, a social housing project at 55 East Hastings. This building will be managed by the City's non-market housing department. Many of the residents will come from existing SROs in the Downtown Eastside and from the Central Residence, also managed by the City. As part of its work to develop Segal Place, the City is interested in studies of the effect of offering housing as an intervention for people with issues relating to the use of substances, including alcohol and drugs.

### 1.1 Purpose

This report provides an annotated bibliography of 32 studies that consider the role of housing for people with issues related to the use of alcohol and drugs. Topics that are addressed include:

- The relationship between alcohol and drug services and housing for homeless or at-risk individuals;
- Different types of approaches/housing models such as supported housing, a continuum approach, housing where the use of drugs and alcohol is permitted, and alcohol and drug-free housing; and
- Components of a comprehensive strategy to address the needs of individuals with issues related to the use of alcohol and drugs.

This report also summarizes a variety of different projects for homeless individuals with alcohol and drug use issues that are described in the literature.

### 1.2 Method

This annotated bibliography presents materials published in Canada and the United States within the last 10 years. Most of the reports were found through a search of the University of British Columbia library system, the internet, and contact with the Canadian Centre on Substance Abuse and National Institute on Alcohol Abuse and Alcoholism (NIAAA).

Most of the literature addresses the needs of homeless and homeless at-risk individuals, and dually diagnosed individuals with co-occurring mental illness and substance use issues. Virtually all the literature that was found presents the opinion that housing is central to providing alcohol and other drug treatment services. However, few empirical studies with solid data were found that demonstrated the impact of housing on the consumption of alcohol or drugs. No Canadian studies are included in this annotated bibliography. Although initiatives may be underway in this country, no relevant published materials were found. In addition, although information was available on alcohol and drug-free housing, very little research was found on the impact of housing where the use of alcohol and drugs is permitted.

## 1. Review of the Literature

### 2.1. *The role of housing*

#### 1) **Community Demonstration Program (United States), 1988-1989**

McCarty, Dennis. 1990. Nine Demonstration Grants: Nine Approaches. *Alcoholism Treatment Quarterly* 7 (1): 1-9; and Lubran, Barbara. 1990. Alcohol and Drug Abuse Among the Homeless Population: A National Response. *Alcoholism Treatment Quarterly* 7 (1): 11-23.

These articles provide an overview of nine community based grant projects in the United States that were funded to provide services to homeless individuals with alcohol and other drug problems. The initiatives were funded through the Community Demonstration Program, which received \$9.2 million in the fiscal year 1988 through the Stewart B. McKinney Homeless Assistance Act of 1987, and an additional \$4.5 million in 1989. The Act specifically authorized funding for the National Institute on Alcohol Abuse and Alcoholism (NIAAA) in consultation with the National Institute on Drug Abuse (NIDA) to establish a demonstration program to develop, expand, and evaluate alcohol and other drug treatment and recovery services for homeless men and women. Program goals were to:

- Decrease levels of alcohol and/or other drug use;
- Increase cooperation and formal linkages among alcohol treatment, drug treatment, and other supportive services for the target population;
- Improve access to shelter and housing (including alcohol and drug-free living environments);
- Increase health and mental health status;
- Enhance economic status; and
- Improve quality of life.

In 1988, grants were awarded to programs for a two year period in Anchorage, Alaska; Boston, Massachusetts; Los Angeles, California; Oakland, California; Louisville, Kentucky; Minneapolis, Minnesota; New York City, New York; and Philadelphia (2 projects), Pennsylvania.

Each of the programs was different depending on community needs and the target populations to be served. Core services included outreach, sobering-up stations, detoxification, residential services, housing, and case management. All projects provided at least one of these services, and most provided several. The development of alcohol and drug-free housing was emphasized in all project cities and each program recognized that the greatest need among the homeless was having a safe place to live.

Orwin, Robert G., Howard H. Goldman, L. Joseph Sonnefeld, Nancy Gray Smith, M. Susan Ridgely, Roberta Garrison-Mogren, Ellen O'Neill, JoAnn Lucchese, Ann Sherman, and Mary Ellen O'Connell. (n.d.) *Community Demonstration Grant Projects for Alcohol and Drug Abuse Treatment of Homeless Individuals, Final Evaluation Report*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, National Institute on Alcohol Abuse and Alcoholism.

The evaluation of the Community Demonstration Program estimated that 6,762 clients were served. Of these, 1,563 were served by projects providing primarily extended services such as residential

recovery, sober housing, non-residential recovery, case management, and in some cases, shelter. One of the lessons learned from the program was that the shelter, sustenance, and security needs of the clients should be met first, and the treatment needs addressed second. Another lesson was that the most successfully implemented programs were those that met individual client needs (e.g. through individualized client contracts) within a structure that included rules and predictable consequences for specific behaviours. “Structure serves to remove the clients from the type of chaos of street life and sets up an environment within which they can begin to learn to control their addictions”. The evaluation also found that 57% of the treatment clients reported drinking fewer days than the average comparison group client.

## 2) Cooperative Agreement Program (United States), 1990-1992

Huebner, Robert B., Harold I Perl, Peggy M. Murray, Jack E. Scott, and Beth Ann Tutunjian. 1993. The NIAAA Cooperative Agreement Program for Homeless Persons with Alcohol and Other Drug Problems: An Overview. *Alcoholism Treatment Quarterly* 10 (3/4): 5-20.

In August 1990, NIAAA funded 14 new projects in 13 cities under the program of “Cooperative Agreements for Research Demonstration Projects on Alcohol and Other Drug Abuse Treatment for Homeless Persons”. Funding was provided for each of the fiscal years 1990, 1991 and 1992. The program’s mission was to support and evaluate the effectiveness of interventions for homeless persons with alcohol and other drug problems. The primary goals of the program were to:

- Reduce the consumption of alcohol and other drugs;
- Increase levels of shelter and residential stability; and
- Enhance the participants’ economic or employment status.

Three broad categories of services were provided including case management, recovery and treatment programs, and housing services.

Ten demonstration projects provided either transitional or permanent housing services. About half of these were in shelter-type settings. Nine projects provided housing that was alcohol and drug-free. Many projects offered supportive services as part of their housing program, including alcohol and drug abuse recovery services and self-help groups. Seven projects offered permanent housing assistance, including expert staff assistance, financial aid, the direct provision of permanent housing or linkage with community resources to develop additional housing options.

Conrad, Kendon J., Cheryl Hultman, and John S. Lyons. 1993. Treatment of the Chemically Dependent Homeless: A Synthesis. *Alcoholism Treatment Quarterly* 10 (3/4) 235-246.

Most of the 14 demonstration projects found that it was extremely difficult to help most of the chemically dependent homeless without providing them with a secure, comfortable, and supervised place to live. It was also found that housing must be supportive of sobriety<sup>1</sup>. Among the project reviewers, opinions differed on how long supervised housing should last, but there appeared to be consensus that supervised housing is desirable to enable resocialization and help clients get “back on their feet.” Once this goal is accomplished, it must be maintained and accompanied by gradual

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<sup>1</sup> The article did not elaborate on what types of housing would be supportive of sobriety.

reintegration into life in the community in independent housing. For independence to be maintained, it is necessary to have established an income through employment and/or benefits. The maintenance of sobriety usually requires participation in self-help groups and/or ongoing participation in program activities.

The hook for attracting and maintaining clients for most of the projects was the provision of housing, food, health care and other services, all of which could be lost if the client did not adhere to the sobriety standard. However, in cases where homeless individuals were not amenable to residential intervention, intensive case management was offered to provide the required support and stability to enable individuals to eventually achieve sobriety and employment and thereby to compete for available housing.

A major barrier to the success of all of the projects was the insufficient supply of permanent housing available to the poor even if the goals of sobriety, employment and improved mental health were achieved. To make addiction treatment programs for the homeless most effective, these projects should have a stock of low income housing to which to refer their successful clients. In most of the communities, obtaining such housing is problematic at best.

## **2.2 Housing approaches and issues**

### **1) Supported housing and continuum approach for dually diagnosed individuals**

Bebout, Richard R. 1999. Housing Solutions: The Community Connections Housing Program: Preventing Homelessness by Integrating Housing and Supports. *Alcoholism Treatment Quarterly* 17 (1/2): 93-112.

Two prevailing models have emerged to address homeless and marginally housed persons with mental illness. One is the housing continuum approach, which features a range of settings with different levels of on-site services. This model often relies on staffed, group living arrangements, and assumes that many persons with major mental illness cannot live successfully in ordinary, independent housing. The other approach is the supported housing model, which emphasizes self-determination, consumer choice, individualized rehabilitation plans, and the creation of permanent homes in normal housing. The supported housing model is gaining popularity among consumers, consumer advocates, and system planners, because of its philosophical and fiscal appeal. Those who favour supported housing are critical of the residential continuum approach for its reliance on staff controlled transitional preparatory settings and medical model treatment philosophies. However, the supported housing approach has received mixed reviews for people with dual disorders. The authors state that it is possible to see these approaches as two, somewhat overlapping segments of a comprehensive housing response. This article provides a review of the Community Connections Housing Program in Washington, DC, which is an example of a continuum model (see example 15).

### **2) Discussion of the housing continuum, including “wet” and “dry” housing**

Dixon, Lisa B., and Fred C. Osher. 1993. Housing for People with Severe Mental Illness and Substance Use Disorders. *The Housing Center Bulletin* 2(3) 1-10.

This article discusses how to treat homeless or marginally housed people with co-occurring mental illnesses and substance use disorders. An integrated treatment program organized around four

treatment phases, is discussed:

- Engagement – involves providing assertive and prolonged outreach. Providing for basic needs, such as clothes, showers and food may be helpful in the engagement process. The promise of safe, clean housing may motivate clients to enter the treatment system. Provision of badly needed material resources can help to draw clients into a trusting relationship where staff can persuade them to enter treatment for substance abuse and or mental illness and help them identify other, long term goals.
- Persuasion – involves reducing a client’s denial about a mental illness or substance use problem. Success can be measured by a client’s acknowledgement that a problem exists and by the commitment to pursue active treatment. The linkage of housing opportunities to abstinence should be emphasized in persuading homeless dually diagnosed people to enter active treatment. Providers may review with clients how substance abuse has narrowed their housing opportunities and point out how their current access to housing options is limited by ongoing drug use.
- Active treatment - clients develop the skills and relationships necessary to achieve and maintain sobriety and minimize disabilities associated with their mental illness.
- Relapse prevention - both addiction and mental illness tend to be relapsing disorders. Addiction specialists refer to the concept of ongoing “recovery” rather than cure. The relapse prevention phase focuses on minimizing the extent of and damage due to client relapse. It is important for programs to plan for this phase and offer continued treatment and support.

The authors state that housing strategies for homeless or marginally housed people with dual diagnoses must be developed in tandem with clinical strategies.

The authors also state that during the early phases of engagement and treatment, “wet” housing may be the only housing choice acceptable to the client. This is defined as housing in which the use of drugs and alcohol is tolerated. It is noted that some clinicians believe that allowing substance use in housing enables use and is counter-therapeutic. Some clients may be motivated to stop using drugs if they are aware that their housing depends on their sobriety. On the other hand, achieving and maintaining sobriety may be unlikely, if not impossible, without adequate housing. Some individuals will continue to use despite prohibitions and will be evicted to wind up on the streets in circumstances that are not conducive to pursuing sobriety.

Most housing options sponsored by mental health or substance abuse providers are “dry”, with alcohol and drug use prohibited. The authors suggest that a continuum of care should provide for “degrees of dryness”. Some have proposed the concept of “damp housing” where there is an expectation of abstinence on the premises, but clients are not required to agree to abstinence off-site. Shelters and other safe havens that are very tolerant of use would be at one end of the housing continuum, while toward the other end of the continuum expectations and limits could be stronger.

The authors suggest that high levels of structure and supervision may be unacceptable to people during the engagement phase. During engagement, clients may require flexible housing regulations while intensive and assertive supportive services are provided. However, during the persuasion and active treatment phases, when peer interaction and clear limits may be therapeutic, clients might tolerate more structure and supervision. Less structure and supervision, consistent with supported housing, may be more appropriate during later phases of treatment, such as the relapse prevention phase. While most people prefer independent housing, they do not always succeed at this choice. Clients with active addiction problems may need more structure and supervision.

Drake, Robert E., Fred C. Osher, and Michael A. Wallach. 1991. Homelessness and Dual Diagnosis. *American Psychologist* 46 (11) 1149-1158.

Adequate housing is the cornerstone of care for homeless persons, and particularly for those with multiple impairments such as dually diagnosed individuals. For those with alcohol and drug problems, including dually diagnosed individuals, maintaining sobriety may be impossible without adequate housing.

Clinicians and researchers who work with dually diagnosed individuals advocate both a range and a continuum of housing options to meet a variety of needs for individuals that may change over time. A continuum of housing can be seen in terms of either the level of expectation for program participation, or phases of treatment (e.g. engagement, persuasion, active treatment, and relapse prevention).

Living on the streets or in shelters presents a complicated set of demands for survival rather than treatment. Shelters may provide an opportunity for screening assessment, but they often fail to offer basic security and cleanliness that would allow engagement to take place. More adequate alternatives should provide safety, individual space, cleanliness, and dignity.

Engagement is more likely to take place in supported housing or “low demand” residences. Although the concept of “wet” housing is controversial within traditional chemical dependency settings, proponents argue that all clients have a right to decent and safe housing and that treatment should be a second-order consideration. The authors state that low-demand settings may at least reduce morbidity and permit the development of trusting relationships so that residents can be persuaded to participate in treatment and pursue abstinence. Based on the authors’ experience, the housing system must be as flexible as possible during this phase of treatment. Clients often leave housing prematurely if too much pressure is placed on them, and they are often evicted by landlords.

For dually diagnosed clients who become committed to abstinence, alcohol and drug-free living alternatives are essential. The next step might be alcohol and drug-free living settings with less structure and more independence. Attendance at self-help groups would be required, and the use of alcohol and other drugs off-site would not be tolerated. Ultimately, the success of transitional facilities depends on the availability of permanent housing.

The authors note that at the time of writing, research on the use of low-demand housing for dually diagnosed clients was not available.

Baumohl, James and Robert B. Huebner. 1991. Alcohol and Other Drug Problems Among the Homeless: Research, Practice, and Future Directions. *Housing Policy Debate*. 2(3) 837-866.

This paper describes what is known about homeless people in the U.S. with alcohol and other drug problems. It is clear that alcohol and other drug problems are widespread among the homeless, involving, as a conservative estimate, 50% of the population. Homeless people with alcohol and other drug problems are in poorer health than others of the homeless, are victimized more frequently, and are arrested more often.

The exclusion of homeless people with alcohol and other drug problems is an important issue. Most shelters do not admit people they judge to be intoxicated, and virtually every shelter has evicted scores of abusive or disruptive alcohol and other drug dependent people.

The authors state that no matter how effectively programs engage their homeless clients and no matter how sensitively and thoroughly the programs implement case management systems homeless people remain homeless without access to permanent housing. Alcohol and other drug treatment for the homeless will fail without such resources. The simplest way to develop housing alternatives for homeless people with alcohol and drug problems is to make housing assistance part of a case management process or one of the supportive social services offered by a treatment program. However, graduates of transitional housing need permanent housing.

The article concludes by saying that the development of alcohol and drug-free housing, where the length of stay is open-ended, must be a priority in the 1990s. However, the authors raise the question: What is to become of homeless people who continue to use alcohol and drugs excessively? In addition to promoting alcohol and other drug-free housing, should “wet”, “damp”<sup>2</sup> or “moist”<sup>3</sup> hotels be subsidized for this population?

### 3) Alcohol and Drug Free Housing

Wittman, Friedner D. 1993. Affordable Housing for People with Alcohol and other Drug Problems. *Contemporary Drug Problems* 20(3): 541-609.

This article points out that studies indicate affordable alcohol and drug-free (ADF) housing can support the efforts of homeless and very low-income individuals to maintain sobriety following initial successful treatment in recovery programs. ADF housing is also being seen as an economical way to provide treatment and recovery programs as an alternative to residential treatment programs since ADF residents can obtain treatment services on an outpatient basis.

ADF housing is defined as ordinary housing, located in residentially zoned areas and distinguished only by the residents' shared commitment not to use alcohol or other drugs. There are generally three basic rules: 1) residents must remain alcohol and drug free; 2) rent must be paid on time; and 3) residents must abide by landlord and tenant agreements. No formal treatment or recovery services are provided on site. There is no maximum length of stay. Residents may remain in the house as long as they wish, and as long as they comply with the rules. Operating policies are clear that residents who violate basic house rules must leave.

ADF houses may have different policies regarding sobriety. Most houses do not permit any drinking or drug use at all, either on or off the premises. They take a firm approach whereby a single episode of drinking or drug use means that the person must leave. Some residences permit individuals to “slip” once or twice before being evicted. In both types of housing, a consistent policy is applied uniformly to all residents. In houses where residents have developed strong interpersonal relationships, mandatory surveillance through urine tests is seen as counterproductive

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<sup>2</sup> In this article, damp residences would permit drinking or drug use only in the privacy of a tenant's personal quarters.

<sup>3</sup> In this article, moist hotels would permit no drinking on the premises but would tolerate the extramural drinking of residents.

to maintaining these types of relationships. Such measures are also seen as unnecessary as these residents generally leave of their own accord. However, “the less the social control of the ADF residence is based directly on peer contacts, the more institutionalized becomes the procedure for identifying drinking or using.” The need to gather evidence becomes more important, and some houses institute urine screens and other surveillance devices.

Other houses do tolerate limited drinking and drug use. Policies may permit a resident who has resumed drinking or drug use to receive help without having to leave the residence. The author comments that this policy can create issues about fairness and complicate relationships based on abstinence. In addition, repeated drinking episodes among residents can disturb the social environment of the house. Some organizations with a range of programs can deal with these situations by asking the resident to move from the sober housing component of the program to detox or a “primary recovery component” of the program.

Some ADF residences permit off-site but not on-site drinking. They have found that this policy works well “to reduce chronic drunkenness among those for whom sobriety is not a realistic expectation”. The author comments that this approach requires great vigilance to ensure that drinking and other drug use does not occur within the house. The author also notes that “a few residences recognize that chronic, late-stage drinkers do best in situations where their drinking is moderated within the house itself.” However, these are not defined as ADF housing.

Some of the other issues addressed in this article include:

- The role of architectural design in creating successful ADF housing;
- The range of different types of ADF housing;
- Overcoming neighbourhood resistance to ADF housing; and
- Ways to increase the production of ADF housing.

Curtiss, Jim, Chester Garrett, Edward I. Geffner, Lou Hughes, Barbara Lubran, Peggy Murray, John V. O’Neill, Richard Power, Ruth Schwartz, Richard Shandler, Kathleen White, and Friedner D. Wittman. 1991. *A Guide to Housing for Low-Income People Recovering From Alcohol and Drug Problems*. Rockville, Maryland: U.S. Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration, National Institute on Alcohol Abuse and Alcoholism.

This guide provides an overview of the characteristics of alcohol and drug free (ADF) housing, the benefits of this type of housing, barriers to development, and strategies for overcoming development issues. Several chapters provide technical information on the process for developing ADF housing, including site selection, architecture and engineering, financial and legal aspects, and funding resources and strategies. Four case studies are also included that represent a range of ADF housing targeted to support homeless people in their recovery from alcohol and other drug use.

### **3. Empirical Studies**

#### **3.1 *Impact of housing on drug use***

Hser, Yih-Ing, Margaret L. Polinsky, Margaret Maglione, and M. Douglas Anglin. 1998.

The main purpose of this study was to investigate whether matching the needs of clients and program services would improve treatment outcomes. Clients in drug treatment programs typically face multiple problems in addition to drug dependence. Problem areas may include medical needs, psychological distress, legal involvement, employment problems, family relationship problems, and/or housing difficulties. Evidence suggests that in addition to addressing drug use, treatment efforts need to address these other problem areas that may be functionally related to drug use. If left untreated, these other life problems leave clients at high risk of relapse to drug use. Clinical experiences indicate that barriers to participating or staying in treatment are often due to some day-to-day practical situations, such as the need for transportation or child care.

The study assessed a sample of 171 clients who participated in community-based drug-treatment programs in Los Angeles County. Overall, the most frequently reported services that were needed were job training (68% of the overall sample), transportation (68%), housing (63%), and medical services (62%). Unfortunately, the number of clients who received each specific service was generally much lower than those who had expressed a need for that service. Overall, unmet needs were extensive. Of the services most clients needed, 53% of the transportation needs and 44% of medical services needs were met by programs. Only 10% of clients' job training needs and 10% of housing needs were met.

Test results showed that matching certain types of services to needs (e.g. vocational, child care, housing, and transportation), seemed to improve the length of time the client remained in treatment. Clients who received the desired services stayed in treatment significantly longer and showed more improvement in the corresponding problem area than those who did not receive the desired services. Meeting the needs for housing services had a significant impact on reducing drug use. There was a 50% reduction in drug use severity among those who received help with locating housing, a 23% reduction among those who did not receive help with locating housing, and a 41% reduction among those who did not declare a need for housing services.

### **3.2 Housing for dually diagnosed individuals**

Drake, Robert E., Richard R. Bebout, Ernest Quimby, Gregory B. Teague, Maxine Harris, and Jeff P. Roach. 1993. Process Evaluation in the Washington, D.C., Dual Diagnosis Project. *Alcoholism Treatment Quarterly* 10 (3/4) 113-124.

The Washington D.C. Dual Diagnosis project was initiated to develop intensive, integrated services specifically tailored for homeless, dually diagnosed persons. The project takes place at **Community Connections**, a private non-profit mental health agency that provides comprehensive mental health services, including case management, psychotherapy, medications, rehabilitation, and housing, for approximately 300 adults with severe mental disorders. The central component of the Community Connections program is clinical case management.

The project includes two experimental models of intensive case management. Clients receiving both types of services have access to a broad continuum of housing services that range from individualized supported housing to highly structured, congregate living situations. Movements

through this system, as well as exits and returns to homelessness and institutions settings were monitored carefully. Stability of housing was one of the aspects of the program to be evaluated.

The research team found clients frequently preferred single-unit apartments in the community rather than structured or congregate living situations. However, single apartments rarely provided a social network support for abstinence and often provided peer pressure and opportunities for continuance or renewal of substance abuse. Despite numerous placements in these kinds of arrangements and extensive outreach by Community Connections staff, few clients were able to maintain these types of supported housing arrangements. Instead, they typically encountered difficulties related to alcohol, drugs, or disruptive behaviours and returned to homeless shelters or institutional situations after brief stays. In contrast, clients who agreed to structured living arrangements of various types, usually congregate living situations, were more likely to develop networks of friends who were not addicted to drugs, to attain stability themselves, and to maintain community tenure.

Hurlburt, Michael S., Richard L. Hough, and Patricia A. Wood. 1996. Effects of Substance Abuse on Housing Stability of Homeless Mentally Ill Persons in Supported Housing. *Psychiatric Services* 47 (7) 731-736.

This study addressed the ability of supported housing to serve individuals with mental illness and substance use issues. A three year demonstration in San Diego County was designed to evaluate the ability of a supported housing program to stabilize homeless mentally ill individuals in the community, taking into account potentially important individual characteristics. The study found that supported housing works for many mentally ill homeless persons. However, supported housing will likely have much greater success among persons *without* substance use problems. Drug and alcohol problems were both strongly associated with a reduced likelihood of clients' achieving consistent housing in the community. The authors conclude that for populations in which drug and alcohol problems are very common, supported housing programs are likely to be much less successful unless special attention is given to these problems. The authors state that the results of the study demonstrate an urgent need for further research on effective ways of working with dually diagnosed homeless individuals.

Goldfinger, Stephen M., Russell K. Schutt, George S. Tolomiczenko, Larry Seidman, Walter E. Penk, Winston Turner, and Brina Caplan. 1999. Housing Placement and Subsequent Days Homeless Among Formerly Homeless Adults with Mental Illness. *Psychiatric Services* 50(5) 674-679.

Providing housing for homeless mentally ill persons is an essential foundation for their community reintegration and the effective provision of services. However, little empirical research has been conducted to determine what type of housing minimizes the risk of further homelessness, which individual characteristics contribute to further homelessness, or whether particular types of housing are more likely to minimize the risk of homelessness for persons with certain characteristics.

This study examined the influence of group or individual housing placement and consumer characteristics on the number of days subsequently homeless among formerly homeless mentally ill persons. A total of 118 homeless mentally ill individuals in Boston were randomly assigned to live in either independent apartments or staffed group homes. All study participants were provided

with an intensive case manager. Each participant met with the case manager at least once a week. The results showed that most study participants (76%) were in community housing of some sort at the end of the 18 month follow-up period, with no significant differences between the percentage in group homes and the percentage in independent apartments. However, individuals with a history of lifetime substance abuse were associated with more days homeless. Study participants who used substances were clearly more vulnerable to further homelessness. The authors concluded that this study suggests that providing housing to individuals with mental illness and substance use issues was not enough to enable them to achieve stability. There may also be a need to provide appropriate treatment options.

Rickards, Lawrence D., Walter Leginski, Frances L. Randolph, Deirdre Oakley, James M. Herrell, and Cheryl Gallagher. 1999. Cooperative Agreements for CMHS/CSAT Collaborative Program to Prevent Homelessness: An Overview. *Alcoholism Treatment Quarterly* 17 (1/2) 1-15.

In 1996, the Center for Mental Health Services and the Center for Substance Abuse Treatment in the U.S. launched a two-phased, three-year initiative to document and evaluate the effectiveness of homelessness prevention interventions that focus on persons with psychiatric and/or substance use disorders who are formerly homeless or at-risk for homelessness. One of the central questions to be addressed is the relative effectiveness of alternative models for preventing homelessness in the target population. This project will include a study of the continuum approach (Community Connections) and a supported housing model (Pathways to Housing).

### **3.3 Outpatient detoxification program with supported housing**

Wiseman, Eve J., Kathy L. Henderson, and Margaret J. Briggs. 1997. Outcomes of Patients in a VA Ambulatory Detoxification Program. *Psychiatric Services* 48 (2) 200-203.

This study demonstrated that supported housing can contribute to successful outcomes of outpatient detoxification for homeless individuals. The study examined outcomes of 517 patients enrolled in a Veterans Affairs outpatient detoxification program. Nearly half of the study participants had been homeless. Eighty-five percent of the patients used VA-supported housing. Out of 517 patients, 453 (88%) successfully completed the outpatient detoxification program, and 434 were referred for further treatment. 406 of these were referred to inpatient rehabilitation and 28 to outpatient rehabilitation. Of the 434 patients referred to inpatient or outpatient rehabilitation, 322 completed the treatment program.

This completion rate of patients in the outpatient detoxification program and for continuing and completing further treatment were higher than in previous studies. The authors believe that several factors may have contributed to the good outcomes. Most of the patients used VA-supported housing, and thus housing status may have contributed to the relatively favourable results. Homeless patients who failed to complete the program were referred to non-VA shelters. Access to VA-supported housing was contingent on clinic enrollment. The housing issue may also have had an impact on the high rate in inpatient rehabilitation after detoxification. Other factors that may have contributed to the successful outcomes of this study included systematic screening, medical protocols for detoxification, psychosocial therapies, and attention to patient satisfaction.

## 4. Examples of Approaches

### 1) Anchorage, Alaska

Example of a program that provides comprehensive services. Discusses the role of entry level diagnostic screening services.

Dexter, Raymond. 1990. Treating Homeless and Mentally Ill Substance Abusers in Alaska. *Alcoholism Treatment Quarterly* 7 (1): 25-31.

In Anchorage, Alaska, the Salvation Army operated a comprehensive substance abuse treatment program that included a:

- Community service patrol (an ambulance services to take intoxicated persons to their homes, hospital, or other treatment facilities),
- 20-bed detoxification centre,
- 38 bed residential treatment facility,
- Specialized women's residential facility for 12 adults and 4 pre-school children,
- 12 bed half-way house, and
- Extensive outpatient facility.

The Salvation Army also operated an alcohol-free living centre (dry hotel) as part of its services.

The Salvation Army used its NIAAA demonstration grant to develop a diagnostic screening centre and walk-in counselling and sobering services in the core area of Anchorage. The grant was also used to provide joint substance abuse and mental health treatment to individuals referred from the screening centre. The diagnostic screening centre became the "vital first link" in the treatment of the target group. Staff attempted to motivate individuals into treatment, and if successful, the client would enter the detoxification unit. After detox, clients could enter the extended care residential program. The length of stay in this facility was generally 70 days. Programs included education on alcohol and other substances, AA and NA step groups, counselling, recreation activities, and vocational education to assist in obtaining employment. After the residential phase, clients with mental illness were referred to transitional housing operated by the Community Mental Health Centre. Other individuals capable of independent living were referred to the alcohol-free living centre maintained by the Salvation Army. In all cases, continued treatment was provided by counselling staff through outreach services.

### 2) Louisville, Kentucky

Discusses the need for a shelter/sobering-up station

Bonha, Gordon Scott, Diane E. Hague, Millicent H. Abel, Patricia Cummings, Richard S. Deutsch. 1990. Louisville's Project Connect for the Homeless Alcohol and Drug Abuser. *Alcoholism Treatment Quarterly* 7 (1): 57-78.

Representatives from numerous agencies in Louisville formed a planning group to review the existing services in the community for homeless individuals with alcohol and drug use issues. The planning group identified a need to target services to homeless males with alcohol and/or drug problems. The goal was to target these individuals who were "cycling from shelters, food kitchens, and jails in order to intervene in that cycle and "connect" these individuals to other

services”.

The Sobering-up Station was the entry point into Project Connect. This was the only shelter in the city where men could go when they were intoxicated. The average length of stay was 10-12 hours. During the first 7 months of operation, 90% of the men who used the sobering centre came on their own, 4% were brought by the police, and the rest were referred by medical services, chemical dependency treatment services, and other shelters. Case managers would try to recruit individuals in the sobering-up station. Case management was the core service of Project Connect. The primary function of the case manager was to help the client connect with existing services. Vocational training and job placement was also a major goal of the program for men who could maintain sobriety for a period of time.

### 3) Boston, Massachusetts

Example of a program that provides comprehensive services, including intensive case management, residential treatment centres, and supported housing. Discusses need for post-detoxification stabilization services, which may be provided in a shelter.

McCarty, Dennis, Argeriou Milton, Milly Krakow, and Kevin Mulvey (1990) Stabilization Services for Homeless Alcoholics and Drug Addicts. *Alcoholism Treatment Quarterly* 7(1) 31-45.

One of the reasons for this initiative was the belief that it is difficult for newly detoxified individuals, who are in early recovery and often still struggling with physical weakness and impaired cognitive functioning, to seek out available services. Cognitive functioning in long-term alcoholics is impaired to the point that three to five days in detox is inadequate for physical and cognitive recuperation. This may be one reason chronic alcoholics do so poorly in recovery homes when referred directly from detoxification. Any one detoxification is unlikely to lead to sobriety. There is a need to provide longer periods of stabilization and ‘drying out’ and improved interagency coordination. Clients would benefit from more time off the streets and coordination would enhance the likelihood of moving to the next level in the continuum of care.

The Stabilization Services Project provided **post detoxification** services to individuals with substance use issues in Boston who were homeless or near homeless. Stabilization services were provided at four sites: two in substance abuse treatment agencies and two in community based shelters for the homeless. Each site had 10 beds dedicated to clients in the demonstration project. Continued treatment occurred through placements in recovery homes, followed by residence in sober housing, and assistance with resuming employment. Half of the project participants received case management services to assist them along the continuum.

The study found that more than half of the individuals (55%) completed stabilization, remained in care for a mean of 35 days and were placed in longer-term residential treatment. The authors concluded that stabilization services appear to make substantial contributions to recovery among homeless men and women. In addition, it appears feasible to provide stabilization services in treatment programs and in shelter settings.

### 4) Los Angeles, California

Discusses the need for longer term recovery (after 90 days) and the need to help individuals re-enter an inner-city environment

Wright, Al, Juana Mora, and Lou Hughes. 1990. The Sober Transitional Housing and Employment Project (STHEP): Strategies for Long-Term Sobriety, Employment and Housing. *Alcoholism Treatment Quarterly* 7(1) 47-56.

The purpose of the Sober Transitional Housing and Employment Project (STHEP) was to address the long-term recovery, vocational, and housing needs of homeless alcoholics. Existing services provided detoxification, emergency housing and recovery centres where participants could reside for approximately 90 days and receive alcoholism recovery services, career counseling, basic skills instruction, and pre-employment training. However, there were no programs available to assist persons with securing long-term housing and employment, or to assure a successful re-entry into independent living in an inner city community. Thus, the recidivism rate for detox and recovery services was high with estimates ranging from 70-80% in Los Angeles County.

STHEP involved a two-phase residential recovery program. Phase 1 involved participation in a 90 day, 20-bed residential primary alcohol recovery and pre-employment program. Homeless alcoholics from the Skid Row area of Los Angeles in a detoxification program were referred to a rural alcohol recovery program. Services in the 90 day recovery phase included individual counselling, alcohol education, and participation in nutrition, exercise and pre-employment activities. Towards the end of the 90 day period, each participant, with assistance from staff, developed an exit plan which contained provisions for maintaining sobriety, stable employment, long-term housing, supportive sober networks, and related social service needs. At departure, residents were encouraged to join the STHEP alumni group and to return to the facility to help newly recovering people.

Phase 2 involved participation in a 120 day, 20 bed transitional recovery, employment and housing program. The centre was located in the city, and participants were re-introduced to the inner city environment. Services focused on preparing participants to re-enter society through development of social skills while living in a sober, supportive environment. Services include vocational training and education, job search activities, self-help recovery activities, and assistance in obtaining long-term housing.

In addition to the direct recovery services offered to clients, the STHEP program also worked to provide technical assistance to alcohol agencies to increase the number of affordable housing units and employment opportunities for alcohol recovery centre residents. The purpose of this additional aspect of STHEP was to build and strengthen the supply of housing, employment, and support services in the local community and thus assure the availability and access to such key services for STHEP graduates.

## 5) Oakland California

Example of a program that provides a continuum of services.

Bennett, Robert W., Hazel Weiss, and Barbara R. West. 1990. Alameda County Department of Alcohol and Drug Programs Comprehensive Homeless Alcohol Recovery Services (CHARS). *Alcoholism Treatment Quarterly* 7 (1): 111-127.

Alameda County, with assistance from NIAAA, created the Comprehensive Homeless Alcohol Recovery Services (CHARS) program to address the needs of homeless individuals with alcohol and drug problems. The program reflects a significant effort to create a full continuum of community-based services for homeless people with alcohol and drug problems, and their families. Components of the system include the following:

- 24 hour Alcohol Crisis Centre – designed to provide crisis and drop-in services for individuals experiencing alcohol-related problems, including those who are inebriated.
- Two Multi-purpose Drop-in Centres – offer homeless people with alcohol problems a primary point of entry if they wish to seek recovery or social services. These centres provide on-site alcohol and drug recovery services, shower and laundry facilities, one hot meal per day, information and referral to other alcohol and drug programs and social services, economic benefits counseling, telephone availability, transportation and outreach to other agencies .
- The County Residential Alcohol Recovery Program system – was redesigned to reduce barriers to homeless individuals and to meet the increased demand for services as a result of the CHARS program. This included a stipulation that 25% of all recovery beds should be reserved for homeless participants.
- The Transitional Housing Component – involved the purchase of a 16 unit apartment complex, to supplement two existing transitional living programs for the homeless in Northern Alameda County. Participants included women who were recovering and those who were victims of another family member's alcohol problem, including victims of alcohol-related violence. Families could remain for up to 18 months. Programs included on-site alcohol and drug recovery services, public benefits assistance, job search training, and assistance in securing vocational training. Participants were provided with vouchers to aid them in securing off-site child care. Participants agreed to maintain alcohol-free homes.
- The Permanent Sober Housing Component - helped participants secure permanent housing by helping them to form stable households, aiding participants to locate affordable housing, accessing available loan and grant programs for tenant rental deposits, assisting community based organizations to assume financial and legal responsibilities for rentals in cases where participants cannot secure housing on their own behalf, and proactively developing relationships with landlords, developers, and real estate agents to locate and secure moderately-priced rental housing.

Individuals were required to establish and maintain sober households as a condition for service under this program. They were assisted in obtaining non-residential recovery services, independent living services, employment training, and other relevant services by program staff who were also available for counseling and mediation should problems arise.

## **6) Minneapolis, Minnesota**

Discusses the role of case managers in helping clients obtain housing.

Willenbring, Mark L., Joseph A. Whelan, James S. Dahlquist, and Michael E. O'Neal. 1990. Community Treatment of the Chronic Public Inebriate I: Implementation. *Alcoholism Treatment Quarterly* 7 (1): 79-97.

The key element of service in this project was adapting a model of intensive case management

that used a modified team approach. There was a primary case manager who formed a long-term relationship with the client, but the team also took on significant responsibility. Case managers advocated for clients' needs, and helped them obtain needed services.

Case managers were very active in advocating for more appropriate housing for their clients. It was recognized that a lack of housing was the single most difficult barrier to overcome for most clients. Case managers worked with clients to help them find housing, provided transportation, and then accompanied their clients to the dwelling and assisted them in making suitable arrangements. In spite of the housing shortage, case managers who advocated for housing on behalf of their clients with landlords and with agencies were able to make a significant difference in improving access to housing for most of the clients. A severe shortage of low-income housing was found to be a barrier in program implementation.

## 7) Philadelphia, Pennsylvania

Example of a program that provides comprehensive rehabilitation services for dually diagnosed individuals, including a supportive residential recovery program, and rehabilitation and socialization services. This model also includes "low-demand" residence in a large group home.

Blankertz, Laura and Kalma Kartell White. 1990. Implementation of Rehabilitation Program for Dually Diagnosed Homeless. *Alcoholism Treatment Quarterly* 7 (1): 149-163.

The goal of this project was to provide comprehensive services for the reduction/elimination of alcohol and other drug use, the improvement of mental health functioning, and the provision of opportunities for clients to acquire the skills and supports necessary to develop economic and social self-sufficiency.

There were three residential sites for the program, including:

- One 28-bed group home;
- 15 board and care slots in the homes of approved and trained providers; and
- 10 supported independent housing units.

When individuals first entered the program, they came directly to the large group home. Here, their dual problems were assessed, they chose individual rehabilitation goals, and they were linked with services and substance abuse treatment, as well as mental health and physical health care. As individuals became adjusted to the program, they were linked with appropriate day programs and educational/support groups both on and off-site. Once a client demonstrated sufficient mastery of daily living skills and made significant strides towards stabilizing his/her mental health problems, they could move on to either the board and care or independent living situations.

The large group home adopted the format of a low demand residence. Many dually diagnosed individuals cannot tolerate a highly structured, restrictive environment, such as a traditional therapeutic community, after living on the streets. They are not willing to relinquish their sense of self-determination (autonomy) and freedom which have been major sources of self-esteem and have given them the strength to survive. Many of the dually diagnosed long-term homeless are not willing to strive for immediate abstinence. These individuals do not have a commitment to

abstinence because either they are addicted, substance abuse is an integral part of their lifestyle and values, or substance abuse has been a means of avoiding the harsh reality of life on the streets. Some have been using substances to “self medicate” their mental health issues. Faced with an environment with structured rigid rules and required compliance, many will leave.

Initially, low demand residences make few demands on their residents. As individuals adjust to life off the streets, the program adjusts and heightens its expectations of individuals.

## 8) New Orleans, Louisiana

Example of a program that provides detoxification, transitional care, and extended care/independent housing. The view is presented that one cannot begin to address the alcohol and drug problems of homeless substance abusers until they are first provided with a clean, secure, and comfortable place to live.

Wright, James D., Joel A. Devine, and Neil Eddington. 1993. The New Orleans Homeless Substance Abusers Program. *Alcoholism Treatment Quarterly* 10 (3/4) 51-63.

The New Orleans Homeless Substance Abusers Program (NOHSAP) was designed to achieve four principal goals:

- an alcohol and drug-free existence (permanent sobriety)
- residential stability (permanent housing of more than minimal adequacy)
- economic independence (jobs and incomes adequate to sustain an independent existence)
- reduction in family estrangement.

The general philosophy behind NOHSAP is that one cannot begin to address the alcohol and drug problems of homeless substance abusers until they are first stabilized residentially – until they are provided with a clean, secure, and comfortable place to live. In addition, the key to successful treatment is to provide social and physical environments where sobriety is positively valued. The program is specifically designed to provide a residential environment where sobriety is the norm and independent living is positively encouraged. It is also recognized that sobriety is a learned behaviour that requires practice and that relapse is an inherent and unavoidable aspect of recovery. Therefore, periods of relapse are tolerated.

The program involves three-phases:

- Detoxification is a 7 day program of sobering up, initial introduction to AA and NA principles, twice-daily group meetings, some counselling, and limited assessment and case management.
- Transitional care follows detoxification and is a 12-bed, 21 day program involving more extensive assessment, greater case management, twice-daily group meetings, placement in an off-campus alcohol or drug group, and general reinforcement of any positive steps taken during detox.
- Extended Care/Independent Living program is for clients who successfully complete the transitional care program. This is a 12 month program and continues all the interventions and strategies begun during transition care plus job training and job placement services. Clients

live in the facility for free.

NOHSAP is located in a 42 unit apartment building in a pleasant residential section of the city. These are modern, newly-renovated apartments with appliances, carpeting, central air condition etc. An attempt is made to give clients the experience of independent living “out there in the real world”, and the treatment facility attempts to model that world as closely as possible.

At the time the article was written, more than 700 clients had passed through the facility. About 500 were “control” clients who received 7 days of detox treatment and were then released back into the community. The remainder were “treatment” clients who were exposed to some period of transitional or extended care. Preliminary results showed that the relapse rate for the “treatment” clients was much lower than among “control” clients, among whom more than 80% relapsed within the first 3 months.

### **9) New Haven, Connecticut**

Uses a 24-hour drug-free shelter for its treatment program for cocaine users.

Leaf, Philip J. Kenneth S. Thompson, Julie A. Lam, James F. Jekel, Esther T. Armand, Arthur E. Evans, John S Martinez, Carment Rodriguez, Wesley C. Westman, Paul Johnson, Michael Rowe, Stephanie Hartwell, Howard Blue, and Toni Harp. 1993. Partnerships in Recovery: Shelter-Based Services for Homeless Cocaine Abusers: New Haven. *Alcoholism Treatment Quarterly* 10 (3/4) 77-90.

The main purpose of the Grant Street Partnership (GSP) initiative was to establish a shelter-based program of services for cocaine-using homeless men in New Haven. A second goal was to be an agent for the improvement of housing, employment and job-training services in New Haven.

The substance use treatment program consisted of two major components. The first was a 90-day residential program operated in a drug-free 24-hour shelter. When clients first arrived at the shelter, they were assigned a case manager. After an assessment and evaluation, clients and case managers developed an individualized substance abuse treatment contract and service plan aimed at achieving and maintaining abstinence and accessing the services necessary to facilitate integration into the community. The resident was also assigned a “Big Brother”, and began daily group counselling and psychosocial groups. The individual participated in AA/NA meetings within the shelter. In level 2, the resident could become a “Big Brother” to incoming residents, receive weekend passes, and have telephone privileges. Participation continued in group and individual programs. The resident also began to focus on implementing the service plan, especially with regard to employment and housing. In level 3, the resident developed plans for maintaining his commitments in the community.

Upon completion of the residential component, clients continued in case management and clinical services for approximately 6 months on an ambulatory basis. This aspect of the program proved problematic as the program was unable to provide sufficient treatment and support for the graduates, especially given the high levels of drug use and violence in the neighbourhoods where most of the available housing existed. However, the program achieved some success with men moving into “clean” group apartments.

Preliminary results of the program noted although it was clear that a 90-day shelter-based treatment program could have important benefits for substance abuse, the feasibility of organizing a successful shelter-based case management program for former shelter residents in the absence of a formal continuum of residential placements still remains to be determined. It is clear that shelter-based programs cannot exist in isolation if they are to succeed.

#### **10) Seattle, Washington**

Addresses the needs of homeless individuals for intensive case management prior to treatment.

Cox, Gary B., Lucia Meijer, Donna I. Carr, and Steven A. Freng. 1993. Systems Alliance and Support (SAS): A Program of Intensive Case Management for Chronic Public Inebriates: Seattle. *Alcoholism Treatment Quarterly* 10 (3/4) 125-138.

The King County Division of Alcohol and Substance Abuse Services (DASAS) in King County, Washington, (which includes the City of Seattle), offers a continuity of care service model with a full range of standard detoxification, residential, outpatient, and aftercare service components. Over the years, the DASAS noted that a small number of clients accounted for a large number of admissions to the King County Detoxification Centre, and administrators began to consider ways to increase the number of clients who could be served in the centre by reducing the number of admissions for the high frequency users. It was believed that one way to achieve this goal would be to provide intensive case management to a sample of homeless high frequency detoxification users.

The first goal of the project was to reduce the harmful effects associated with chronic substance abuse, including homelessness, illness, personal victimization, and criminal activity. It was recognized that this would involve helping clients with basic issues such as financial aid, housing, health care, household management etc. The second goal was to help clients reduce, and preferably cease, their consumption of alcohol and other drugs. However, case managers did not focus on the client's drinking, and the provision of case management was never contingent on the client stopping or reducing drinking.

A major component of the program was the establishment of "protective payee" status for clients with disability payments. This enabled clients to continue to function in the community even when they were too incapacitated by their alcoholism to continue to function independently.

Preliminary results from 6 month follow-up data suggested that clients significantly increased their income, reduced the number of nights spent on the streets and in shelters, increased the number of nights spent in their own housing, and have fewer, but not statistically significantly fewer, detox admissions.

#### **11) Albuquerque, New Mexico**

Discusses issues with providing unsupervised transitional housing.

Lapham, Sandra C., Marge Hall, Marsha McMurray-Avila, and Harry Beaman. 1993. Albuquerque's Community-Based Housing and Support Services Demonstration Program for Homeless Alcohol Abusers. *Alcoholism Treatment Quarterly* 10 (3/4) 139-154.

Prior to the NIAAA-funded demonstration program, the only state-funded inpatient alcohol rehabilitation program serving the county had 14 beds for medical detoxification and 26 beds for rehabilitation (a 21-day program). This meant that homeless persons seeking treatment services could receive up to one month of housing before being discharged back onto the streets. Maintaining sobriety was often an insurmountable challenge.

The NIAAA-funded demonstration program, Project H&ART (Housing and Alcohol Research Team), added to existing services by adding essential residential programs for homeless substance users in the community. The services thought to be most essential were a residential detox program, and a transitional housing, case management, and support services program.

Participants who completed detoxification were assigned to one of the study groups, and transported to their residences.

Group 1. This was the high intensity, intervention group in which clients received case management and substance abuse treatment services and were provided with alcohol and drug-free transitional housing, staffed by peer residence managers. Group 1 housed up to 30 clients for up to 4 months.

Group 2. Participants in this medium intensity intervention had less active intervention. They were provided an alcohol and drug-free living environment, and support from recovering residence managers. The only requirements of Group 2 residents was that they remain alcohol and drug free; attend weekly community meetings; and inform staff twice weekly about services they have received in the community (including job placement, health care, mental health, and substance abuse counselling services).

Group 3. Persons assigned to the low intensity comparison group were provided with unsupervised, community-based housing. There was monitoring of self-initiated treatment services, and clients were to submit to random alcohol and drug testing. Clients were not allowed to use alcohol or drugs, either at the housing sites or elsewhere. Relapse was to result in removal from housing. The clients themselves voted to support this policy.

This project faced a serious problem in maintaining the integrity of Group 3. Without supervision, alcohol and drug use became a significant problem among Group 3 clients. There were several incidents in which multiple homeless friends were invited to move into the Group 3 residences. Property was damaged and stolen, and landlords began refusing to continue renting apartments to this group. Clients shifted from well-kept, single residence units to seedy motel rooms and 2 bedroom apartments. It became apparent that the safety of clients and staff could not be assured. After about 1 year from the beginning of start-up, housing for members of this group was discontinued, and a fourth group, a non-housed control group replaced the original group 3.

Preliminary results indicated that 75% of participants for all three intervention groups (282 of 378 subjects) left the program prematurely – before their four month period of transition housing ended. In Group 1, most of the individuals who left (53%) did so of their own accord without

providing a specific reason. In Groups 2 and 3, most of the clients who left were discharged for chemical use or other rule violations.

## 12) **Birmingham, Alabama**

This program involved an enhanced level of treatment that included the creation of drug-free permanent housing.

Raczynski, James M., Joseph E. Schumacher, Jesse B. Milby, Max Michael, Molly Engle, Maggie Lerner, and Tom Wolley. 1993. Comparing Two Substance Abuse Treatments for the Homeless: The Birmingham Project. *Alcoholism Treatment Quarterly* 10 (3/4) 217-233.

The purpose of the Birmingham project was to compare a model of usual care to an enhanced day treatment program for homeless persons with substance use disorders.

The enhanced treatment differed from usual care and customary treatment in several ways. It provided a more intensive form of treatment and offered participants a fuller range of treatment services. The enhanced program also involved vocational and social training, and renovation of drug-free housing for successfully rehabilitated clients.

During the initial two-month day treatment phase, participants were involved in active programming from 7:45 a.m. until approximately 2:00 p.m. every day and live in shelters or other temporary living arrangements obtained on their own or through the assistance of counsellors. Individualized contracts were developed within the first week of treatment and provided goals and specific tasks for each client.

After completion of the first 2 month treatment phase and a minimum of 2 weeks of drug-free test results, clients become eligible to participate in the work and housing components. This phase is designed to provide on-the-job vocational skill development and paid work experience. Work experience includes the renovation of structures to be occupied by the clients themselves and as drug-free residences for the project. Housing was available to clients who were working and able to pay a modest rent and who remained drug-free and responsible renters. House meetings, in-home AA/NA/CA meetings, and house governments modeled after the Oxford House program were incorporated into the housing component at clients' request. Upon completion of both the day treatment and work and housing phases, clients were able to remain in the drug-free housing provided by the project on a *permanent* basis. Clients were encouraged to attend weekly after-care groups which concentrate on relapse prevention, work and shelter maintenance issues.

Milby, Jesse B., Joseph E. Schumacher, James M. Raczynski, Ellen Caldwell, Molly Engle, Max Michael, and James Carr. 1996. Sufficient Conditions for Effective Treatment of Substance Abusing Homeless. *Drug and Alcohol Dependence*. 43: 39-47.

Preliminary findings from the Birmingham NIAAA/NIDA-funded research demonstration project found that of the 176 clients who entered the study, 131 (74.4%) experienced some treatment and completed at least one follow-up. The research also demonstrated that the enhanced day treatment program that included drug-free work therapy and program-managed, drug-free housing may be more effective than the usual care model (which involved twice-weekly individual and group counselling, medical evaluation and treatment, and referrals for housing and vocational

services) in producing clinically significant reduced alcohol and cocaine use and homelessness. These conclusions are tentative and are awaiting more carefully controlled research to confirm the findings.

The authors propose that there may have been critical elements in the EC intervention which may be considered as necessary and sufficient conditions for effective treatment of substance abusing homeless persons. Necessary conditions include 1) those which meet survival needs of homeless persons, such as the provision of safe shelter, warmth, and food; and 2) elements which comprise an effective treatment intervention for substance abuse including extensive aftercare. The authors hypothesize that “shelter care without effective substance abuse treatment is doomed to providing crisis first aid rather than substantive intervention. Similarly, substance abuse treatment without available housing and therapeutic work experiences is likely to be equally ineffective.”

### **13) Pathways to Housing Consumer Preference Supported Housing Model, New York**

This article describes a supported housing model.

Tsemberis, Sam and Sara Asmussen. 1999. From Streets to Homes: The Pathways to Housing Consumer Preference Supported Housing Model. *Alcoholism Treatment Quarterly* 17 (1-2): 113-131.

The Consumer Preference Supported Housing Model (CPSH), was developed by Pathways to Housing Inc., a private non-profit social services organization in New York City. The agency concentrates on individuals rejected by other housing programs due to refusal to participate in psychiatric treatment, active substance abuse, histories of violence or incarceration, and other behavioural personality disorders. This population is often described as “treatment resistant” or not “housing ready” by other housing programs.

The CPSH program offers, homeless street-dwelling individuals with dual diagnosis immediate access to independent apartments. Unlike traditional housing programs, housing is not connected to compliance or treatment. However, every individual in the program receives support services or treatment. Service teams provide services to tenants in their new homes and communities 24 hours a day, 7 days a week. The program prevents the cycle of homelessness by achieving long-term housing stability through the provision of client-centred, home/community based support services that are relevant to the tenants needs, such as rapid crisis intervention to avert unwanted hospitalizations, client-determined service plans, and a harm reduction approach to alcohol and substance use.

The CPHS Model is based on the principle that homeless individuals with psychiatric disabilities can maintain independent housing of their choice when provided with the right supports. Program elements include the following:

- The consumer selects his/her own housing (apartment);
- Apartments are rented from landlords in the community and the landlord does not provide the support services;
- Clinical crises such as relapse to substance abuse or psychotic episodes do not place the tenant at risk for losing his/her housing;

- Services are offered in the community 24 hours a day;
- Type, frequency, and sequence of services is determined by the tenant;
- Sobriety, medication compliance or any other form of treatment is not a requirement; and
- Staff use a harm reduction model for drug and alcohol abuse.

Tenants must agree to two program requirements. First, the tenant must make the agency a representative payee. This requirement is introduced at different times for individual tenants. The reasons are 1) Pathways is responsible for paying the tenants' rent, including 30% of the tenant's income; and 2) this ensures that tenants' utilities, food and other essentials are provided for and in the instances of dually-diagnosed tenants, this service limits their expenditures for alcohol or drugs. After the rent is paid, a monthly budget is developed by the tenant and service coordinator. Some tenants receive the entire balance of their funds while others may have weekly or biweekly budgets. The goal is for all tenants to eventually manage their own money.

The second program requirement is that the tenant agrees to meet with the service coordinator at least twice per month in the first year. The service coordinator is a member of a service team.

#### 14) **Project H.O.M.E., Philadelphia, P.A.**

This is an example of a homelessness prevention program that offers a comprehensive package of services for individuals with severe mental illness and/or substance use disorders.

Coughey, Kathleen, Kelly Feighan, Karlene Lavelle, Kristen Olson, Maureen DeCarlo, and Monica Medina. 1999. Project H.O.M.E.: A Comprehensive Program for Homeless Individuals with Mental Illness and Substance Use Disorders. *Alcoholism Treatment Quarterly* 17 (1-2): 133-148.

Project H.O.M.E. (Housing Opportunities, Medical Care and Education) is a homelessness prevention program in Philadelphia, PA designed to reduce the recurrence of homelessness among individuals with severe mental illness and/or substance use disorders. The program aims to reduce individual risks by providing three levels of housing and multiple supportive services.

Street outreach is a cornerstone of Project HOME's intervention, as it opens the door to needed housing and services for those living on the street. The primary purpose is to establish a trusting relationship with homeless individuals by using a process of engagement characterized by active listening, sensitivity, and respect for individuals' rights and decisions. Appropriate placements are key to the success of outreach efforts. Outreach staff offer homeless individuals information about housing options, rules and regulations and provide introductions to on-site staff.

Project H.O.M.E. has three levels of housing: **safe havens** (entry-level shelters), **highly supportive residences** (transitional housing), and **minimally supportive residences** (independent living facilities). The sequence of the intervention generally begins at safe havens and ends at independent living. However, residents can move from a more independent living situation to a more supportive one during periods of relapse. Residents are encouraged to move toward higher levels of independence, but progress through the program at their own pace, and may stay at any of the housing facilities for as long as necessary.

Safe havens - Provide entry-level residential facilities for severely mentally ill or dually diagnosed individuals who require intensive supervision, support and structure. Staff are available 24 hours a day. Residents are not required to be clean and sober, but must not use substances on the premises or exhibit aggressive or disruptive behaviour. Discussions about drug and alcohol issues are held, and residents are encouraged to attend recovery meetings. A major goal of the safe havens is to stabilize mentally ill residents and educate them about the importance of taking their medications.

Highly supportive residences – Residents meet regularly with case workers and 24 hour staffing is provided. Residents receive psychiatric care from nearby community mental health centres. All residents attend outpatient drug and alcohol treatment programs and are encouraged to take part in daily activities. Random urine screens are conducted to monitor substance use activity.

Minimally supportive, permanent residences - Designed for individuals with high-level functioning who are ready for more independent living. No drug or alcohol use is permitted. A certified addictions counselor provides counseling services and workshops for all recovering residents and conducts random urine screens. Residents who relapse are not asked to leave if they have an interest in recovery and/or re-entry into a treatment program. Residents do their own cooking, laundry, cleaning and other daily chores. Most residents maintain their own budgets, although some are assigned to representative payees. Case workers regularly meet with residents and assistance is available for emergencies. The residents utilize community-based services for mental health care and drug and alcohol treatment, and a nurse practitioner provides primary health care.

Other services include linkages to physical health, mental health, and drug/alcohol treatment programs; an on-site certified addictions counsellor, educational programs, residential employment program, political and social activism.

At the community level, short-term goals of Project H.O.M.E. are to prevent social isolation among families and individuals living in at-risk communities and to improve their quality of life. The long-term goal is to prevent homelessness in these impoverished areas. Staff believe that revitalizing low-income neighbourhoods is paramount to preventing homelessness.

At the societal level, the goal is to combat NIMBY by educating the public about answers to the problem of homelessness and to encourage everyone to participate in the struggle against homelessness. Another goal is to increase resources available to individuals at-risk of becoming homeless.

## **15) Community Connections, Washington, DC**

This is an example of the continuum model.

Bebout, Richard R. 1999. Housing Solutions: The Community Connections Housing Program: Preventing Homelessness by Integrating Housing and Supports. *Alcoholism Treatment Quarterly* 17 (1/2): 93-112.

This article describes a housing continuum approach in Washington D.C. that is currently being evaluated in Washington. The program is located at Community Connections (CC), a large

private non-profit mental health provider. The CC Housing Continuum represents a comprehensive housing response that includes a wide range of options that are linked to one another and to mental health services within a single organizational structure. The range includes several different levels of staffing support intensities. Both permanent and transitional housing are available.

CC provides intensive case management services to more than 350 adults with severe mental disorders and has the capacity to house approximately 200 people in agency controlled housing units.

The CC housing approach is a non-linear continuum model. An individual can enter the housing continuum at any point and movement between components is fluid. Services are individualized and flexible, and both internal and external supports are adjusted over time as needs change. Clinicians and consumers collaborate in matching individuals to housing settings where supports are tailored to the individual's needs.

The overarching goal of the program is to prevent housing loss and limit exposure to harm. A few basic principles guide the operation of CC's Housing Continuum:

- Mental health and housing supports should be integrated. Persons with mental illness and other interacting impairments have complex needs, and mere coordination is not enough.
- A broad range of housing options is needed. One-size-fits-all approaches cannot work. Comprehensive housing response should incorporate low demand environments, highly-structured residences with varying degrees of staff supervision, as well as less intensively supported independent settings.
- Stabilization is a longitudinal process. Providers should expect to see continued residential instability for months, even years, during which people must be assured of continuous access to core services. Transitional settings with flexible time-limits have a role alongside permanent housing.
- The continuum is non-linear. The residential model allows for multiple points of entry along the continuum. Participants need not move along the continuum in a pre-ordained fashion. Movement within the continuum is fluid. Residents can move from any given setting to any other.
- Supports must be individualized and flexible. Supports vary both across and within housing components.
- The integrated continuum is designed to assure responsiveness. They co-locate housing and clinical staff within a single organization to minimize barriers to effective communication, to assure early detection of problems, and to facilitate rapid responding. The integrated continuum responds rapidly to consumers' changing support needs. An important aim of the program is to adjust supports without a residential change whenever possible.
- Consumers and providers should make decisions collaboratively. CC works hard to strike a balance between consumers' preferences and their legitimate need for self-determination on the one hand, and the necessity of factoring in sound clinical judgment on the other.

Housing opportunities range from intensively staffed crisis/respite beds and longer term supervised congregate residences to single and shared apartments with no on-site staffing. The continuum includes temporary, transitional residences as well as permanent housing. Housing units are leased or owned by the agency.

## 16) The Oxford House Model

This is an example of self-run, self-supported alcohol and drug-free housing.

Molloy, Paul J. (n.d.). Self-Run, Self-Supported Houses for More Effective Recovery from Alcohol and Drug Addiction. *Technical Assistance Publication Series Number 5*. U.S. Department of Health and Human Services, Public Health Services, Alcohol, Drug Abuse, and Mental Health Administration, Office for Treatment Improvement. Rockville, MD.

The Oxford House model provides self-run, self-supported house for individuals recovering from alcohol or drug use. The concept is the same as the one underlying Alcoholics Anonymous and Narcotics Anonymous – addicted individuals can help themselves by helping each other abstain from alcohol and drug use one day at a time for a long enough time to permit a new set of values to be substituted for the values of a lifestyle in which alcohol and drugs were used. The model began in Montgomery County, Maryland when the County decided to close a traditional half-way house because of lack of funds. The men living in the house were not ready to leave. Eventually, these men decided to rent the house themselves, and to run it democratically, but with the understanding that they would vote out any resident who returned to drinking alcohol or using drugs.

The members of the first Oxford House organized as a non-profit corporation, opened a checking account, determined what each resident would have to pay to cover house expenses, and wrote a manual of operations. Six months after the first Oxford House started, it had a surplus of funds in its checking account of \$1,200. The residents decided to use this extra money to rent another house. This example was followed by other Oxford Houses. In 1988, when the United States Congress passed the Anti-Drug Abuse Act, it included a provision to encourage the development of democratically self-run, self-supported recovery houses. At that time, there were 14 Oxford Houses. Ten of the houses were for men and four were for women. By 1989 there were 39 such homes.

Oxford House provides a self-help recovery environment that reinforces such behaviour change over the long term. The length of time needed for one to become comfortable with an alcohol and drug-free lifestyle differs for each individual. Therefore, there is no time limit on how long an individual can live in an Oxford House. However, the average length of stay in an Oxford House is one year and one month. The advantage of Oxford House is that newcomers have the opportunity to live with others who have a longer period of sobriety. The “oldtimers” provide the knowledge of how a self-run, self-supported recovery house works. Once established, the residents of the recovery house use their experience to foster continuing stability for all members of the house.

Oxford Houses have three underlying goals:

- Recovery – the process by which addicted individuals become free of the results of addiction for the rest of their lives;
- Responsibility – the means by which an individual gradually assumes control over his or her lifestyle so that choices can be consistently made to avoid the use of alcohol and drugs; and
- Replication – the means by which addicted individuals living in a self-run, self-supported

recovery house share their newfound lifestyle of living in an alcohol and drug free environment with other individuals having a similar desire by starting other recovery houses.

## **5. Summary and Conclusions**

### **1) The role of housing**

There is consensus in the literature that “housing is the cornerstone of care” for homeless persons. Studies of a variety of projects in the U.S. have concluded that one cannot begin to address the alcohol and drug problems of homeless persons unless they are provided with appropriate housing. For example:

- One of the lessons learned from a study of nine community based grant projects in the U.S. targeted to homeless individuals with alcohol and other drug problems is that the shelter, sustenance, and security needs of the clients should be met first, and the treatment needs addressed second (Orwin, n.d.).
- A review of 14 demonstration projects in the U.S. found that it is extremely difficult to help chemically dependent homeless individuals unless they are provided with a secure, comfortable and supervised place to live. It was also found that the provision of housing, food, health care and other services may be a hook for attracting and maintaining clients in treatment. In cases where homeless individuals are not ready for residential treatment services, case management may provide the required support and assistance with basic life necessities (e.g. food and shelter) that will enable them eventually to work towards sobriety (Conrad, 1993).
- A study of 171 clients who participated in community-based drug treatment programs in Los Angeles found that meeting the need for housing services had a significant impact on reducing drug use. Among those who received help with locating housing, there was a 50% reduction in drug use, compared to a 23% reduction among those who did not receive help with locating housing, and a 41% reduction among those who did not declare a need for housing services (Hser, 1998).
- Several programs demonstrate a need for longer term or permanent housing for individuals who complete treatment programs. A lack of such housing is a major barrier to continued recovery (Conrad, 1993).
- A study of 517 patients enrolled in a Veterans Affairs outpatient detoxification program demonstrated that the provision of supported housing can contribute to successful outcomes (e.g. continuing and completing further treatment (Wiseman, 1997).

### **2) Housing models for dually diagnosed individuals**

The literature addresses the question of what type of housing can work best for dually diagnosed individuals who have both severe mental illness and substance use disorders. Two prevailing models have emerged to address the needs of persons with mental illness. The more traditional program utilizes a “level of care” or “continuum” approach, where the varying needs of clients are addressed by offering several housing settings, each with different levels of service and

supervision and restrictiveness. This model often relies on staffed, group living arrangements. Clients “advance” to more independent alternatives as they master the appropriate skills required to move on. The other approach, supported housing, enables individuals to remain in their residence and access community-based services. It is the intensity of supported services that changes according to the needs of the client.

The supported housing model has received mixed reviews for people with dual disorders. While some authors see merit in both approaches as being part of a comprehensive housing response, there are indications that dually diagnosed individuals may require additional supports or services than those generally provided in supported housing. At this time, there are no conclusive studies on this point. However, a U.S. study is underway to evaluate the effectiveness of the two models (Rickards 1999).

### **3) Wet and dry housing**

The literature discusses the need for a variety of housing options to meet the diverse needs of individuals with alcohol and drug issues, and to meet the changing needs of individuals over time. Some authors express the opinion that wet housing (where the use of drugs and alcohol is tolerated) has societal and individual benefits for people who are not interested in changing their substance use. This form of housing can reduce morbidity and may permit the development of trusting relationships so that residents can be persuaded to participate in treatment. They believe that a continuum of housing should include shelters and other safe havens that are very tolerant of use. On the other hand, the authors note that some clinicians believe wet housing enables substance use and is counter-therapeutic. They believe that some clients may be motivated to stop using drugs if maintaining their housing depends on this.

The literature includes strong support for alcohol and drug-free (ADF) living alternatives for individuals who are committed to abstinence. Studies indicate that affordable ADF housing can support the efforts of homeless and very low-income individuals to maintain sobriety following initial successful treatment and recovery programs.

### **4) Examples of approaches**

The following are some key findings from the programs described in the literature:

- There is a need for communities to be able to offer a comprehensive package of services that could include:
  - community service patrols
  - outreach
  - 24-hour crisis/drop-in centres
  - sobering-up stations/diagnostic screening centres
  - safe havens/(entry level shelters where use is permitted)
  - detoxification centres
  - post-detoxification stabilization services,
  - residential recovery facilities
  - transitional housing
  - low demand (wet) housing

- supported housing
  - permanent housing (some of which is alcohol and drug-free)
  - outpatient programs
- Walk-in counselling programs and sobering-up stations can serve as an entry point for individuals to begin to think about treatment. They also provide an opportunity for case managers to recruit individuals and help them connect with existing services (examples 1 and 2, Anchorage and Louisville).
  - Individuals who complete detoxification require additional residential services or care to maintain sobriety (examples 3 and 8, Boston and New Orleans).
  - Individuals who leave recovery homes (after 90 days) may need additional assistance for successful re-entry into the inner-city environment (example 4, Los Angeles).
  - Case managers can play an important role in advocating for clients and helping them to secure housing (example 6, Minneapolis).
  - Providing intensive case management services to homeless individuals can reduce the harmful effects associated with chronic substance use. Preliminary results of a study in Seattle suggested that clients who received these services increased their incomes, spent fewer nights on the streets and in shelters, spent more nights in their own housing, and had slightly fewer detox admissions (example 10, Seattle).
  - Enhanced treatment programs that also include drug-free work therapy and program-managed drug-free housing may be more effective than traditional treatment programs in reducing alcohol and other drug use and homelessness. The authors hypothesize that “shelter care without effective substance abuse treatment is doomed to providing crisis first aid rather than substantive intervention. Similarly, substance abuse treatment without available housing and therapeutic work experiences is likely to be equally ineffective (example 12, Birmingham).
  - A supported housing program in New York is providing independent apartments and support services or treatment to formerly homeless, dually diagnosed individuals that are often described as “treatment resistant” or not “housing ready” by other housing programs (example 13, New York).
  - Street outreach can be key in opening the door to needed housing and services for homeless individuals with severe mental illness and/or substance disorders living on the street (example 14, Philadelphia).

## 5) Conclusions

The literature demonstrates the importance of housing in providing alcohol and other drug treatment and recovery services to homeless and homeless at-risk individuals. There is a need for communities to be able to provide access to a comprehensive package of services and types of housing including entry level shelters where alcohol and drug use is permitted, post-detoxification stabilization services, residential recovery facilities, transitional housing, low demand

(wet) housing, supported housing, and permanent housing, some of which is alcohol and drug-free.

There are questions about how best to meet the needs of dually diagnosed individuals. Further research is necessary to determine effective housing and support/treatment models for this population.

Although one can conclude that housing is a necessary pre-condition for addressing the needs of individuals with issues related to the use of alcohol and drugs, the provision of housing alone is not a guarantee that people will be able to maintain sobriety or achieve housing stability. In many cases, some form of support or treatment will be necessary. The nature and level of services needed will vary with each individual.

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