



Research paper

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

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ABSTRACT

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

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

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

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

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Introduction

Chronically homeless individuals often have co-occurring alcohol-use disorders, which lead to increased risk for various related problems (Turnbull, Muckle, & Masters, 2007; Wright & Tompkins, 2006), including alcohol-related deaths (Hawke, Davis, & Erlenbusch, 2007; O'Connell, 2005; Public Health – Seattle and King County, 2004). Research has also shown that this population encounters various barriers to engagement in supportive services

(Young, Grusky, Jordan, & Belin, 2000) and that traditional treatment options are generally ineffective (Zerger, 2002). One reason why traditional infrastructures may not engage this population is that the primary focus on abstinence from alcohol eclipses other important factors such as individuals' overall quality of life and the larger context of their alcohol use and its role in their lives (Denning, 2000).

Where housing first meets harm reduction

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

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

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

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

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

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

Despite promising initial findings for HF and harm-reduction approaches in this population, the “continuum model” of housing represents the mainstay of housing provision in the US (Locke, Khadduri, & O’Hara, 2007). This model typically requires individuals to fulfil certain requirements, such as abstinence achievement and treatment attendance, before they may transition from a

shelter to transitional housing to permanent housing. These aspects of the continuum model of housing are complementary to the medical model of alcohol treatment, which holds that alcohol dependence is a “chronic, relapsing brain disease” (Leshner, 1997; National Institute on Drug Abuse, 2008), and is optimally treated with abstinence-based housing, treatment and services.

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

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

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

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

Table 1
Baseline descriptive statistics for the initial project-based HF population ($N = 95$).

Variable	$M(SD)/\%$
Sociodemographic variables	
Age	48.39(9.39)
Race/ethnicity	
American Indian/Alaska Native	27.4%
Asian	1.1%
Black/African-American	7.4%
Hispanic/Latino/a	7.4%
Native Hawaiian/Pacific Islander	3.2%
White/Caucasian	40.0%
"More than one race"	10.5%
Self-reported "Other"	3.2%
Relationship status	
Married	2.1%
Consider self married	1.1%
Widowed	4.3%
Separated	7.4%
Divorced	33.0%
Never married	52.1%
Highest education level	
Some high school	37.2%
HS graduate/GED	29.8%
Vocational school	8.5%
Some college	18.1%
College graduate	4.3%
Some graduate school/advanced degree	2.2%
Alcohol-use variables	
Typical alcohol quantity (standard drinks/day)	24.39(21.87)
Peak alcohol quantity (standard drinks/day)	39.85(39.28)
Alcohol-use frequency (days/past month)	23.75(10.49)
Intoxication frequency (days/past month)	19.82(12.26)
Alcohol-related problems (SIP-2R)	23.34(1.37)
Experience of delirium tremens (% lifetime)	65.2%
Number of alcohol dependence symptoms currently endorsed	5.22(1.80)
Number of alcohol treatment episodes (lifetime)	17.19(59.13)

Notes. M = mean. SD = standard deviation. Quantity and frequency variables are based on the past 30 days. All other variables based on past 3 months. SIP-2R = Short Inventory of Problems summary score.

Methods

Participants and setting

Both staff and residents in a project-based HF programme located in the US Pacific Northwest provided data in the context of a larger programme evaluation conducted during 2009–2010. At the time of this evaluation, the project was staffed with 16 full-time equivalent staff members, including a project manager, residential counsellors, clinical support specialists, a nurse and on-call counsellors. Residents were chronically homeless individuals with alcohol problems ($N = 75$) who were identified using two main sources: (a) a rank-ordered list of individuals who had incurred the highest public costs for alcohol-related use of emergency services, hospital, sobering centre (i.e., a local "sleep-off" facility), and county gaol; and (b) a list of eligible individuals suggested by community providers as also having high crisis systems use (see Table 1 for descriptive statistics for residents involved in an initial evaluation at the housing project). Case managers and housing agency staff proactively sought out and recruited the residents from community settings (e.g., hospital ERs, sobering centre).

Data collection procedures

Data collection for this evaluation was part of a larger, multi-phased programme evaluation aiming to document helpful aspects of the programme and to identify further means of addressing residents' alcohol use. In the first phase, we conducted naturalistic observations of staff-resident interactions in shared community

spaces in the HF project. To capture a variety of daily experiences, we (the first three authors) took near-verbatim notes on resident–staff interactions in 2-h shifts at different times of day. These observations yielded over 20 h of hand-recorded transcripts. In the next phase, we followed staff on two, 2-h rounds and took field notes on the activities and conversations that ensued. We then conducted individual, audio recorded resident interviews ($n = 17$ residents). Resident interviews were semi-structured and lasted approximately 30 min each. We interviewed residents regarding their experiences at the project, their relationships with staff and other residents, and their ideas for future project enhancement. Residents received \$10 for their participation. Finally, we conducted one, 2-h focus group with programme staff ($n = 8$ staff members). In this semi-structured focus group, we provided prompts regarding staff's day-to-day experience, their perceptions of the housing project community, and their appraisal of its strengths and challenges, particularly compared with other housing, treatment and clinical services they had previously been exposed to. We audio recorded and transcribed focus groups and interviews and removed all names and identifying information to preserve confidentiality.

Qualitative data analysis plan

The goal of the current analysis was to understand alcohol-related themes that emerged in a project-based HF setting. Naturalistic observation data, field notes and transcribed focus groups and interview sessions were managed and coded in Atlas.ti version 6 (Muh, 2009). Qualitative data were independently coded using a constant comparative process consistent with grounded theory methodology (Glaser, 1992; Miles & Huberman, 1994). Initial coding was conducted incident-by-incident using the observational data, whereby coders narrated the actions occurring in staff's and residents' verbal exchanges (Charmaz, 2006). After an initial independent coding phase, we created a codebook in consensus meetings, pooling incident-by-incident codes and removing or collapsing idiosyncratic or redundant codes. After the codebook was established, all observational sessions were re-coded independently, and inter-rater coding consistency (80%) was established using guidelines in the literature (Miles & Huberman, 1994; Shek, Tang, & Han, 2005). The focused coding phase consisted of the most frequently observed initial codes. After data collection was complete, we pooled our memos from the focused coding phase and explored potential thematic codes (Dey, 1999). Residents, programme staff and agency management had various opportunities to review and contribute to the findings. Their feedback served as a means of assessing usefulness, fit and resonance and was integrated into this article.

Results

Themes in the current evaluation reflected the central role that alcohol plays in the lives of formerly chronically homeless individuals with alcohol problems residing in a project-based HF facility. First, we describe motivations underlying residents' alcohol use. Next, we discuss residents' and staff's reactions to the nonabstinence-based, harm reduction approach to alcohol that is implemented within the project-based HF model. Finally, we discuss the effects of the moral model of alcohol use that continues to pervade these individuals' and their communities' understanding of alcohol use.

Reasons for alcohol use

Although reasons for alcohol use were specific to the individual, we noted a few themes that appeared to be universally

acknowledged. We did not have specific prompts in interviews addressing perceived reasons for alcohol use. Instead, we found that this was a topic that both staff and residents grappled with in the course of their day-to-day experiences. For many residents, alcohol use has long been tied to their physical and psychological well-being, as well as their ability to maintain housing, relationships and employment.

Alcohol staves off withdrawal

At the time of their move-in, 90% of residents evinced symptoms that are congruent with alcohol dependence, and 65% reported lifetime experience of delirium tremens (Collins et al., *in press*). Residents' own statements reflected these quantitative findings, as many intimated that their alcohol use is a means of survival. Without daily alcohol use, many of these residents reported experiencing severe withdrawal symptoms that range from uncomfortable:

... and the shaking the shaking. I know what will take the shaking away. And it's like a merry-go-round. You go around and around and around,

to life-threatening,

[Before moving in, I was] sleeping in a park all by myself. I have seizures. I just started having seizures not all that long ago. And having those you know is dangerous because you could die from them. ... I was all alone, and it's like nobody could have seen me. I could have died out there.

Residents and staff acknowledged that residents often referred to alcohol as the "medicine" that staves off alcohol withdrawal and keeps them "well":

You know sometimes you don't drink that much but it's enough to get you well – to stop the shakes. (resident)

... like if one of 'em's sick, alcohol sick, they'll be somebody that'll give 'em a beer or a shot, or whatever, just to get 'em stable. (resident)

If you are sick you will find eight people in this building who will find you a beer or find you a drink and will bring it to you. (staff)

Alcohol provides self-medication for psychiatric symptoms

It was generally acknowledged by staff that alcohol use is a key precipitating factor involved in many residents' social, psychiatric and physical problems. Most staff members, however, indicated that they had not fully understood the practical, and from their perspective, potentially adaptive role that alcohol plays in these residents' lives before they worked in the HF project:

I mean I understood alcoholism as an addiction, but I had no idea that such a large percentage of alcoholics had such profound mental illness. ... I didn't realise that people drank to, you know, stop hearing voices... [There are] different reasons, practical reasons, that people continue to drink.

Whilst acknowledging the helpful, short-term, self-medicating effects of alcohol, one resident noted that the side effects of this self-medication compound over time to create long-term problems.

For some of us alcohol does make us feel better in the immediate short term, it helps us forget the things that are hurting us, but then, after a while, it becomes the problem.

Alcohol contributes to a sense of community

Their alcohol use is often cited as a reason why residents have difficulties maintaining the relationships, housing, and jobs expected in mainstream society. We learned, however, that alcohol dependence and chronic homelessness are two main factors that have brought residents together in a loosely-bound community – both on the streets and, now, in housing. This sense of community was pointed out by one resident, who had since become abstinent from alcohol, but chose to continue living in the project because, "this is my family, all these alcoholics and whatever. That's my family. That's my people."

Residents' social interactions are shaped by the role of alcohol. They often drink together as a social activity and will offer each other alcohol as a way of building trust and community. One resident described his relationship with the man in the neighbouring unit:

He's my next door neighbour, and he's sincere. He just walks in and wakes me up, too. I don't mind that. He gets 2 beers every 2 hours, and he'll give me one.

Some residents reported being less directly engaged in the housing project's social network, yet even they acknowledged the importance of abiding by certain social norms regarding alcohol. For example, if a resident is going through withdrawal, other residents will provide alcohol. At the same time, residents know to not take each other's last beer. One resident noted, "Stay away from people's refrigerators, don't be ripping off anybody's beer, and you'll be alright around here."

There was also an acknowledgement and acceptance of a range of alcohol-related behaviours that would be considered to be outside of the mainstream norm but are considered typical amongst residents. With a sigh reflecting frustration yet empathy, one resident described the fine line he and others in the housing project must walk to manage both their blood alcohol level and their behaviour:

You got somebody up at the front buck-naked. You got somebody running around there ready to fight anybody. You got somebody cussing the staff. They're drunk and they're on medications or maybe they didn't take their medication. Or maybe they ain't drunk enough. That's another issue. If you don't get your booze in you to go to sleep or to settle your nerves, to settle your blood pressure, whatever, you can go haywire.

Where housing first meets harm reduction

Project-based HF removes barriers to attaining housing

This project is one of a few, specialised, low-barrier housing facilities in the United States that targets chronically homeless individuals with alcohol problems whilst eliminating abstinence requirements and allowing alcohol consumption in individual units. This fact is not lost on residents, who were mainly appreciative of the harm-reduction approach in the project: "I love it. I don't have to drink outside and go to gaol."

Residents also nearly universally cited the nonabstinence-based aspect of the programme as a primary motivator for attaining and maintaining their housing. In an interview, a resident inadvertently indicated he had not been able to attain housing before entering this HF programme:

Resident: I like it. . . It's better than drinking outside.

Interviewer: How about compared to other housing programs you may have lived in?

Resident: I don't know any other housing.

Interviewer: This is the only housing you've been in?

Resident: Yeah.

The same resident later noted that he accepted a place in this project “. . . just to be out of the streets. . . They said we don't stop you from drinking. You can drink, smoke, whatever. I said, ‘Yeah, that'll be fine.’” This resident's self-report reflected the fact that most residents we talked to would not have been ready, willing and/or able to attain and maintain housing if it had been abstinence based.

Alcohol-specific harm reduction interventions are compatible with project-based HF

Staff were universally in favour of harm reduction, indicating that it is necessary and perhaps the “only thing that works” for this particular population – even if it did not fit with the initial clinical orientation of all staff members.

I would like to see our residents never drink again. I would like to see abstinence. But. . . that's an unrealistic hope for our population. . . that's an option that will only do more harm than good. . . so you want them to have the liberty to drink, but not hurt themselves or anyone else.

Another staff member noted the importance of harm reduction as a goal in and of itself:

This is a population of folks who don't do anything in moderation. . . The harm reduction techniques we use. . . bring people [to]. . . a more moderate approach. . . You know, eliminate those risks.

Working from a harm reduction perspective means that residents and staff recognise and reward “any positive change” and not just abstinence (Marlatt, 1998). One concrete aspect of this approach that we observed was the staff's implementation of a “managed alcohol programme.” Similar to other models in the literature (Podymow, Turnbull, Coyle, Yetisir, & Wells, 2006), residents could volunteer to have staff hold their alcohol. Alcohol was then redistributed to residents in amounts and at intervals agreed upon in residents' alcohol management plans. Within these plans, staff may withhold distribution if residents are judged to be too impaired. In our naturalistic observations, we noted that residents who participated in the managed alcohol programme had more frequent contact with staff, which provided more points for micro-interventions, including check-ins with residents about their current alcohol use, medication compliance, mental status, and interpersonal situations.

Staff also reported applying harm reduction techniques by encouraging residents to consume alcohol in less harmful ways, such as avoiding nonbeverage alcohol products that can be purchased with food stamps.

[Payee sessions are] always a good opportunity for me to talk to folks about what type of alcohol they're choosing to consume. But um, the Listerine and the cooking wine, [that residents call] “sake,” which is cooking wine, is one of those things that I think

are hard for all of us to watch and to smell. . . so I find myself having those conversations on a regular basis.

Finally, staff were supportive of providing voluntary, alternative, nondrinking activities both in and outside of the housing project (e.g., outings to the store, bingo night, meditation group, book club, community dinners and cook-outs). These activities give residents a time-out from their alcohol use, and residents universally indicated that they enjoy and look forward to these community activities. According to staff, however, the implementation of these programmes is limited in light of the prioritisation of crisis management and the lack of staff-time that can be committed to activity organisation.

Project-based HF supports residents' autonomy over their own harm reduction goals

In response to the harm-reduction approach used in the project, residents reported successfully reducing their drinking or becoming abstinent. It appeared reduction in alcohol use after their move-in was approached pragmatically – in part to maintain housing because they found they had greater self-control when not drinking to intoxication. One resident, who reported being abstinent from alcohol for over a year, indicated,

[Since attaining abstinence], I just mind my own ps and qs, and all I want to do is keep the roof over my head. And so far out of all this time I've kept it. I got a lot of my life changed. And that was the whole process. . . getting' you a little more stable on your feet.

Another resident noted,

. . . you've got to maintain a certain amount of intelligence to be able to stay here and get drunk at the same time. You don't have to get drunk, just enough to go down, lay down, take a good, nice sleep. . . Maintain. That's it.

During a meeting with researchers to provide feedback on these findings, one resident was drinking a soda. He referred to it in passing and mentioned that he was trying to “maintain some sort of sobriety because I gotta go sell my papers.” Since moving into the housing project, the resident had reportedly cut back on pan-handling and had started selling newspapers for a local non-profit organisation. Taken together, these residents' reports reflect the fact that the project-based HF approach has provided space for interests that have intrinsically reinforced both drinking reduction and harm reduction.

On the other hand, the harm-reduction approach employed in project-based HF model can be challenging. One resident who expressed interest in cutting down or stopping drinking said that it was harder to do so in the project. The following quote reveals the complexity of his ambivalence about his own use and the project's harm-reduction approach.

I was on the streets for almost two years before I got in here. And it's been a blessing because I'm not out there – especially now that winter's approaching. . . So I'm grateful and thankful for that, but it's hard to stop [drinking]. I mean it's hard to stop here, you know what I mean? Because. . . [if] I don't have [alcohol], somebody else does. People invite you to come along and all that other kind of things. . . and it's hard.

Most residents, however, reported having a better chance at reducing their drinking once in the HF project. Before some residents moved into the project, they reported being unable to

effectively reduce drinking because they could only receive shelter at the local sobering centre (i.e., sleep-off facility) if they had reached a certain, clinically indicated level of intoxication. Many residents recalled feeling relieved that this was no longer the case:

I heard about this place, man. I was in a sobering centre for a year and a half before finally they said, 'That's it, [resident's name], we've got a place over here for you,' . . . I remember it was great! They said I don't have to get drunk, and I can come over here and go to sleep, and I don't have to be drunk to sleep inside. That's what I liked.

Traditional abstinence-based programming is less aligned with residents' interests and goals

Although some residents were successful in self-regulating their alcohol use once they had attained housing, most residents continued to be reluctant to commit to abstinence-based goals or attend abstinence-based recovery groups, such as Alcoholics Anonymous (AA). During a counselling session we observed, one resident corrected a counsellor who overestimated residents' interest in abstinence-based goals:

Staff: Even though this is not a big group today, those of you who are here have all talked about how you want to try and get sober.

Resident: I don't necessarily want to get sober. I just want to get some money to pay my bills.

During this group, another resident responded to the counsellor's encouragement to try AA with a clear dismissal of the approach.

Staff: Have you ever done AA?

Resident: Oh, yeah.

Staff: Right on. What do you think about AA?

Resident: To be honest, I see them as a bunch of Nazis.

The moral model and marginalisation

Project-based HF residents feel marginalised by the larger community

Some residents reported concerns that living in what local media outlets had termed "bunks for drunks" was perceived negatively by the larger community (Kowal, 2006). One resident reported having difficulties applying for jobs because people made assumptions about him based on his address. He noted potential employers "think this is the wet house where all the drunks live." Another resident said that he used to frequent a nightclub in the neighbourhood and enjoyed meeting new people. At some point, someone at the nightclub found out he lived in the HF project, and he was subsequently "ostracised" from the club. Thus, in some ways, residents reported feeling marginalised in the larger community even after moving into permanent, stable housing. They attributed their marginalisation primarily to others' perceptions of their alcohol use.

Residents continue to struggle with internalised shame

Despite the positive experiences residents reported in housing, it became apparent that a more alcohol-tolerant housing situation is not enough to reframe years of an internalised sense of shame about alcohol dependence and chronic homelessness. Many

residents reported struggling with a sense of "being bad" that has been shaped by being chronically homeless and having alcohol problems in a society still shaped by the medical/moral model of alcohol dependence and recovery.

When asked what it was like to live in the housing project, one resident simply repeated again and again, "I was a bad man, but the staff were patient and helped me change my ways." One resident assured us that he is "not a bad person. I do have friends and I do want to contribute to this community." When interviewing another resident, we asked if there was anything else she wanted to say about what kinds of rules she knew about in the housing project. She volunteered, "I don't have a bad heart. I feel awful." After having answered initial demographic questions, one resident was close to tears, and told us how she struggled with feelings about what it means to be or not be a "bad person":

I'm not a bad person. You know, I feel like I'm not a bad person. I wanna help, you know? I wanna be – I don't feel like a bad person. . . . I'll get out of hand, but I stop myself, you know. . . . I'm trying to turn from. . . this person [to] that person. This person was a bad person, and that person is a good person. So I'm tryin' to. . . [Resident trailed off.]

Discussion

Findings indicated that alcohol plays a central role in the lives of formerly chronically homeless individuals with alcohol problems residing in a project-based HF facility – albeit in different ways than would be predicted by the dominant medical and moral models of alcohol dependence. Although it was acknowledged as a precipitant of negative consequences, alcohol use was also cited as means of staving off acute withdrawal, medicating psychiatric symptoms, and facilitating community-building. Further, the harm-reduction approach employed in this project-based HF setting was cited by both residents and staff as an essential factor in their attaining and maintaining housing. Despite this harm-reduction approach, however, the moral model of alcohol use continues to contribute to residents' ongoing sense of ostracism by the larger community and internalised shame about their own alcohol use.

Reasons for alcohol use

We found that alcohol plays a long-standing, pervasive and multifaceted role in this community. Although staff and residents acknowledged the adverse consequences of residents' drinking, they also acknowledged the utilitarian aspects of alcohol use. These findings highlight the importance of a key tenet of harm reduction in working with this population: people engage in substance use to obtain benefits they find important (Denning, 2000; Harm Reduction Coalition, 2010). Without ignoring the negative consequences of residents' alcohol use, it is important to acknowledge and openly explore their perceptions of *both* the pros and the cons of their behaviours (Denning, 2000; Harm Reduction Coalition, 2010). This recognition is not only evidence-based (Collins, Carey, & Otto, 2009); it can build insights into reasons for alcohol use as well as a more compassionate base from which more tailored and effective interventions may be launched.

Where housing first meets harm reduction

Most residents we spoke with had long histories of alcohol dependence and did not view treatment or abstinence-based housing as viable or desirable options. The nonabstinence-based aspect of the project-based HF model is thus what many residents cited as a primary reason they were able to attain and maintain their

current housing. Some residents also asserted that the project-based HF approach actually facilitated decreases in their drinking. For example, a few residents said they were motivated to drink less to increase their sense of control over maintaining their housing. Other residents noted that having stable housing helped them drink less because they no longer needed to drink to reach elevated blood alcohol levels for temporary shelter at the sobering centre.

These qualitative findings corroborated those from a recent quantitative article involving the same HF project, which indicated that residents significantly reduced their drinking and their experiences of alcohol-related problems over their first two years of residence (Collins et al., *in press*). It is, however, at odds with the medical and moral models of alcohol dependence, which purport that supporting clients' own drinking goals in harm-reduction contexts may "enable" or facilitate the worsening or maintenance of continued, harmful drinking (Jamieson, 2002; Kertesz, Crouch, Milby, Cusimano, & Schumacher, 2009; Milby et al., 2010). In contrast, our findings add to growing evidence that nonabstinence-based HF approaches can also be clinically appropriate for people with more severe levels of alcohol problems (Larimer et al., 2009; Podymow et al., 2006; Tsemberis et al., 2004). Finally, participants in this evaluation were open with their assessment that they would not have been ready, willing or able to enter into abstinence-based housing. Thus, the project-based HF approach seems to provide housing to a different subset of the larger homeless and substance-using population than is usually tapped for housing opportunities (cf. Milby et al., 2010). Namely, it is a more marginalised and vulnerable subset that has not been helped by traditional, abstinence-based approaches in the past.

The moral model and marginalisation

Even after attaining housing and reducing their drinking, some residents still struggled with both externally imposed (i.e., their perceptions of how society views them) and internalized identities as "bad" people. Both external and internal perceptions of chronically homeless people with alcohol problems as being "bad" likely stems from the fusion of the medical and moral models as the dominant belief system regarding alcohol dependence in the past century. Within the medical model, alcohol dependence is characterised as a "chronic, relapsing brain disease" (Leshner, 1997). Once people are diagnosed with this disease, their behaviour is believed to be alternately divorced from their control (medical model) and a matter of rallying their own volition to change (moral model) (May, 2001). At this point, the moral model is fused with the disease model: the disease is so malignant and pervasive that it produces character defects (Alcoholics Anonymous, 1984, 2008). These character defects lead to the inevitable result: alcohol dependent individuals are "bad".

On the other hand, the harm reduction model, which involves neither moral judgement nor pathologising of alcohol problems, is being increasingly introduced to affected communities via HF programmes (Tsemberis et al., 2004). Harm reduction describes a set of compassionate and pragmatic approaches that aim to minimise harm related to alcohol use and maximise quality of life for affected individuals and their communities (Marlatt, 1998). During our observations, we documented staff's often spontaneous use of harm reduction interventions (e.g., managed alcohol programmes, provision of safer drinking tips, nondrinking community activities). Further enhancement of staff's existing training in harm reduction style (i.e., empathetic and nonjudgmental communication) and the introduction of further techniques (e.g., differentiating amongst models of alcohol-use disorder aetiology and treatment; putting harm reduction principles into practice via micro interventions and day-to-day interactions with residents) may be helpful in ensuring a consistent application of this approach. Following

from social learning theory (Maisto, Carey, & Bradizza, 1999), the modelling of the compassionate and pragmatic harm reduction stance may encourage greater acceptance of people "where they're at" amongst both staff and amongst residents themselves. Such enhanced, tailored and intentional training may reinforce the use of harm reduction versus medical and moral model paradigms that may otherwise exacerbate internal and external representations of the "bad alcoholic."

Limitations

The unique setting and population involved in this programme evaluation limit the generalisability of the current findings. This evaluation was carried out in a very specific setting (i.e., a single, project-based HF programme) and its larger social context (i.e., location in a progressive, urban setting in a mid-sized city in the US Pacific northwest). This particular project-based HF facility recruits and intentionally serves a relatively narrow and more severely affected segment of the larger homeless population – chronically homeless individuals with alcohol problems. Accordingly, our findings reflect the fact that alcohol represents a universal and unifying factor that shaped the themes we presented. In reviewing this manuscript, one agency manager pointed out that this population has "lots of negative social behaviours... but they do know how to have a good time with other people. That is the key difference and a protective factor of sorts." Our findings might therefore be less applicable to other segments of the homeless population or in settings serving populations with less uniform alcohol problem severity.

Additionally, the themes in this evaluation may not correspond one-to-one with other applications of the HF approach, such as scattered-site HF. On the one hand, both project-based and scattered-site HF models advocate immediate, permanent, low-barrier, nonabstinence-based supportive housing. Thus, as would be expected, themes in this evaluation coincided with themes noted in scattered-site settings, such as a decreased perception of substance use as a housing barrier and an increased sense of autonomy (Padgett et al., 2008). On the other hand, the project-based HF approach involves individual units in a single housing project, whereas the scattered-site HF model involves individual units scattered throughout a larger community. Although there are no studies to date explicitly comparing key themes in these two models, we would expect these distinct living configurations to differentially affect various factors, including daily social interactions, substance-use patterns, service provision and community-building. Because it is unclear whether project-based and scattered-site housing are associated with differential positive/negative effects, generalisability of the findings and recommendations should be carefully considered in their interpretation and application within other populations, settings and approaches.

Conclusions and future directions

In this evaluation, we documented the role alcohol plays in the lives of chronically homeless individuals with alcohol problems living in a project-based HF setting. Our findings suggest it is important to take into account residents' complex views on their alcohol use, which may include both positive and negative consequences. Further, it appears that a harm reduction approach facilitates housing attainment and maintenance amongst some of the most vulnerable, marginalised and severely affected individuals in the larger homeless community. Residents and staff confirmed other findings in the literature that have indicated that traditional, abstinence-based approaches associated with the moral and

medical models of alcohol dependence and treatment are neither desirable nor effective for this particular population (Padgett et al., 2008, 2010). Finally, we learned that elements of the moral model of alcohol dependence continue to pervade residents' views on their identities as well as the community's perceptions of them. Taken together, these findings have contributed to our understanding of alcohol use in the context of project-based HF and suggest the importance of exploring related symptoms and disorders in future research and programme evaluation (e.g., understanding the roles of other drug use/psychiatric symptoms/medical disorders in the context of project-based HF). The current findings suggest the need to place traditional ideas about alcohol use and approaches aside to better understand, align with, and address this population's needs. In doing so, we might gain further insights into how to enhance the existing project-based HF approach by crafting more finely tailored, alcohol-specific harm reduction interventions.

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Conflict of interest

The author(s) declared no conflicts of interest with respect to the authorship and/or publication of this article.

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