




Have you given a call to San Francisco?

Homelessness and Substance Abuse



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CSAM Review Course



Conflicts of Interest

- There are no personal or family financial conflicts of interest in this presentation

What Can We Explore in Thirty Minutes?

- Epidemiology of Homelessness
- Causes of Homelessness
- Substance Abuse in Various Homeless Populations
- What Does Research Tell Us About Treatment
- Kindness

How Many People Are Homeless

- 7.4% Adults literally homeless at some point in their life
- Up to 11% of urban woman of childbearing age are homeless
- Perhaps 2.5-3.5 million homeless people in U.S.

IOM Clasification of Homelessness

- Temporary Homeless: Displaced by disaster/eviction (e.g. Katrina).
- Episodically Homeless: In and out of homelessness (monthly check lasts less than 30 days, periodically housed with family, "doubled up" some of time)
- Chronically Homeless: More than one year on streets without any period of housing.
- Different needs for these 3 groups

Chronically Homeless

- Varies from 15-57% of homeless population in urban areas
- Average of 30% of urban homeless
- ~75% suffer from mental illness and/or substance abuse problems

Aging of the Homeless Population

- Hahn, et al studied 3,534 homeless adults in San Francisco recruited over a 14 year period
- Median age increased from 37 to 46
- Time spent homeless increased from 12 to 39.5 months
- ER visits, hospitalizations, chronic health problems increased

Hunger

- Comprehensive Data from 408 children of Homeless and Low income mothers
- ~50% homeless, average income \$11,000
- Among school-aged children, 50% experienced moderate child hunger and 16% experienced severe child hunger
- Children with severe child hunger were nearly twice as likely to be homeless

Severe Child Hunger

- Severe Child Hunger was a significant predictor of:
 - Chronic illness
 - Anxiety/depression
 - Internalizing behavior problems

Causes of Homelessness

- Structural Historical Causes
 - Increasing Poverty
 - Decline in Public Benefits
 - Loss of Affordable Housing
- Individual Vulnerabilities
 - Mental Illness
 - Substance Abuse
 - Medical Illness
 - Personal History
- Systematic oppression (gender, race, etc.)

Poverty Increases

- From 1970-1988 people living in poverty increased from 25.4 to 31.9 million (26%)
- In 1995, 36.4 million were in poverty, with children representing 40%.
- Nowhere in the US does a full-time minimum wage job cover the rent for a one bedroom unit at fair market rent!

What About Public Benefits?

- From 1970 to 1994 the average AFDC benefit for a family of three fell 47%
- Prior to its replacement by the “Personal Responsibility and Work Opportunity Reconciliation Act of 1996,” the value of AFDC and food stamps was below the poverty level in every state.

What Happened to Housing?

- 1973-1993: 2.2 million low rent units disappeared, while the number of low income renters increased by 4.7 million
- 1 million SRO units were lost during the 70's and early 80's
- Public sector housing (housing projects/subsidized/Section 8) also decreased while waits increased

Focus on Chronically Homeless

- Current Federal Policy is focused on chronically homeless (> 1 year or multiple episodes over several years)
- They have very high rates of mental illness and substance abuse
- In a medical population of homeless served by a HCH center in SF, >75% have substance dependence problems

"If we are going to make a difference with substance abuse problems, then we have to realize that drug abuse is related to housing is related to health care is related to joblessness is related to poverty. You can't deal with any one of those without dealing with all of them.

Dr. Larry Meredith

The Shifting Focus of Public Health Research

- Meyer and Schwartz: public health research focus has shifted from 1980's to 90's
 - Decreased focus on health problems of homeless (77% to 41%)
 - Increased focus on personal risks for homelessness (15% to 44%)
 - “in practice, despite the conceptual understanding of the role of structural causes of homelessness, homelessness has been studied as if it were a disease, an outcome defined as residing in the individual”

Meyer IH, Schwartz S. "Social issues as public health: promise and peril." American Journal of Public Health. 90(8):1189-1191, 2000.

The Federal Approach to Substance Abuse

- In the 1980's, federal government began to support programs to address alcohol and drug abuse in the individual
- There has been little effective federal effort to address issues of affordable housing and poverty
- These issues were echoed in Thatcher era policies in England with similar results.

Use of Drugs, Alcohol, and Tobacco Among Homeless People

“Despite the programs—ranging from neglect to starvation to incarceration to detox—that have been devised for the public inebriate, the percentage of alcoholics among the homeless has apparently hovered around 30% for nearly a century”

Stark L "A century of alcohol and homelessness: Demographics and stereotypes" Alcohol Health and Research World, Spring 8-13, 1987

Prevalence of Alcohol and Drug use from a national survey of Homeless Assistance Providers and their Clients (Burt et al, 1999)

ALCOHOL, DRUG, AND MENTAL HEALTH (ADM) PROBLEMS AMONG HOMELESS CLIENTS			
	PAST MONTH	PAST YEAR	LIFETIME
Any ADM Problem	66%	74%	86%
Alcohol Problem	38%	46%	67%
Drug Problem	26%	38%	58%
Mental Health Problem	39%	45%	57%

Burt et al. 1999 (Table 2.4)

Quoted in Substance Abuse Treatment: What Works for Homeless People? A Review of the Literature (Suzanne Zenger)

Utilization of Substance Abuse Services by Homeless Adults

- Koegel et al conducted face to face interviews with 1563 homeless adults in LA
- 2/3 met criteria for chronic substance dependence
- Only 1/5 of these people reported receiving treatment for their disorder in the last 60 days
- Systemic issues related to organization and financing of substance abuse treatment were substantial barriers for these patients

Dual Diagnosis

- Substance use plus “severe mental illness” is 10-20% of homeless persons
- Among chronically homeless the percentage is much higher
- These people may have much greater difficulty accessing services (no door is the right door for them)

Treatment: A Quick Tour of What We Know

Barriers to Engagement

- Disaffiliation (social isolation, lack of support system)
- Distrust of authorities/Disenchantment with service providers
- Mobility (geographic instability, scheduling)
- Multiplicity of Needs

Breakey WR. "Treating the homeless." Alcohol Health and Research World. Spring; 42:90, 1987.

Methods of Engagement

- Outreach (minimally, an individual making first contact with the homeless person in his/her own environment)
- Housing/Practical Assistance
- Safe, Non-Threatening Environment (may include a low-demand setting)
- Use Strategies that Increase Motivation
- Peer Leadership

Zayas & Substance Abuse Treatment: What Works for Homeless People? A Review of the Literature, June, 2007.

Coordination of Care?

- Research indicates that effective treatment depends on collaboration between agencies to address complex needs of homeless
- “At the systems level, mental health and substance abuse services are commonly administered by separate governmental agencies that are often in competition of the same dollars.”
- Integrated vs Linked services

Kline J, Harris M, et al. "Contrasting integrated and linkage models of treatment for homeless, dually diagnosed adults." New Directions for Mental Health Services, 2005, 106, 199.

What Kind of Treatment do Homeless People Receive?

Table 8.3 excerpt

	AMONG CURRENTLY HOMELESS WITH ANY ALCOHOL PROBLEMS	AMONG CURRENTLY HOMELESS WITH ANY DRUG PROBLEMS
EVER RECEIVED ANY ALCOHOL OR DRUG TREATMENT	43%	42%
Inpatient treatment	36%	36%
Hospital detoxification	55%	40%
Other detoxification	20%	30%
Outpatient treatment	20%	27%
Alcoholics Anonymous	65%	39%
Narcotics Anonymous	40%	33%
Individual counseling	30%	30%
Outpatient detoxification	30%	30%

Burt et al. 1999

Smoking Cessation in a Homeless Population

- Connor et al studied 236 homeless adults
- 2/3 were current smokers (70% is typical)
- 37% ready to quit
- Self-efficacy to quit increased with availability of assistance
- Nicotine replacement was most requested form of assistance

Homelessness and Smoking Cessation: Insights from Focus Groups

- Okuyemi et al led six 90 minute focus groups
- 76% planned to quit within 6 months
- Barriers identified: pervasiveness of smoking in homeless settings, difficulty quitting, boredom, stress
- Many wanted pharmacotherapy with behavioral treatments.

Women Only Treatment Programs

- Unanimous conclusion that women-specific programs have better outcomes
- Women have different experiences in engagement to treatment, different routes to homelessness, and different treatment needs
- Homeless mothers need childcare in order to access substance abuse treatment
- Reunification of mothers with children leads to positive outcomes for women

Analysis of Drug Treatment in LA by Program Gender Composition

- Grella studied 4117 women in LA county between 1987 and 1994
- Women in Women-only programs had more problems at program outset, but compared to women in mixed gender programs:
 - They spent more time in treatment
 - Twice as likely to complete

Grella CE. "Women in residential drug treatment: differences by program type and pregnancy." *Journal of Health Care for the Poor and Underserved*. 10(2): 216-29, 1999.

African-American Women who use Crack Cocaine: A Comparison of Mothers who Live With and Have Been Separated From Their Children (Lam, 2004)

- Compared out of treatment care-giver mothers (living with at least one of children) to non-Caregivers
- Non-Caregivers reported higher frequencies of drug use, risky sex practices, and victimization

Logistic Regression Analysis

- Non Care-giver mothers more likely:
 - To have been physically abused as children
 - To trade sex
 - To be homeless
 - To be uninsured

Treatment Modalities that Probably Work for Homeless

- Modified Therapeutic Community for Homeless Individuals (most effective for mentally ill)
- Multi-faceted Day Treatment
- Housing First
- Abstinence Contingent Housing/Work
- Case Management (definitely can decrease hospital/ER visits)

Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals with a Dual Diagnosis (Tsemberis, 2004)

- 225 participants randomized to housing contingent on treatment/sobriety or immediate housing without prerequisites
- Immediate Housing group obtained housing earlier and remained stably housed at a higher rate
- Contingent group had higher rates of substance abuse treatment, but there were no differences in substance use or psychiatric symptoms

Things That Might Work

- Contingency Management
- Hospital-based inpatient services
- Payees
- Brief Intervention (some experts are dubious of long-term benefit)

Short-term Effects of a Brief Motivational Intervention to Reduce Alcohol and Drug Risk Among Homeless Adolescents (Peterson, 2006)

- 285 Homeless adolescents recruited from drop-in centers and street intercept
- Random assignment to 1 session MI style session or control
- MI group reported less illicit drug use than control at 1 and 3 month follow up

Improving Outcomes in Outpatient Treatment (NIH)

- Linkage with shelters and public housing
- Help with food, medical, social services
- Quality case management
- Long-term rehabilitation (job skills, literacy)
- Innovative Strategies to Engage Chronically Homeless

NIH. "Intensive outpatient treatment for alcohol and other drug abuse." Treatment Improvement Protocol Series 8, 2001.

Summary Points

- Homelessness is a complex and varied phenomenon
- Structural causes of homelessness including poverty and lack of affordable housing have dramatically worsened in the last few decades, largely due to political and social policy changes
- Chronically homeless patients will need flexible, longer term and more comprehensive interventions

Summary Points

- Dropout rates from treatment are high for homeless people and there are many barriers to engaging in treatment
- In most cases, choice of treatment modality does not appear to differentially affect outcome
- Treatment programs must focus not only on addiction but on the everyday needs of homeless people (housing, income, employment)
