

**PROVIDING TREATMENT FOR HOMELESS PEOPLE
WITH SUBSTANCE USE DISORDERS**

CASE STUDIES OF SIX PROGRAMS

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EXECUTIVE SUMMARY

Clinicians who work with homeless people with substance related disorders are aware of the critical need to provide appropriate, accessible, and effective treatment for individuals and families in their care. Unfortunately, much of the scientific research about treatment for substance use disorders does not sufficiently inform the distinctive characteristics of treatment required for people experiencing homelessness, many of whom have multiple, complex needs and often encounter significant barriers in receiving the services they need.

In April 2001, the Translating Research Into Practice (TRIP) Subcommittee¹, a group of clinicians from Health Care for the Homeless (HCH) programs and researchers working in the field of homelessness and health care across the United States, decided to examine what comprises effective treatment for the people they serve. This resulted in the publication in June 2002 of a literature review “Substance Abuse Treatment: What Works for Homeless People?” by National HCH Council staff member Suzanne Zerger.² The Subcommittee found that the literature, though valuable in many ways, did not sufficiently address what they considered to be most relevant to HCH practice, such as the importance of access to housing and providing comprehensive, well-integrated, client-centered services with uniquely-qualified staff.

Consequently, the Subcommittee decided to gather information from programs recognized for providing effective substance abuse treatment for homeless people. From among the more than twenty programs nominated by administrators and clinicians in the field, six programs were chosen based on criteria developed by the Subcommittee. Selection was not restricted to HCH grantees, though each of the programs was expected to be integrating treatment for substance use disorders with primary health care. The authors spent approximately two days at each of the six selected programs to collect information about what seems to work well in practice, and for whom, according to those currently working in the field.

Programs consistently emphasized that a homeless person’s substance-related issues cannot be treated apart from addressing the needs of the whole person in the context of his or her environment. Common examples include assistance with accessing food, clothing, shelter/housing, identification papers, financial assistance and entitlements, legal aid, medical and dental care, psychiatric care, counseling, job training, and employment services. Thus, a continuum of comprehensive services is needed to address people’s various safety, health, social and material needs. Many treatment programs provide a scope of services within the program itself, within the larger umbrella organization of which they may be a part, and through linkages with existing services in the community.

The programs studied here uniformly recognize that stable housing is central to attaining treatment goals, and that an inadequate supply of affordable housing is one of the most significant gaps in the substance abuse treatment system. Some make the claim that “housing is treatment!” Most of these programs emphasize the importance of helping clients secure housing as early as possible in the treatment process.

At the service delivery level, programs emphasize the importance of providing integrated care through interdisciplinary teams typically made up of medical, mental health, substance use, and social service providers. Not only are providers co-located but they also work collaboratively; each team member has some level of involvement and investment in all aspects of the homeless person’s care. Services tend to be offered concurrently rather than sequentially or in a parallel manner.

All of the programs identified client-centered care as a hallmark characteristic of effective treatment for substance related disorders for homeless people. Some programs practice client-centered care in the context of

¹ The TRIP Subcommittee is part of the National HCH Council and HCH Clinicians’ Network Research Committee. See Acknowledgments for a list of Subcommittee members.

² This literature review is available online at www.nhchc.org/Publications/SubstanceAbuseTreatmentLitReview.pdf

requiring clients to be abstinent from substance use to participate in the program. Other programs focus on helping individuals meet whatever goals they have, regardless of their desire to be abstinent. These latter programs tend to rely on a harm reduction approach. Nearly all of the clinicians interviewed were enthusiastic about and regularly used motivational interviewing/motivational enhancement techniques in their interactions with clients. They viewed this approach as far more effective than the use of confrontational methods.

The published research on substance abuse treatment for homeless people omits or minimizes the influence of staff characteristics as they relate to client success. Nonetheless, all of the individuals interviewed stated clearly that, in addition to the importance of education, training and experience, the relationship between the staff and the client is absolutely critical to treatment success. Interviewees identified the following characteristics as particularly important for effective staff: compassionate and empathetic, “well-grounded,” able to deal calmly and rationally with difficult circumstances, works well in a team, has a sense of humor, and has patience. The programs consistently make an extra effort to attract and retain valued staff. Teams are provided with needed administrative support and resources and tend to be given a significant degree of autonomy. Staff frequently expressed the importance of working collaboratively with other team members and appreciating the freedom to exercise creativity in planning and problem-solving. While staff value the communication and socialization that results from working in teams, they also acknowledge the ongoing challenge of balancing time spent together as a team and time for providing direct client care.

While the six programs selected have much in common, it appears there is considerable latitude in the forms that treatment takes. Below is a sampling of some of the unique strategies and innovations of the programs interviewed that are discussed in this report:

- Conflicting treatment philosophies within the same program
- Various social detoxification models
- A “housing early” approach
- Use of acupuncture and Chinese herbal medicines
- Recovery Mentor Program
- Modified Therapeutic Community approach
- Recovery Reading Circle
- Involvement of community volunteers and interns in care
- Culturally appropriate services
- Integration of data collection with service provision
- Home-based services
- Trauma-sensitive services

Treatment for homeless people with substance related disorders needs to be appropriate, accessible and effective. Based on the experience of the six programs profiled here, these expectations are best met by prioritizing access to appropriate housing and providing comprehensive, well-integrated, client-centered services with uniquely-qualified staff.

TABLE OF CONTENTS

ACKNOWLEDGMENTS	1
INTRODUCTION: BACKGROUND AND METHODS	4
PART I: COMMON THEMES	
Comprehensive Services	6
Integrated Services	6
Client-centered Approach	7
Uniquely Qualified Staff	8
Access to Housing	9
PART II: CASE STUDIES:	
<i>Diverse Treatment Approaches</i>	
Albuquerque Health Care for the Homeless, Inc. Albuquerque, New Mexico	11
<i>Co-occurring Serious Mental Illness</i>	
Pathways Home - Chicago Health Outreach Chicago, Illinois	17
<i>Alternative Treatment Services</i>	
Portland Alternative Health Center Portland, Oregon	21
<i>Crisis Center</i>	
Chemical Dependency Crisis Center - Bowery Residents' Committee New York, New York	25
<i>Homeless Youth</i>	
Larkin Street Youth Services San Francisco, California	29
<i>Homeless Families</i>	
Worcester Homeless Families Program Worcester, Massachusetts	33
APPENDICES	
A: Invitation for Case Study Program Nominations	
B. Topics of Inquiry and Questions	

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Members of the Translating Research into Practice (TRIP) Subcommittee, listed below, contributed greatly to the formulation of this study. This group of HCH clinicians and administrators provided critical input into: the design of this study; the selection of the six model programs; the framework and questions for the case studies; and, the content of this monograph.

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**Dr. East is no longer a member of TRIP, but he was actively involved in the Subcommittee throughout the development of this project.*

Interviewees

The following individuals from the six programs took valuable time from their busy schedules to share information with the authors about their programs and their individual roles within them. Persons with an asterisk (*) beside their names additionally assisted in the logistics of the case studies, including travel and lodging arrangements (when necessary) and organization of staff interviews.

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Director

Randy Sorvisto
Addictions Recovery Mentor

Jill Kahnert
Addictions Recovery Mentor

Bruce Mineau
Addictions Recovery Mentor

Note: This site visit also included observation of an interview with four PAHC patients by a local newspaper reporter for a story related to looming budget cuts in State of Oregon expected to affect patients' treatment.

Bowery Residents' Program (New York City, NY)

Ronald Williams, MHS*
Program Director

Nick Miele, CASAC
Clinical Supervisor

Laurel Molloy, MS
Director of Performance Measures and Evaluation

Russell C. Gross
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Larkin Street Youth Services (San Francisco, CA)

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INTRODUCTION: BACKGROUND AND METHODS

Clinicians working with homeless individuals who have substance use disorders understand the critical need – and dire lack of – appropriate, accessible, and effective treatment for those in their care. And, much of the scientific research on what effective treatment for substance related disorders looks like is not directly applicable to persons without homes. The National Health Care for the Homeless Council convened interested clinicians and researchers as members of the “Translating Research Into Practice” (TRIP) Subcommittee to discuss this situation. First, they explored the published scientific research in a literature review prepared for the Subcommittee by staff member Suzanne Zerger entitled “Substance Abuse Treatment: What Works for Homeless People?”¹ They found that the research did not sufficiently inform what they considered to be most relevant in their work with homeless clients, such as the importance of providing well-integrated, client-centered services with uniquely-qualified staff. In response to these gaps, the group then decided to glean knowledge from those providing “model” treatment to homeless people with substance related disorders, to share with others what seems to work well in practice, and for whom, according to those currently working in the field. This report summarizes the results of these efforts.

Selection of Programs for Case Studies

In September 2002, the TRIP Subcommittee sent an invitation to federal Health Care for the Homeless grantees,² HCH Clinicians’ Network members³, and others on the National HCH Council e-mail distribution list, to submit nominations for “model” treatment programs to be involved in this case study project (see Appendix A for a copy of this invitation). They also solicited nominations from non-HCH sources, such as recipients of federal grants for substance abuse treatment with homeless persons. The numerous nominations sent in represented a diverse grouping of outstanding programs from across the country. The Subcommittee developed specific criteria to select a final group that would be diverse in terms of geographic region, urban vs. rural areas, treatment modality and philosophy of care, and client focus (e.g. adult, family, adolescents; ethnic and racial groups). The Subcommittee also wanted to ensure that all of the programs were integrating substance abuse services with primary health care, and that the selection would not be restricted to HCH grantees only. After collecting additional information from the nominees, and identifying programs to fill gaps, the Subcommittee ultimately decided to invite the following six programs. Directors from all of these programs agreed to participate in this project, volunteering to provide program documentation and access to staff for interviews, though no incentives were offered.

Diverse Treatment Approaches

- Albuquerque HCH, Inc., Albuquerque NM

Co-occurring Serious Mental Illness

- Pathways Home - Chicago Health Outreach, Chicago IL

Alternative Treatment Service

- Portland Alternative Health Center, Portland OR

Crisis Center

- Chemical Dependency Crisis Center – Bowery Residents’ Program, New York NY

Homeless Youth

- Larkin Street Youth Services, San Francisco CA

Homeless Families

- Worcester Homeless Families Program, Worcester MA

¹ A copy of the literature review on substance abuse treatment for homeless persons can be found at www.nhchc.org/Publications/SubstanceAbuseTreatmentLitReview.pdf

² See a description of the federal HCH program at www.bphc.hrsa.gov/Hchirc/

³ For information about the HCH Clinicians’ Network, go to www.nhchc.org/Network/aboutnetwork.htm

Data Collection

Although this project is primarily an exploratory one, Subcommittee members developed a framework to guide the data collection process; they devised topics to focus the inquiry as well as specific questions. The primary areas of inquiry included: treatment model, program services and resources, engagement and retention strategies, definitions of success and effectiveness, and the use of research. (The detailed framework can be found in Appendix B of this report.)

To carry out the data collection, a staff member from the National HCH Council spent approximately two days visiting each program, conducting interviews and collecting relevant program information. Ken Kraybill, Clinician Specialist, completed four case studies and Suzanne Zerger, Research Specialist, completed two case studies. They worked collaboratively with each other, the Subcommittee members, and representatives from the six programs to draft this monograph.

This Report

This report is divided into two main sections. Part I provides an overview of some overarching themes which recurred throughout these interviews - the importance of comprehensive, integrated, client-centered services, of certain staff attributes, and of housing availability – and how they contribute to program effectiveness. Part II presents basic descriptive information about each of the programs studied, and a narrative summarizing those strategies deemed to be most helpful to providers working with homeless clients with substance use disorders. This narrative emphasizes: programmatic innovations, especially those which may be replicable; strategies which staff believe make the program effective; lessons learned; and/or specific aspects of the program which challenge or affirm the published research findings.

Various terms are used interchangeably in this paper – *substance use disorder*, *substance abuse*, *substance dependence*, and *addiction*. They are not used here in a technical sense, such as for the purpose of differential diagnosis, but as they tend to be used in common discourse. It is anticipated that the meaning for the reader will be evident from the context.

PART I: COMMON THEMES

Based on the published literature and the knowledge gathered from the six programs profiled in this report, effective treatment for homeless people with substance use disorders appears to be fundamentally related to providing comprehensive, highly-integrated, and client-centered services. In addition, certain staff characteristics are believed to play a critical role in contributing to client success. And, the centrality of stable housing to success in treatment was repeatedly noted. Below we discuss these overarching themes that emerged in interviews with the six programs.

Comprehensive Services

Particularly for people experiencing homelessness, substance use disorders cannot be treated apart from the concerns of the whole person in the context of their environment. A rich blend of services is required to address people's breadth of needs. Many of the programs described here had very modest beginnings, often responding to homeless people's basic food, shelter, and survival service needs. For example, Larkin Street Youth Services in San Francisco began as a simple drop-in site for homeless youth in 1984. Over time, in recognition of the scope of client need and significant service gaps in the mainstream system, Larkin Street, and programs like it, developed a comprehensive array of services internally and worked to establish strong external links with relevant services in the community.

All of the substance abuse treatment programs described here, perhaps not coincidentally, operate under umbrella organizations that administer multiple programs in a coordinated manner, thus creating in-house continua of comprehensive services. For example:

- In Portland, Oregon, the Portland Alternative Health Center operates under Central City Concern (CCC) which provides a range of substance use treatment, health care, and employment services, business enterprises, and housing. Central City Concern is the largest employer of formerly homeless people in Portland. CCC also owns or manages over 2,000 units of low-income housing, about 800 of which are specifically alcohol and drug free communities.
- In New York, the Chemical Dependency Crisis Center operates under the umbrella of the Bowery Residents' Committee (BRC). The BRC provides services to over 4,000 homeless or low-income people annually through a continuum of programs including addiction treatment programs, education and employment, HIV/AIDS programs, housing, mental health programs, and senior services.

In addition to intra-agency working relationships, these programs have developed formal and informal linkages with external organizations such as shelters, clinics, state welfare agencies, legal aid, hospitals, and jails. Typically, programs establish memoranda of understanding/agreement with various agencies for such purposes as clarifying referral procedures, identifying services that might be prioritized for use by the referring program, establishing protocols for staff sited in another agency, and spelling out problem resolution procedures.

Moreover, all of the programs report having numerous informal working relationships with other social service organizations that share a common mission to serve homeless and low-income people. The effectiveness of these informal relationships is often sustained primarily through personal contacts at the direct service level.

Integrated Services

Historically, substance use treatment services for homeless people have been offered either in a sequential or a parallel manner. In a sequential approach, the client is treated for one problem first followed by another, often by different systems of care. For example, it has not been uncommon for clients to be told they must receive treatment for their substance use disorder before they can be treated for their mental illness (and vice versa). The requirement for homeless people to go through substance use treatment in order to be "housing ready" is another example of providing services sequentially.

In a parallel approach, the client receives services from two or more systems simultaneously, such as receiving medical care at one site, mental health services at another, and treatment for substance-related problems from yet another agency. The effectiveness with which these services are coordinated varies; when coordination is poor clients may receive confusing or even conflicting messages, or fail to have important issues addressed.

To address the needs of homeless people, who often have co-occurring conditions, evidence from the field suggests that an integrated approach to treatment is the most beneficial for the client, wherein treatment for multiple concerns is provided concurrently in a well-coordinated manner. The degree to which these programs provide integrated treatment services varies, but all of them co-locate services to the extent possible and provide care through an interdisciplinary team approach.

These six model programs share some characteristics in regard to providing integrated care, including:

- Services are provided through interdisciplinary teams that address patients' physical health, mental health, substance use, and social service needs concurrently.
- Housing is viewed as integral to effective treatment and consequently is given high priority early in the treatment process.
- Services are physically co-located to the extent possible.
- Individual team members understand and appreciate the perspectives brought by other disciplines and are involved in various levels of cross-training.
- Open and regular communication is valued; differences in opinion are encouraged.
- Traditional hierarchical relationships among disciplines are diminished.

Client-centered Approach

All of the programs in this report endorse client-centered care regardless of the treatment setting, characteristics of the client population, or the program goals. Client-centered care, in general, refers to customized individual treatment that is based on the client's needs, wishes, capacities, and timeframe rather than on the program's pre-determined benchmarks for client outcomes. Among the programs interviewed, some are client-centered to the extent that they impose no program-defined goals on clients. Other programs require clients to adhere to certain program goals, such as abstinence for example, as a condition to remain in treatment. Even so, these programs strongly endorse client-centered care as it applies to tailoring treatment around clients' various needs and wishes.

Client-centered care, referred to colloquially by staff as "meeting the person where they're at," focuses on working collaboratively with the client. The client is actively involved in setting goals and planning his or her own treatment program. The power differential between provider and client is minimized. The primary role of the provider is to listen carefully, help the client to identify achievable goals, and facilitate incremental steps that the client wants and is ready to take. Program staff consistently describe the importance of showing respect for the individual and valuing the client's own experience and expertise. The client is regarded as the expert on the client.

Staff frequently noted the critical need to exercise acceptance and empathy in working with homeless clients. Several cited the work of the psychologist Carl Rogers¹ as providing the basis for employing a client-centered approach. Rogers believed that treating clients with empathy and "unconditional positive regard" is necessary for any therapeutic progress to take place. This approach stands in contrast to heavily confrontational approaches that do not appear to be effective in treating homeless people with substance use disorders. Rogers emphasized the importance of seeking to understand the client and promoting the client's self-understanding through the use of reflective listening. As a result, the client in essence becomes self-confronting about his or her own situation. It is not surprising that many of these six programs embrace motivational interviewing

¹ Rogers, Carl. "Significant Aspects of Client-Centered Therapy." First published in *American Psychologist*, 1946.

theory and techniques such as those described by Miller and Rollnick¹, authors whose work draws heavily on Rogerian principles. Motivational interviewing uses reflective listening as a primary skill to understand clients, their readiness to change, and to create within them motivation to take a next step.

Harm reduction theory and approaches² fit naturally within the construct of client-centered care as well. Harm reduction encourages clients who do not wish to become abstinent to take actions to reduce the risk or harm of their substance use (or other behaviors), such as reducing the amount or frequency of use. Any positive change is seen as valuable. In some programs, such as Pathways Home and parts of the Albuquerque HCH treatment program, harm reduction is the guiding principle of addictions treatment. Other programs use harm reduction in more limited ways. Even in abstinence-based programs, providers acknowledge that harm reduction approaches are useful in certain circumstances and can be instrumental in leading a person towards abstinence.

Uniquely Qualified Staff

The published research on substance abuse treatment for homeless individuals does not emphasize the importance of staff characteristics in contributing to client success, yet many HCH providers have said these are critical. We tested this perception by asking staff from these six programs to what extent they thought practitioners' personal manner and interaction style influence client engagement, retention, and/or "success" in treatment. All of the individuals interviewed were adamant that the relationship between the staff and the client is critical to treatment success, however one defines success. This is not to say that education, training, and experience are not also important; however, building a relationship is unanimously considered the first and most important step. They therefore strongly advocated hiring a diverse staff to maximize the likelihood of achieving rapport with diverse clientele (comments include: "[Our] agency strives to have balance – to have staff who reflect the clientele" and "Diversity of staff is critical.>").

Following are typical comments about the role of staff:

"It's everything! We emphasize to staff that everything is about rapport. This includes all staff including the psychiatrist, nurses, case managers, coordinators, receptionists, etc. Your personal manner and relating style is absolutely crucial."

"It's what builds trust. If [clients] have reasonable trust in you, you have a shoe in the door."

"People need to be treated with respect, dignity, and feel cared about. It's essential."

"Relationships are key, because you can't affect change without relationship."

"Hiring is focused more on personality traits than on level of education."

"Building the relationship and trust is the biggest thing."

We then asked our interviewees to identify those personal characteristics which seem to predict whether a staff person will be effective at trust and relationship-building. Though they discussed a variety of traits, compassion and empathy were most frequently mentioned:

"I ask myself if I were a homeless youth, 'how might I feel interacting with this person.'"

¹ See Miller WR and Rollnick S. 2002. Motivational Interviewing: Preparing People for Change (2nd edition). Guilford Press.

² Go to www.harmreduction.org for more information and a bibliography.

“A lot of what you lack in education and experience can be made up by empathy and compassion, which is the most important thing.”

“Non-judgmental about others’ behaviors.”

“A lot of it is listening.”

“[Staff should] be able to attend to clients’ conversations, to be present with the client.”

“Staff have to be the ‘keepers of hope’ when clients become discouraged or suffer setbacks.”

Several also mentioned being “well-grounded” or able to deal rationally and calmly in unpredictable and difficult situations. For example,

“Experience working in crisis situations is helpful, not leaping to judgment.”

“...genuine, grounded, passionate and interested in working with this population.”

“[Needs] inner strength.”

“Can tolerate ambiguity and ambivalence.”

“Able to tolerate very slow ‘progress’ or change.”

“Really good boundaries, well-grounded personally, not trying to ‘rescue’ others.”

Related to these characteristics were mentions of the ability to work well in a team (“*People who can leave egos at the door and work as a team.*” and “*team player*”) and to have a sense of humor, patience, and flexibility.

Interviewees also discussed various techniques they use to “test” for these characteristics during the hiring process, including observing the potential staff person with clients (“*do a ‘shadow shift’ after interviews to observe and ensure it’s a good match*”) and asking them to explain how they would respond to specific scenarios (“*we use vignettes in hiring interviews, asking ‘what would you do in this situation?’*” and “[*We*] *give worst case scenarios to see if the person can deal with them*”). In some cases, program staff have significant input into the hiring process: “*At a lot of places, just the supervisor has a say in who gets hired. We decide as a team who we want to work with.*”

Not surprisingly, finding staff who are a “good fit” can be immensely difficult, made more-so by the strenuous nature of the work and salary levels which are not always competitive. These programs therefore work hard to retain good staff. One common method for doing this is providing strong team support. All of these programs have solid staff teams who support each other (“*I like the team approach – I can go over to other staff people to vent. I try to get it out here.*”). And, they try to provide ample opportunities for teams to meet with each other and collaborate on client care. While staff all acknowledge that the communication and socialization afforded by these meetings is extremely valuable (“*There are a lot of meetings. But, you need to know about all of the families, not just the ones on your caseload, in case you’re called in a pinch.*”), it is also an ongoing challenge to balance the value of the time together as a team with the time it takes away from direct care.

Access to Housing

These six programs uniformly assert that stable housing is nearly always central to attaining treatment goals, and that an adequate supply of affordable housing is one of the most significant gaps in the substance abuse treatment system. Homelessness subjects people to multiple health and safety risks and creates a great deal of

stress related to meeting basic survival needs from day to day. Having appropriate housing provides individuals with a greater sense of safety and stability, enabling them to meet their basic needs and have increased control over their lives and their environment. These programs consistently report that individuals living in appropriate housing are more likely to be successful in treatment.

All of the substance abuse treatment programs in this study make access to a stable living situation a priority early in the treatment process. They regard housing as treatment. Commonly, clients move initially into some kind of transitional housing situation and later on seek permanent housing. Both transitional and permanent housing (including supported housing) are accessible through a larger umbrella organization of which the program is a part.

PART II. CASE STUDIES

Diverse Treatment Approaches

ALBUQUERQUE HEALTH CARE FOR THE HOMELESS, INC.

1217 1st Street NW

Albuquerque, New Mexico 87102

Telephone: (505) 766-5197

Program Description:

Mission:

- *To provide caring and comprehensive health and supportive services, linking people experiencing homelessness to individual and collective solutions, and*
- *To be a leader in creating service delivery models and solutions to homelessness.*

In addition to providing comprehensive primary medical and dental care, children's outreach and a community-based art studio space (ArtStreet), the Albuquerque HCH offers a variety of options to those homeless individuals with substance abuse problems and/or who are interested in recovering from substance use disorders. Working collaboratively with the client, qualified staff assist in engaging the client in the option most likely to serve their needs, philosophies, interests. These options include:

Harm Reduction Outreach Program: In 1997, the Harm Reduction Act was signed into law in New Mexico, legalizing syringe exchange (providing sterile syringes and harm reduction materials and education) to help prevent HIV infection in the state. When the already well-established HCH Harm Reduction Outreach Program augmented its services by providing syringe exchange in early 1998, it quickly became the largest syringe exchange program in New Mexico. Currently, syringe exchange comprises approximately one-quarter of the work of the Harm Reduction Outreach Program. Staff estimate approximately 80 percent of their syringe exchange participants were unknown to them prior to providing this service.

Tierra Del Sol -Women's Residential Recovery Program: This program, established with a harm reduction philosophy, recently opened to fill a serious gap in Albuquerque's substance abuse treatment bed capacity for women, especially for women with children. Women and their children can stay in the community-based, non-institutional housing setting for 6-9 months. The majority of the women expected to be served by this program are Latina/Hispanic, African American, and Native American. Tierra Del Sol serves many clients with co-occurring disorders, and services include psychiatric assessment and medication management with a psychiatric nurse practitioner. Some of the women are on psychotropic medication; methadone maintenance is also acceptable in this program. The site includes housing units for 12-15 women and 3-6 children, group activity/common space, and staff offices. On-site services include individual treatment planning/assessment and therapy as well as group counseling on: recovery/relapse prevention, violence issues across the trauma spectrum, anger management/assertiveness training, coping skills/building resilience, and relationships. In addition, psychiatric services, smoking cessation, legal services, case management, and transportation are provided.

LaPuerta/Mental Health: This program is for persons experiencing homelessness who have been diagnosed with chronic mental illness or co-occurring disorders and require extensive support. The goal of the program is to help these individuals develop the capacity to live as independently as possible. Intensive case management is key to the program; each case manager serves approximately 14 clients. Case managers help clients obtain benefits, access housing, and develop daily living skills; they also provide crisis management, symptom stabilization, medication adherence/management, and individual support.

Stepping Stones Program: Stepping Stones serves homeless persons at all stages of change in their recovery from substance use addictions and/or co-occurring conditions. Part of the program includes drop-in, which

offers a safe, nonviolent, respectful environment for these persons, who are not likely to engage in services elsewhere. Some of the services provided during drop-in include: coffee, food, psycho-social groups, crisis counseling, entertainment (weekly movies), referrals, and other recovery support. The Stepping Stones Program also offers recovery programming that includes assessment, referral, therapeutic groups, out-patient counseling, intensive case management, and supportive housing.

Casa Los Arboles – Modified Social Model Recovery Program: This 6-9 month 12-bed residential recovery program for homeless men has been operating since 1992. This program is based on a modified social model: residents play a large part in the recovery program decisions, operation of the residence, and eventual transition from volunteer to paid work (which offsets their room and board expenses). Current staff at Casa Los Arboles are themselves recovering addicts. When admitted to Casa Los Arboles, new residents to the program are assigned a case manager and begin the first of three Phases, which are progressively less structured. The goal of the first “Orientation” phase (45-days) is that the resident begins to express a willingness to change within the environment (they cannot leave the premises alone during this phase). In the second “Skills Phase” (45-days or longer), residents have fewer required groups to attend, may come and go from the site unescorted, and are expected to complete a minimum of eight hours of volunteer work each week. In the final “Transition” phase, residents are expected to work and/or go to school; thus, they have fewer required groups and volunteer work hours, more flexibility around visitation rules, and increased free time. Readiness to graduate out of each Phase is determined collaboratively with the resident, his case manager, and the other residents in the program.

Villa de Paz- Transitional Housing Program: Villa de Paz is a 23-unit sober transitional housing program for homeless men and/or women who have a minimum of four months of recovery prior to residency. Residents can live in the Villa de Paz apartment complex for up to 18 months while they work, attend school, and/or try to access permanent housing. The program has been operated by Albuquerque HCH since November 1992. Residents are required to participate in programming, which includes individual counseling, case management, relapse prevention groups, and community meetings.

These Albuquerque HCH programs are primarily funded from a conglomeration of diverse federal, state, and city sources. For example, SAMHSA/CSAT fully funds Tierra del Sol, while the City of Albuquerque funds the vast majority of CLA and VDP program expenses. Roughly ten percent of program funding comes from private sources, including locally-based Foundations and fundraising efforts.

Program Narrative: Strategies and Innovations

Opportunities for Engagement

A client can enter substance abuse treatment at Albuquerque HCH through numerous avenues— receiving health care, clean socks or syringes during one of the numerous outreach visits, showing up at a drop-in center, creating art at the open-door community art studio, having a medical or dental appointment with an HCH provider, or being referred from numerous community agencies. That is, Albuquerque HCH employs nearly all of the multiple strategies shown to be effective in engaging homeless individuals into treatment: outreach, offering housing/practical assistance, providing a safe, non-threatening environment, strategies that increase motivation (psycho-social groups are part of the Stepping Stones Program), peer leadership/involvement (former clients help at outreach, drop-in and some of the recovery programs), and family-based treatment engagement strategies (children’s outreach and ArtStreet). Interviews with staff indicate that these same strategies are effective in retaining clients over the long-term because they help build self-esteem and trusting relationships.

Syringe Exchange

The research on syringe exchange has consistently shown that it does not increase crime or drug use, and is effective in preventing the transmission of blood-borne diseases. Data collected in New Mexico indicate its experience with syringe exchange (legalized in 1997) is no exception. New Mexico, like many states, has very limited inpatient treatment options and a large population of individuals without health insurance. A newspaper article from 1999 (*Albuquerque Tribune*, July 27, 1999) cited New Mexico Department of

Epidemiology data which showed 40 percent of those registered for syringe exchange would opt for detoxification and/or treatment if it were made available to them. According to the CDC, preventing HIV viral transmission to just one injecting drug user saves New Mexico taxpayers \$154, 402 in lifetime treatment costs. Between 85-90% of injecting drug users are hepatitis C positive, 65% hepatitis B positive, and less than 1% are HIV positive – and Albuquerque’s estimated drug-injecting population was as high as 6,600 in 1999. Anecdotal evidence from Albuquerque HCH Harm Reduction Outreach Program staff strongly supports the success of this Program in gaining access to homeless persons they may not otherwise have reached (as noted above, they estimated 80% of their syringe exchange had been unknown to them), but also in building trust and saving lives.

One-Stop Shopping

All of the staff interviewed indicated that their recent move to a new single site facility offering the core programming, has been very beneficial in helping to serve clients effectively and efficiently. Though they previously were located in buildings nearby – just a few blocks away - the communication between/among staff has greatly improved since co-locating. Typical comments of veteran staff included: *“The physical location and proximity has made a big difference.”* and *“How we do business at HCH is totally different – it’s more streamlined than before.”*

Addressing Conflicting Philosophies in Substance Abuse Treatment

Albuquerque HCH is somewhat unique in that it provides services which are based on philosophies of treatment which can be conflicting when staff believe strongly in them. For example, staff who believe abstinence is fundamental to any recovery process/success may not be supportive of harm reduction approaches which are willing to serve clients not yet ready for abstinence. This has caused tension among staff in the past, but the current focus is on hiring and retaining staff in *all* of these substance abuse treatment services who adhere to a philosophy which embraces a “whatever works for the client” approach. For example, staff who currently manage the Casa Los Arboles program are themselves recovering addicts who believe strongly in the abstinence-only approach and consider that focus key to their program’s effectiveness, but in interviews they readily acknowledge that an abstinence-only approach is not the best approach for everyone and are therefore glad other options are available to those clients. The Outreach Case Manager is similarly quick to point out that the needs among homeless individuals vary a great deal, and believes a variety of options is critical to serving greater numbers of clients. Another staff member concurs: *“HCH can’t possibly meet all of the needs of homeless folks in Albuquerque – we need a ‘clients first’ approach.”* Weathering this potential source of staff conflict has arguably strengthened the mutual respect staff members have for each other, and greatly increased communication and collaboration – all of which improve the care that homeless clients encountering Albuquerque HCH receive.

Serving Women

The published research is clear that women’s experiences with (and needs for) substance abuse treatment are unique, but few programs are expressly designed by and for women with children. Making Tierra del Sol Women’s Residential Recovery Program even more unique is its basis in a harm reduction philosophy. Unlike its male counterpart program (Casa Los Arboles), Tierra del Sol has very few rules (e.g. no substance use on-site, for safety reasons) and no pre-determined structure or agenda. This variance makes sense, suggests the Program Manager, because women are socialized very differently from men. Relapse is considered a natural part of the treatment and recovery process, so program staff expect it and tolerate it – they work to keep women engaged in the program despite relapse. (*“It’s that treatment fails people, not that people fail treatment. ...Addiction is the only disease for which, when treatment fails, you go to jail.”*) And, because most homeless women have experienced some form of trauma in their lives, the Program provides counseling groups which address violence issues across the trauma spectrum. In early recovery from trauma it can be damaging to try to deal with the issues by confronting the sources directly -- as the Program Manager commented, *“They’re just dealing with having feelings, period.”*-- so counseling groups are offered in anger management and assertiveness training; staff also try to role model non-confrontational methods for addressing conflict.

Administrator Involvement

Numerous Albuquerque HCH staff considered the abilities and ongoing active involvement of the senior administration to be an important contributor to the program's effectiveness. Senior administrators "hang out" with clients, know the programs extremely well, and meet regularly with staff to hear their viewpoints. The administration is committed to developing the program in a grassroots manner, and not going after funding "just for funding's sake." All staff contribute to the development of a detailed Annual Operating Plan – a clear description of program goals, objectives, and action steps – which is consulted frequently at staff meetings throughout the year.

"We as staff have a say in how things happen. [The Development Director] listens to what we're talking about."

"The administration has been supportive of us being innovative. There is a freedom for creativity here... Being in an impoverished state [New Mexico] forces us to be creative with our resources."

Social Model Detox

No hierarchy exists among the staff at Casa Los Arboles in practice. All are former addicts, and are working in the Program because they want to ("*The reason I'm here is because somebody helped me.*"), and all have given up much higher-paying jobs to be there. Data collected on residents between July 1, 2001 and June 30, 2002 are impressive: Of 20 intakes completed, 8 residents left due to relapse and 12 had graduated within 9 months. Of the 12 graduates, they knew 8 were still clean and sober nearly a year later. These experienced program staff said they would not change anything about their program or expand it; if anything, they would replicate it to serve more men in the community. Asked to identify elements they consider integral to the success of their program, staff noted the following:

The Dinner Table: Throughout their approximate nine-month stay, residents are required to eat dinner together sitting around a large wooden table which was built by an early cohort of residents as a team project. (Residents pair up to make the evening meals, and are given culinary training if necessary.) For many residents, such an experience is either one they have never had and/or one they have not had in a long time. They must resolve any conflicts during this time around the table, which puts the responsibility on the residents – not a familiar thing for street addicts – and increases the investment they have in each other. As one staff person, himself a benefactor of the program, said, "*They hash things out at the table – that's where a lot of recovery takes place.*" In some ways the table is a metaphor for the importance of trusting in the social model – staff suggest it is important to allow things to "get out of hand", and force residents to figure it (recovery and what it takes) out on their own. ("*Those who relapse don't come back here because the feeling of recovery is so powerful.*")

Long-term: The research on homeless persons and substance abuse treatment is clear that long-term residential programs are much more effective than short-term programs which do not offer housing support. Staff at Casa Los Arboles agree strongly that their program's length of stay is critical to its effectiveness. ("*28 day recovery is for people who just got their second DWI and might lose their Beamer.*")

Commonality Among Residents: When the program was first proposed to the neighborhood, the response was not a welcoming one. Eventually, the courts became involved and a neighborhood agreement drawn up. At least in part, this agreement established some of the admission criteria for Casa Los Arboles residents, including prohibition of any individuals who have pending legal concerns, violent felonies or drug-related crimes in their history, have serious mental illness, or use methadone. The agreement further stipulates that no drugs or alcohol can be used on the premises and that a curfew be enforced. Although this affords the program limited flexibility, the current program coordinators consider it a "blessing" of sorts because it has ensured some commonality among the residents, a factor they consider critical in developing a safe and supportive recovery environment. ("*What's powerful is the small group – that they're focused on the same thing, they're*

safe in their group.”) This lesson was reinforced once when they allowed a client into the program who had spent many years in a prison environment; they quickly found him a bad fit for the program because, as the staff put it, he had learned too well the lesson that intimidation was his only protection.

What is “success” for your clients?

“One guy would spend all of his money at the beginning of the month on drugs. Now he can get through the whole month and has his money last – he has his food. He has money to the end of the month.”

“They’re always a client, but...it’s a success to not see them so often.”

“Success used to mean – get him off the streets and into housing. Now success means, showing someone I care.”

“The most important [thing] is that they know if they die tomorrow it’s going to matter.”

Co-occurring Serious Mental Illness

CHICAGO HEALTH OUTREACH – PATHWAYS HOME

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Chicago, IL 60640

Telephone: (773) 334-7117 x 1010

www.heartland-alliance.org

Program Description

The Chicago Health Outreach (CHO) Pathways Home program offers an integrated continuum of assertive outreach, outpatient, and residential services designed to address the needs of difficult-to-reach homeless individuals with serious mental illness and co-occurring substance use disorders. The Pathways Home program goals are:

- To engage homeless individuals and build a trusting, therapeutic alliance
- To encourage participation in mental health and substance abuse services as the participant is ready
- To build motivation to explore change
- To assist participants in locating, securing and maintaining housing in the community
- To improve the success and stability of linkage to necessary services
- To address barriers and fill gaps in the service delivery system so that it may better serve members of the target population

Pathways Home utilizes stage-based interventions, motivational enhancement approaches, and life skill development strategies to assist participants in making progress toward the goals they identify as most important to them. Throughout the continuum, mental illness and substance use disorders are treated in an integrated manner by multi-disciplinary service delivery teams. Teams are comprised of a psychiatrist, nurse, masters level clinicians, substance abuse specialists, mental health workers and “prosumers” – individuals who incorporate their own experience as service consumers in their efforts to develop a working alliance with participants.

Pathways Home is made up of three component programs: Safe Haven, Permanent Housing, and the Outpatient Program. The Safe Haven is a 24 - bed facility designed to engage members of the target population who are particularly reluctant to participate in treatment. Staffed around the clock, the program works primarily with individuals who are in the “pre-contemplation” stage of the change process. The staff works to build trust and form a therapeutic partnership with each participant. Within this partnership, participants are encouraged to explore their ambivalence about mental illness, substance use and other issues and to “contemplate” change.

Participants in the Permanent Housing program tend to be in the “determination/preparation” or “active treatment” stages of the change process. The staff in this program assist individuals in assessing their needs and developing skills necessary to live independently in the community. Through both group and individual interventions, Permanent Housing staff help program participants develop effective recovery management plans that address mental health, substance use, daily living and other issues concurrently.

The Outpatient Program staff works to engage participants at any point in the change process, incorporating psycho-social rehabilitation and substance abuse treatment into a drop-in center environment. In the Outpatient program, participants are provided with case management as well as group and individual counseling that is consistent with each individual’s stage in the change process. Participation in services follows the pace and parameters set by each participant.

Pathways Home, which opened in 2001, is a program of Chicago Health Outreach (CHO), established in 1985 as a Health Care for the Homeless demonstration project. CHO provides primary, oral, and mental health care to low-income people, most of whom are homeless. CHO is an affiliated partner of Heartland Alliance for

Human Needs and Human Rights, an anti-poverty human rights organization which – together with its partners Century Place and Chicago Connections – provides housing, health care, and human services to 55,000 marginalized Chicagoans annually.

The Department of Housing and Urban Development (HUD) provides the lion's share of funding for Pathways Home. The Illinois Office of Alcoholism and Substance Abuse and the Division of Mental Health also provide grants. Private foundations make significant contributions to the program. Other sources of financial support include Medicaid reimbursement and program participant fees for housing based on 30% of adjusted or 10% of a participant's gross income.

Program Narrative: Strategies and Innovations

Assertive Outreach

Pathways Home outreach workers search alleys and parks and visit shelters and drop-in centers, looking for people with untreated psychiatric and substance use disorders. When individuals refuse service, the teams challenge themselves to develop strategies that will engender the trust and the motivation necessary to bring the individual in from the outside – whether or not he or she has decided to stop using alcohol or other drugs. In the words of one experienced outreach worker, *“There is always a place at the table for each person.”*

Client-driven Emphasis

Client-centered care is given much more than lip service in Pathways Home. It is the foundation upon which the program is built and is pursued more diligently than in most programs. One staff person describes the program as *“client-centered, client-driven, and hope-based with a focus on meeting people where they're at.”* The program seeks to meet the goals of individual participants versus requiring participants to meet the predetermined goals of the program. The client really does drive his or her own treatment program.

Staff members partner with individuals to determine what they need and want. Treatment goals and interventions are defined and redefined on a case by case basis. At any given time, the primary goal for one participant might be to take a shower while for another it will be to secure permanent housing. Staff and participants see this individualized “case by case” approach as humane, respectful, and ultimately effective.

Harm Reduction Philosophy and Strategies

In concert with a client-centered emphasis, harm reduction philosophy is central to the Pathways Home approach to care and is applied to both substance use and mental health concerns. Based on stages of change theory and coupled with the use of motivational enhancement techniques, harm reduction informs clinical and programmatic decisions. Harm reduction views change as a series of incremental steps along a continuum and that any change in a positive direction that reduces risk or harm is viewed as a success. For example, a participant might choose to switch from using a more harmful to a less harmful drug. Or an individual suffering with psychotic symptoms might not wish to take medications but may be open to receiving assistance for improving other areas of functioning.

Harm reduction as related to substance related problems does not preclude abstinence as a goal, but acknowledges participants' ambivalence about change and that people are at different levels of readiness to change their behavior in regard to substance use and other issues they face. Some may never choose to be totally abstinent. The role of staff is to help resolve ambivalence and build motivation towards any positive change. According to staff, *“the key is to develop a non-judgmental approach.”*

Commitment to Training

Pathways Home has a strong commitment to providing training to staff in the theory and techniques of motivational interviewing and harm reduction, and in keeping those skills sharply tuned. New staff members are required to attend a 12-hour motivational interviewing training and a harm reduction 101 session. On an on-going basis, these approaches are emphasized in staff meetings, in-services, supervision and consultation. A Harm Reduction Work Group has also been established to develop a continuum of intervention guidelines in relation to specific situations that arise, for example, if a participant is exchanging sex for drugs or money.

The Pathways Home program is also a strong advocate in the larger community for mentally ill substance abusing (MISA) people and the development of responsive treatment for them. Staff regularly provide training to providers at the local, state, and national levels especially on topics of harm reduction and motivational interviewing.

Stable Housing as Treatment

The Substance Abuse and Mental Health Services Administration (SAMHSA) has gathered a substantial body of knowledge concerning the provision of effective services for homeless people with serious co-occurring mental health and substance use issues. A key finding is that the provision of stable housing is an essential component of effective treatment. Pathway Homes staff members strongly endorse the idea that a stable place to live is fundamental to successful treatment for this population. Helping participants obtain appropriate housing is given high priority as a treatment intervention.

Provision of Treatment in Housing

The experience of the Pathways Home program confirms that supportive housing, providing support and treatment onsite in the Safe Haven and Transitional Housing programs, is crucial. The residential environment permits relationships between staff and participants to develop naturally in the daily course of living through shared activities and conversation. Staff believe they can develop a more accurate picture of how participants are functioning than if the treatment setting were separated from participants' housing. Participants are able to receive responses to questions and concerns with minimal delay. Furthermore, participants can readily access additional treatment services when they are ready to do so and staff can monitor treatment responses more easily.

Staff note that their presence in the residential setting allows them to offer treatment more holistically, addressing not only issues related to one's malfunctioning brain, but also to their material needs, life skills, and social functioning. As one staff person stated, "*Homelessness is like having another diagnosis.*" It is helpful to see the bigger picture of someone's needs and level of functioning in order for staff to be more realistic in their interventions and expectations.

Support for Innovative Ideas

Pathways Home staff express gratitude for being given the freedom to initiate creative ideas and activities, often incorporating the interests and talents of participants and staff members. Thus, at any given time there might be opportunities for mask-making, drumming, yoga, chess, or recreational outings. In addition, there may be opportunities for enhancing life skills such as shopping, cooking, or balancing one's checkbook. Teams are also given latitude to tailor interventions as appropriate for clients in the residential setting. Those in management and supervisory positions talk about intentionally trying to create an environment where staff can disagree and challenge one another and not be afraid to suggest new ideas.

Alternative Treatment Services

PORTLAND ALTERNATIVE HEALTH CENTER

625 SW 12th Avenue

Portland, OR 97205

Telephone: (503) 228-4533

Program Description

Portland Alternative Health Center (PAHC), a program of Central City Concern, is a multidisciplinary, integrated health clinic licensed as an outpatient drug and alcohol treatment program. The clinic primarily serves homeless and low-income people with multiple diagnoses. Alcohol and drug treatment, psychiatric services, mental health services, Chinese medical services including acupuncture and herbal therapy, primary medical care, naturopathic services, case management, mentor services, and alcohol and drug free housing are coordinated at the PAHC site which is located in downtown Portland, Oregon.

The clinic was initially developed in recognition of the need for detoxifying patients to have access to barrier-free, intensive outpatient alcohol and drug treatment. In March of 1987, Central City Concern implemented the first treatment program on the West Coast to incorporate acupuncture into its inpatient detoxification program at the Hooper Center in downtown Portland. Completion rates for alcohol and other drug detoxification at the Center went from 25 percent to 75 percent when acupuncture was utilized. In 1991, Central City Concern opened the Portland Alternative Health Center (PAHC), providing acupuncture by state-licensed acupuncturists in addition to wellness practices and traditional counseling programs.

PAHC represents an abstinence-based model of treatment. The program is philosophically opposed to interventions such as the use of opiate replacement therapies. However, it does recognize that harm/risk reduction approaches may be useful in the pre-entry level to treatment. PAHC believes that alternative non-drug forms of treatment are cheaper and more effective. As one staff person who is a recovering heroin addict stated, *“Why take methadone when there are better ways that allow you to have a clear head and a better life?”*

The philosophy of PAHC involves empowering people to take an active role in their own recovery and general health care. Services are client-centered and culturally specific. Nearly 300 individuals are involved in treatment at any given time at PAHC with 1700 clients being provided services in a given year. About 90% are homeless upon entering the program.

In an independent interim evaluation conducted by PAHC in 1999, successful completion rates for alcohol- and drug treatment (42%) were the two times higher than the county average. In addition, when clients received alcohol- and drug-free housing, their successful completion rate was 88% percent. The combination of alcohol- and drug-free housing with treatment appeared to have a considerable impact on completion rates. And, indications of satisfaction with the program by those who were formally discharged exceeded staff expectations.

PAHC receives financial support through seventeen different funding streams including federal (e.g. Ryan White, CSAT, McKinney), state, and local sources. Medicaid and other third party reimbursements provide revenue. The program also contracts with other agencies in the community to provide alternative treatment.

Program Narrative: Strategies and Innovations

Use of Complementary and Alternative Treatment

Patients are offered acupuncture during their initial visit to the clinic. *“Being able to offer something [acupuncture] physically and immediately to addicts wanting help and that won’t get them high is an incredible engagement tool”* according to the program director. Acupuncture and Chinese herbal medicines

are utilized as the preferred treatment for detoxification purposes, and patients are referred to medical detox as needed.

Acupuncture and Chinese medicine are used as adjuncts to the Western medical treatment that patients receive. As supported by a growing body of scientific evidence, acupuncture has been found to decrease physiological stress, reduce craving, diminish other conditions such as depression and physical pain, and promote relaxation. There is also evidence that patients remain in treatment longer, have higher treatment completion rates, and require fewer re-hospitalizations. The use of acupuncture seems to be especially effective when administered by caring practitioners. In the words of one patient, *"I can feel the compassion coming right through the needles in my ear."*

The program also believes the use of alternative approaches reduces costs. A 2002 retrospective study compared costs for providing traditional Western psychiatric treatment and alternative treatment for 128 PAHC patients and concluded that every dollar spent on alternative care saved \$6.25.

Access to Transitional and Permanent Housing

PAHC views housing as integral to successful treatment and recovery for addictions. Upon entry into the program, patients sign up for transitional housing operated by Central City Concern, PAHC's parent organization. There is typically a 4-5 week wait for this housing to become available. In the meantime, individuals might stay at a local shelter where PAHC has 25 designated beds.

Central City Concern, PAHC's parent organization, owns or operates over 2000 units of low-income housing, about half of which are for special needs populations with mental illness, substance use disorders, HIV/AIDS, or multiple diagnoses. About 800 units are specifically Alcohol and Drug Free Communities (ADFC). Many patients are able to leave transitional housing and move directly into permanent housing or permanent support housing operated through Central City Concern.

Addictions Recovery Mentor Program

The Mentor Program consists of staff people, all in recovery, who guide newly recovering people from substance addiction through the initial 4-6 difficult weeks of sobriety. *"They literally take them by the hand upon discharge from detox, get them enrolled in treatment, find them safe housing, food, clothes and introduce them to a community of recovering people for crucial support,"* according to the Project Director. The Mentor concept, adapted from the sponsor model in 12 step programs, attempts to address the patients' social isolation and lack of connection with services. Mentors work with about ten clients at a given time. Although the program goal would be for every person to have a mentor, there are resources to serve only about 30% of the patient population at any given time. The determination of who is assigned a mentor is based on the assessed level of need.

The Mentor Program, which PAHC has pioneered, has proven to be quite successful. According to an evaluation¹ conducted for PAHC, the Mentor Program increased the number of heroin addicts completing long term treatment by 276%. *"The goal is recovery, independence and an end to homelessness for some very desperate people. The alternative is continued expensive hospitalizations, prison terms, stress on neighborhoods and unnecessary suffering,"* says the Project Director.

Culturally Specific Services

PAHC clients typically experience chronic poverty conditions, homelessness, multiple health-related issues, and a lack of access to needed resources and social supports. The program seeks to address the various concerns of this at-risk and high-needs population. Furthermore, PAHC strives to provide services that are culturally appropriate to various sub-groups of patients. For example, treatment groups are provided in Spanish and other languages as needed, and interpretation services are available for individuals. Treatment groups are tailored specifically to groups of

¹ Moore, T. (2001, January). Addictions Recovery Mentor Program Bridging the Gap: Detox to Treatment Service Engagement. Portland, OR: Central City Concern

patients with common issues and concerns; these groups include people living with HIV/AIDS, women, families, and persons with co-occurring mental illness and substance use disorders. PAHC continually seeks to develop culturally appropriate services in response to the needs presented by patients.

Crisis Center

CHEMICAL DEPENDENCY CRISIS CENTER (CDCC)

324 Lafayette Street

New York, NY 10012

Telephone: (212) 533-3281

www.bowrescom.org

Program Description

"We're more a state of mind, than a bricks and mortar place."

CCDC Director

The Chemical Dependency Crisis Center (CDCC) is a program of the Bowery Residents' Committee (BRC), a community-based organization whose focus is to address the needs of homeless and low-income people in metropolitan New York City. Through its various programs, BRC serves clients who are chemically dependent, psychiatrically disabled, aged, and/or living with HIV/AIDS. The organization provides a comprehensive array of services including housing, meals, detoxification, mental health and addiction services, health care, vocational rehabilitation, AIDS services, community education, and advocacy. Begun in 1973, BRC serves more than 5,000 people annually; it offers individuals the means to function successfully in society, and seeks to improve the quality of life in the community.

The Chemical Dependency Crisis Center is a residential detoxification program providing short-term services to 24 recovering individuals. The program operates 24 hours per day, 7 days a week, and is open to both men and women. Clients typically stay for up to two weeks. Approximately 950 unduplicated individuals, of whom 85% are male, are admitted to CDCC annually. CDCC clinical staff includes peer-trained individuals, alcohol and substance abuse counselors, physicians, psychologists, nurse practitioners, nurses, licensed practical nurses, and a volunteer psychiatrist. All of the counselors are certified alcoholism and substance abuse counselors, which requires 450 hours of didactic training and 6000 hours of direct practice experience.

In addition to providing sub-acute detoxification services, CDCC operates as a crisis center. Upon admission, clients are assessed for physical health, mental health, and chemical dependency needs. Treatment is provided to alleviate withdrawal symptoms as well for other medical and psychiatric conditions. After the initial phase of detoxification, clients receive individual and group motivational counseling as well as didactic health and substance abuse education, therapeutic activities, and institutional 12-step programs. At CDCC, clients reside in small dormitories under the supervision of a round-the-clock nursing staff. Three nutritious meals are provided daily.

CDCC provides a medical respite service to clients in need of short-term medical care under the auspices of a physician and a full-time nurse practitioner. The medical respite program provides a safe resting place for homeless people who are not sick enough to be hospitalized but are too ill to be out on the streets or staying in shelters. Respite patients have access to hygiene facilities, nutritious food, storage for medications, and medical care. As they recuperate, patients can participate in other services provided at CDCC.

Two types of admissions of sober individuals occur at CDCC. A *Holdover* admission is a person who is being discharged from an inpatient detoxification program and who has already been accepted by an inpatient aftercare program, but is awaiting an opening. A *Safe Harbor* admission is a person who has a history of alcoholism and/or drug abuse, and is unable to remain abstinent without admission. Both of these types of admissions receive the full complement of program services.

CDCC is funded primarily through a block grant from the New York State Office of Alcoholism and Substance Abuse Services that comes through the City of New York. CDCC also receives some financial

support from private foundations. In-kind donations of volunteer time and materials to the program are estimated to be \$100,000 annually.

Program Narrative: Strategies and Innovations

Open Admission Policy

CDCC has a barrier-free, open admission policy. The program admits virtually anyone who has substance use problems and who wants to make a change in their lives, including people living with HIV and AIDS, with mental illness, homeless individuals, and sexual minorities. CDCC prides itself on treating people as human beings first. *“At any time day or night you can have the idea you want to clean up and just walk through the door, like treatment on request”* states a CDCC staff person. *“Everyone who comes in gets assessed and more than likely will get admitted here.”* An exception would be someone who needs acute withdrawal, or has an acute and emergent medical illness. That person would be referred to an appropriate medical facility.

CDCC accepts referrals 24 hours a day, seven days a week. Clients need to be 18 years and older. Each person who comes in receives a nursing assessment. Most referrals are homeless and have medical, substance abuse and mental health concerns. The goal of CDCC is not to turn anyone away without at least trying to assist them in some way.

Because CDCC is an abstinence-based program, the desire to be sober is a condition of remaining in the program. If clients do not want to pursue sobriety or participate in the program itself, they are given a list of 12-step meetings and bid farewell, but always with the message that they are welcome to return. Staff report that probably four out of ten individuals leave within the first 72 – 96 hours. Counselors, who try to explore with clients whatever ambivalence and concerns they might have, say they often discover that individuals who leave are running from the law, are on probation or parole, or have some form of mental illness and are disconnected from mental health treatment.

Although harm reduction is not part of the CDCC approach to care, staff are not opposed to it per se. They see it as a useful part of the continuum of services for chemically dependent people. Most staff acknowledge the necessity of syringe exchange programs for example and recognize that harm reduction can lead to abstinence. However, as one staff person stated, *“I do not believe in controlled use with the cohort of people we serve; their lives are too unstable.”* Another stated, *“I’m not against harm reduction but here we are trying to raise it to a higher level.”*

Welcoming to GLBT Community

The program director notes that many treatment programs either will not provide treatment for gay, lesbian, bisexual, or transgender (GLBT) individuals, or *“will give subtle and not so subtle messages that we don’t want to serve you here.”* He continues, *“At CDCC, it’s the treatment that comes first, not one’s sexual orientation.”* The program makes a point of reaching out to sexual minorities and creating an agency environment that conveys a clear message of welcome to everyone. The director notes that this is an important consideration in hiring staff. He adds that in his 13-year history with the organization there have not been any known incidents involving negative interactions among clients themselves in relation to someone’s sexual orientation.

Modified Therapeutic Community Model

According to the existing research, appropriately modified Therapeutic Communities (TCs) have been shown to be relatively cost effective and have demonstrated generally positive outcomes for homeless people with substance use disorders, including co-occurring mental disorders.¹ The Chemical Dependency Crisis Center is an example of such a modified TC. In the CDCC model, it has been adapted to fit a shorter time frame of treatment within a Crisis Center milieu and includes program components not found in traditional TCs.

¹ See pages 24-27 in “Substance Abuse Treatment: What Works for Homeless People?” by Suzanne Zerger. Available on-line at www.nhchc.org/Publications/SubstanceAbuseTreatmentLitReview.pdf.

Like most TCs, the CDCC program is quite structured and places a strong emphasis on personal responsibility. Rules are strictly enforced. Clients arise at 6:00 a.m., participate in meditation at 7:00 a.m. and are involved in counseling and educational classes throughout the day. Activities such as watching television are regulated. Staff emphasize that “*clients need to want to do the work*” in the CDCC program.

On the other hand, the CDCC program steers clear of certain aspects of the traditional TC model. Highly confrontational methods are not used nor are participants punished or publicly shamed. Instead, the peer community is encouraged to offer guidance and assistance to one another in a supportive manner. Staff are trained to use motivational enhancement techniques to help clients take the steps they need to take. An effort is made to address the holistic needs of the client and to instill hope. Consequently, the program atmosphere is described as “*very caring*” by both staff and clients.

Unlike in traditional TC programs where psychiatric medications are not permitted, psychiatric treatment is integrated with chemical dependency treatment at CDCC. Medical treatment and auxiliary social services are also incorporated into the treatment approach. In addition, within the context of this modified Therapeutic Community approach, CDCC places a strong emphasis on client-centered care. To the degree possible, treatment is individualized based on the client’s wishes. According to staff, “*What you need we’ll try to get it for you.*”

Connection with Corrections

CDCC has a close working relationship with the corrections system, accepting both voluntary and mandatory referrals. For some courts in the city (e.g. Brooklyn Mental Health Court, Manhattan Drug Court, Mid-town Community Court, and others) CDCC is the mandatory treatment option as an alternative to incarceration. CDCC staff will conduct pre-assessments for the courts to see if an individual is appropriate for admittance to the CDCC program. The program also works with parolees who are mandated into treatment through the state corrections system.

The Recovery Reading Circle

The Recovery Reading Circle is a creative therapy approach developed by Terrell L. Porter, an off-Broadway director, in the aftermath of the events of 9/11/01. The concept involves the reading of humorous television sitcom scripts and incorporating elements of a real production of a play. Clients are encouraged to participate as a producer, director, or character from the script chosen on a particular day. Alternatively, clients may simply relax and listen as scripts are read. One staff person comments, “*Many clients play roles while living on the streets. In the Reading Circle, they get to turn these liabilities into assets. The experience can be very moving.*”

Porter’s written description of the Recovery Reading Circle notes that it provides much-needed laughter and relief in the otherwise stressful setting of a detoxification unit. In the group discussion that follows the reading, clients are invited to share their current life situations with one another. Porter writes, “*It is at this time that a consumer will loosen his/her guard, and share some of their feelings openly in this nonjudgmental setting.*” These comments can provide useful insights to assist with various aspects of case planning with the individual.

Treatment Broadly Defined

The program director reports that for a long time there was a sign at the front door of CDCC that stated: “*Treatment begins here.*” Treatment is defined broadly at CDCC in keeping with a commitment to address people’s needs and conditions in a holistic manner. For example, detoxification is not viewed as separate but as a part of treatment. In addition, treatment for chemical dependency is seen as directly related to medical and mental health treatment and to the provision of social service and support needs. None are viewed as ancillary but rather all are necessary. CDCC also fosters the notion that treatment is provided not only by staff but by clients as well. As one staff member notes, “*Clients are always teaching one another.*”

Group treatment is an integral aspect of the CDCC approach. Groups provide one of the main vehicles in moving clients beyond detox toward longer-term treatment. Topics for groups vary based upon staff and

client interests. Common themes include: introduction to the Twelve Steps, relapse prevention, exploration of personal strengths and weaknesses, meaning of achievement, listening skills, self-esteem, expectations of treatment, importance of first impressions, secrets, life after incarceration, self-destructive behaviors, history of drugs in America, stress reduction, and meditation. Groups employ various techniques including discussion, educational tapes, role-play, and various forms of artistic expression.

Homeless Youth

LARKIN STREET YOUTH SERVICES

1138 Sutter St.

San Francisco, CA 94109

Telephone: 415-673-0911

www.larkinstreetyouth.org

The mission of Larkin Street Youth Services is to create a continuum of services that inspires youth to move beyond the street. We will nurture potential, promote dignity and support bold steps by all.

Larkin Street Youth Services (LSYS) is a community-based organization that provides a continuum of services for homeless and runaway youth in San Francisco, CA. LSYS serves approximately 2,000 young people between the ages of 12 and 23 each year. The organization was founded in 1984 as a neighborhood effort to divert homeless and runaway youth from prostitution, drug dealing and theft in the Tenderloin/Polk Gulch area of San Francisco. Larkin Street began as a drop-in center—providing food, clothing and a safe haven for 70 youth in its first year.

After a decade of providing crisis intervention and basic care for homeless youth, Larkin Street began to identify and address other unmet needs of runaway and homeless youth. The agency developed eight new programs to fill service gaps and increase opportunities for youth to stabilize their lives, secure permanent housing, and achieve economic independence.

Currently Larkin Street operates eighteen programs in ten San Francisco locations. These programs provide a comprehensive continuum of services designed to respond to youth's immediate needs, while encouraging them to participate in programs that provide the skills and resources necessary to move beyond street life for good. Annually, over 80% of the young people who participate in Larkin Street's case management services permanently exit street life.

Larkin Street's continuum of services includes:

Point of entry services - street outreach, drop-in center, information and referral center

Support services - case management, medical clinic, mental health services, substance abuse services, arts program

Housing services – emergency shelter, transitional housing, and permanent housing

HIV specialty services – residential care and scattered site housing, HIV specialty clinic

Educational and employment services – on-site school, day labor, work force readiness, work force placement and retention, career training programs

LSYS' continuum is designed to have multiple entry points for youth into services. All youth who receive comprehensive services complete an intake, which is done within the first week of participation. This intake collects general demographic information as well as substance use history and presenting issues. Addressing youths' immediate needs is the primary concern upon entry into services followed by assistance in developing a stabilization plan.

Approximately 90% of youth who have completed a LSYS intake report a history of alcohol or drug use. About 60% of these individuals are considered to have a substance abuse or substance dependence disorder. Larkin Street's substance abuse and mental health services, which are overseen by the Director of Mental Health and Substance Abuse Services, are fully integrated across the agency's continuum of care. The close relationship between these two components is essential to serving the increasing numbers of youth who enter LSYS' programs with co-occurring substance use and mental health issues.

The substance use team includes ten staff – seven Substance Abuse Specialists and three Substance Abuse Peer Counselors – who work at LSYS’ various sites. The mental health team is comprised of ten Mental Health Specialists which includes a consulting psychiatrist, case managers, and program coordinators. The integration ensures that youth with substance use problems have access to a full range of housing, case management, medical, and supportive services.

Program Narrative: Strategies and Innovations

Youth-Centered

Larkin Street annually serves approximately 2,000 youth and young adults ages 12-23 living on the streets in San Francisco. They are a diverse group demographically. However, many share histories of abuse and neglect that make moving beyond street life a challenge: 82% have histories of physical or sexual abuse, 73% cannot return home because their families are unwilling or unable to care for them, and over 62% have histories of suicidal ideation or attempts. To assist these youth, Larkin Street provides specialized services around the clock, 365 days a year, that embody a supportive, client-centered approach. LSYS’ stated purpose is *“to be there for the thousands of youth we meet each year – each in search of what should have been theirs to begin with: a stable home, nurturance and a chance to realize their potential.”* Youth who come to LSYS seeking services will find the following “Bill of Rights” hanging on the wall:

We the Children of the United States are endowed with certain inalienable rights:

Article I
To grow up in a safe and drug free environment

Article II
To receive an education which gives us the ability to make informed choices

Article III
To be respected by our peers and parents

Article IV
To have our basic needs cared for

Article V
To pursue dreams and ambitions

Emphasis on Outreach and Engagement

According to research, outreach has been shown consistently to be a successful method for targeting and contacting a segment of homeless substance abusers otherwise difficult to engage.¹ Larkin Street employs four staff outreach workers who, along with numerous community volunteers, go out regularly in pairs on street outreach. Workers make repeated contact with youth over time which is essential to the relationship building process. Outreach workers always wear purple jackets which identify them as LSYS workers. These jackets are well known by youth living on the streets of San Francisco and serve as an important engagement tool particularly because of LSYS’ positive reputation.

First contact with youth is facilitated by the distribution of important items such as food, bleach kits, hygiene kits, alcohol pads, candy (a high-demand item according to staff), handi-wipes, condoms and lubricant. Outreach workers assess substance use and mental health issues and provide health education on various topics including nutrition, hygiene, safer sex, and less risky drug use practices. Workers also refer youth to additional services at Larkin Street and other providers and offer educational pamphlets and written information about services available through various resources. Similar services are offered at two youth drop-in centers operated by LSYS in the Tenderloin and Haight Ashbury neighborhoods. These drop-in sites provide a safe, non-threatening environment that is critical for engaging individuals with special concerns such as runaway youth.

¹ Tommasello, A.C. et.al. 1999. “Effectiveness of outreach to homeless substance abusers.” Evaluation and Program Planning, 22:296-303.

Decisions about where to conduct outreach are based on periodic exercises in “community mapping” to determine the extent of youth homelessness in a given neighborhood. Staff and volunteers walk around in different areas of the city and talk to people on the streets and in shops, arcades, internet cafés to try to estimate the number of homeless youth in the neighborhood and to get a sense of what are their needs.

Use of Motivational Enhancement and Cognitive Behavioral Approaches

Larkin Street’s substance abuse services are based on and adapted from Motivational Enhancement Therapy and Cognitive Behavioral Therapy for Adolescent Cannabis Users: 5 Sessions (MET/CBT5). Published by SAMHSA, this curriculum is designed to train substance abuse treatment counselors to conduct brief five-session treatment interventions for adolescents with cannabis use disorders. It combines one-to-one motivational enhancement therapy with cognitive behavioral therapy provided in a group format.

LSYS has modified the MET/CBT to be particularly useful in providing substance abuse assessment and interventions for runaway and homeless youth. The program has adapted the model to address polysubstance use in addition to cannabis in a flexible schedule of interventions. Family members are not included in the interventions as they are infrequently involved in the youths’ lives. While the stated intent of the intervention model is to promote abstinence from alcohol and other drugs, staff are committed to working in a client-centered manner.

The Substance Abuse Services program utilizes the MET/CBT5 intervention model in a flexible manner depending on the service site and the needs of individual clients. For example, in transitional housing sites it is more feasible to conduct sequential group therapy sessions whereas in drop-in center settings where contacts tend to be more episodic, one-to-one approaches are generally more practical. It is also recognized that some youth interact best on a one-to-one basis and are not comfortable in group situations. Other youth do well in groups but are ill at ease in one-to-one encounters. LSYS has also changed some of the language used in the training manual. *“We had to get rid of the jargon and use language that youth can relate to. It’s about knowing your audience. For example, Refusal Skills groups got changed to Decision Making groups.”*

Housing Based Model

Housing is central to the services that LSYS provides and in stabilizing the lives of the youth the agency serves. Larkin Street’s housing services provide homeless and runaway youth with over 160 beds each night. The 20 bed Diamond Youth Shelter provides emergency shelter for underage youth ages 12-17. The LOFT is a 10-bed transitional facility for youth 15-17 who cannot return home. Lark-Inn, with 40 beds, is San Francisco’s only full-service emergency center for youth ages 18-23. Avenues to Independence, a transitional housing program, provides young adults aged 18-23 with a “practice round” of living in the real world before moving to independent life. The Ellis Street Apartments provide permanent affordable supported housing for formerly homeless youth ages 18-23. The agency also provides residential and scattered site housing for HIV positive youth.

The experience of LSYS is consistent with the research literature regarding the critical importance of housing for treatment success. Staff members comment that *“housing makes everything easier because it’s so critical”* for helping youth gain stability and move forward in their lives. While housed, youth have the opportunity to develop a specific plan to help them permanently exit street life using LSYS’ continuum of education, employment, and support services.

In-house Continuum of Services

Staff report that it is very difficult to find services in the larger community appropriate and specific to the needs of homeless and runaway youth. For example, there are no medical or social detox programs available for youth in the Bay area. Drop-in centers often serve as de facto sleep-off detox facilities. There are basically two residential substance abuse treatment programs available to homeless youth. However, both are abstinence-based and have very long wait lists. Suitable housing, education, and job training are difficult to find.

Consequently, Larkin Street has developed a continuum of in-house programs and services that build confidence and offer real opportunities for youth to succeed. “*Youth feel safe accessing services because they are in-house*” according to staff. This continuum of care includes outreach and engagement, information and referral, various levels of housing, case management services, treatment for medical, mental health, and substance use disorders, HIV specialty services, and a variety of educational and employment services. In the LSYS model, a youth with substance abuse problems has full access to this array of services.

Involvement of Volunteers and Interns

Larkin Street depends on numerous community volunteers who are committed to the agency’s mission and give generously of their time and talents. Volunteers provide thousands of hours of service annually, enriching the agency’s various programs. Volunteers provide assistance and friendship and help to significantly extend the community of care that surrounds the youth. The organization takes care to match volunteer’s interests and skills to program needs and provides ongoing support and training opportunities for them. The organization routinely acknowledges the contributions made by volunteers in a variety of ways including stories in the LSYS’ newsletter *Streetwise*.

Homeless Families

WORCESTER HOMELESS FAMILIES PROGRAM

Family Health Center of Worcester
26 Queen Street
Worcester, Massachusetts 01610
Telephone: (508) 860-7700

Program Description

The Worcester Homeless Families Program (WHFP), based in the Family Health Center of Worcester in Worcester, Massachusetts, has provided comprehensive, integrated services to homeless families since 1988. Mental health, substance abuse, parenting, advocacy, and child-focused services are integrated with primary health care and include:

- Primary health for all family members, obstetrical services, and urgent care
- Family-centered Case Management Services
- Clinic-, group- and shelter/home-based parent support, education, and skills training
- Children's services (developmental/behavioral screening, sexual abuse screening, child care placement, educational advocacy services, mental health counseling, children's groups)
- Mental health and substance abuse treatment to homeless mothers with children, including individual and group counseling and psychiatry consultation
- Nurse outreach and care management services
- Pharmacy
- WIC offices
- TB Clinic
- Teen Clinic
- Dental
- Hepatitis C and HIV testing
- Legal services
- Radiology

Additionally, transportation and child care are provided when necessary to ensure access to services.

Families receive the following core set of services: primary care, family advocacy services, and 3-4 sessions with the clinic-based psychologist which provides parent education and support and child assessment services. Upon entry into the program, families are assigned a health care clinician and a Family Advocate. Assessment of mental health, substance abuse, and trauma experiences occurs in the context of the routine initial health visit by WHFP health clinicians. The Family Advocates meet with mothers to do a thorough assessment of basic family needs (e.g. housing, income), set goals, and develop a plan with mothers for achieving goals. The Advocates serve as the point person for the families in the program and are responsible for monitoring family progress and maintaining records. Mental health clinicians work with mothers to develop positive parent-child interactions, and provide guidance and support for the child(ren)'s development. A nurse conducts systematic monitoring for clients with mental health or serious medical problems to facilitate adherence to treatment recommendations. Home-based services assist families once they move to housing. Services are flexible and offered in multiple settings to meet client needs.

Each family is reviewed by the multi-disciplinary team after completing initial assessments with the advocate, mental health clinician, and primary care provider and discussed at three month intervals. The team consists of Family Advocates, mental health clinicians, Outreach Nurse, Child and Adult Psychiatrists, a Family Practice physician and nurse practitioner, and the Program Director. This team meets weekly to review new families, progress of families in the WHFP, and program issues. The advocates and nurse meet an additional time weekly to review families' progress. Family Advocates also meet one-on-one with the Program Director twice a month to review records and specific issues as they arise. This "integrated team approach" differs from the traditional case management model in that responsibilities for components of the assessment and goal planning are shared among all team members. This allows the client to case manager ratio to be 25:1.

The WHFP receives partial funding through a subcontract agreement with Community Healthlink, the HCH grantee in Worcester. The Program is also currently the only health-based initiative being funded in Phase II of SAMHSA's Center for Mental Health Services/Center for Substance Abuse Treatment "Homeless Families Program." The WHFP is also a site for SAMHSA's Building Mentally Healthy Communities Targeted Capacity Expansion initiative.

Program Narrative: Strategies and Innovations

Integrating Data Collection and Service Provision

The Center for Mental Health Services (CMHS) and the Center for Substance Abuse Treatment (CSAT) collaborated in the funding and administration on the "Collaborative Program on Homeless Families: Women with Psychiatric, Substance Use, or Co-occurring Disorders and Their Dependent Children", the first federal initiative to document and evaluate the effectiveness of time-limited, intensive intervention strategies to treat and support homeless mothers with psychiatric and/or substance use disorders who are parenting children. Program funding occurred in two phases – the first, beginning in 1999, involved a range of program refinements and a two-year process evaluation, and the second, beginning in 2001, is a three-year outcome evaluation. Dr. Linda Weinreb (the Principal Investigator on the grant and founder of the WHFP program) from the University of Massachusetts Medical School, is collaborating with the Family Health Center, local shelters, and colleagues from Center for Mental Health Services at UMass and Harvard University Children's Hospital to evaluate the Worcester Homeless Families Program. Dr. Weinreb also works as a physician in the Program. Dr. Weinreb is also Principal Investigator of a SAMHSA funded three year Targeted Capacity Expansion (TCE) initiative, Building Mentally Healthy Communities, in collaboration with FHC and the City of Worcester, which provides funding for expanded outreach, mental health, substance abuse, and trauma-related services to be integrated into the WHFP.

Both SAMHSA projects have enabled the WHFP to develop a systematic intervention that is offered to all client families as well as the collection of evaluation data as part of routine service delivery. One method for collecting these data has been the design of a clinical record assessment tool which provides data which are valuable both to the evaluation effort and to the services being offered; that is, evaluation is built into the program itself, not as an add-on. The Family Advocates, responsible for record-keeping, have been fairly responsive, saying the assessment tool: "*provides good information. It gives a good idea of what they [the mothers] have been through.*" Data collected from the program allow for ongoing improvements to be made; they will also provide concrete evidence about which interventions are working for whom.

Integrating Mental Health, Substance Abuse, and Trauma Services with Health Care

The WHFP takes advantage of the non-stigmatizing health setting to engage families in a range of mental health, substance abuse, and trauma-related services. The primary care setting: 1) allows the engagement of women with mental health/substance problems (MH/SA) to proceed with greater ease due to the reduced stigma of physical illness and typical prioritization of health care treatment needs over MH/SA problems; 2) can facilitate earlier identification and treatment of MH/SA problems; and 3) may better ensure eventual MH/SA treatment if trust with other service providers has been attained. The health care setting is an ideal starting point from which to organize the provision of comprehensive services.

Family-Centered

The entire family is the "client" in the family-centered approach, and the composition of the family is defined by its members. The WHFP provides services to family members of all ages who are interested in receiving support. Goals are set with each family member, considering his or her expressed needs and desires, and the resources he or she brings to the setting and situation. Specialized child-focused interventions and supports are available, including developmental screening; sexual abuse screening; referrals to special services, e.g., early intervention, as appropriate; counseling; and consultation to schools and other providers.

An array of supports is available to mothers, who typically approach the health center with specific "physical" health needs, rather than with the issues of substance abuse, mental health, or trauma and victimization foremost on their minds. However, the health center and relationships with health care providers provide a

non-stigmatizing gateway to the identification and potential treatment of many issues. For example, the health care provider meeting with a mother about her child's ear infection may notice and inquire about the mother's current stresses and related depression. Effort is made to engage each family member in addressing issues and achieving the highest level of functioning, as these issues are identified. While some mothers are not ready or willing to engage in a focused way about issues identified by WHFP providers, others welcome the opportunity to discuss their concerns and are relieved that someone has finally "cared" enough to ask. Supports are offered and put in place for those who request them.

The focus of the Parents Achieving Self-Efficacy (PASE) component of the WHFP is the health and well-being, and functioning of homeless mothers, the vast majority of whom are survivors of trauma and abuse. Parenting experiences may remind mothers of issues from their own histories, may result in "re-traumatization" of mothers, and may offer opportunities for tremendous healing if adequate supports are in place. Clearly the substance abuse and mental health issues of many of these women have their roots in histories of traumatic victimization. The WHFP staff work to engage mothers as parents, rather than as patients, by identifying and supporting their strengths as mothers, and providing support and skills-building opportunities. Women are provided clinic- and home-based consultation regarding parenting issues and children's adjustment, as well as a structured PASE group and an informal "drop-in" meeting. Childcare is provided to women to enable them to attend WHFP activities.

Strengths-Based

The content of the WHFP's work is strengths-based; that is, the focus is on identifying strengths in these families which can become the foundation for affecting change in their lives. This approach to care in practice runs counter to the philosophy of traditional training, which tends to produce providers focused on deficits and pathology. Successfully employing a strengths-based approach requires substantial staff training and team-building – all of which is time intensive. Several staff commented on the difficulty they face in providing support for these homeless families using a strengths-based approach:

Women need to be met "where they're at," and then provided the right level and type of supports to help them get "where they're going."

"We're modeling how to advocate for herself. For many women this is the first time they've been taken seriously."

Trauma-Sensitive

A majority of homeless mothers have experienced trauma and interpersonal violence; statistics indicate two-thirds of homeless women report serious physical assault by a partner, two-thirds experienced severe physical abuse as a child, usually by an adult caretaker, and 40% were sexually molested by age 12. (Homeless Families Program Overview, SAMHSA) And, because women head the large majority of homeless families, it is important to address the consequences of these experiences if any treatment is to be successful. WHFP staff consider substance use among these homeless mothers "*a natural reaction to the trauma they've endured*" and, "*many of the moms [with substance use disorders] are self-medicating trauma.*" Many trauma survivors suffer from physical problems, and often seek help first in medical settings. As such, "*The health clinician may be the first caregiver to make connections between traumatic experiences and physical symptoms, such as chronic pain, for the client.*" (SAMHSA grant narrative) A clinician who understands that victims of violence often seek care for physical complaints and can be re-traumatized during routine health care practices may play an important role, not only in avoiding re-traumatization via intrusive procedures or unnecessary medical testing, but also in providing care, educating women, and building trusting and safe relationships. Homeless mothers who have established relationships with clinicians or other staff at WHFP are invited to participate in an ATRIUM group (described below) to further address trauma-specific concerns.

ATRIUM – “Addiction and Trauma Recovery Integration Model”

The ATRIUM curriculum is a 12-week (one 90-minute session/week) curriculum developed for women who have been sexually abused and have developed addictions - primarily, but not necessarily, substance abuse addictions. The curriculum was developed as a collaborative effort by consumer/survivor experience as well as professional expertise. (It is based on Dusty Miller’s *Trauma Reenactment Model*, published in 1994.) The model is based on the idea that the survivor is affected by trauma at three levels: the body, the mind, and the spirit, and so should be assessed and intervened at all of those levels. Psychoeducational, process, and expressive activities in the protocol are “structured to address key issues linked to trauma and addiction experiences, such as anxiety, sexuality/touch, self-harm, depression, anger, physical complaints and ailments, sleep difficulty, relationship challenges and spiritual disconnection.” (Miller) Participants are given information on the effects of trauma to the body, mind, and spirit, and are introduced to new ways of thinking about self-care and self-expression. Two of the WHFP staff, one of whom is bi-lingual in Spanish, recently attended a training in this model and ran an ATRIUM group with five homeless women in the program. They found the results “powerful”, saying the women had perfect attendance and did not want the program to end; staff were impressed at how readily the mothers were able to implement what they had learned in the groups.

Shelter- and Home-Based Services

Family Advocates, mental health clinicians, and the Outreach Nurse provide home-based or shelter outreach services to families, as well as advocacy in schools and courts. These services are considered critical to the success homeless families have in maintaining positive changes in their lives. As explained in the grant application: “Home visits are essential to continuity of care for these families, and to combat the isolation many mothers experience when they move from shelter into independent housing.” All follow-up home-based services are tailored to the needs of individual families.

Working with Immigrant Populations

Languages spoken by staff at the Family Health Center include: English, Spanish, Vietnamese, Khmer, Albanian, and Russian. WHFP Family Advocates are required to be bicultural/bilingual. The ability to offer services in a client’s first language and with an understanding of her culture is key to building a trusting relationship and making treatment effective. One example of this was given by a Family Advocate, who noted that an understanding of Latina women’s perception of various types of helpers, e.g., “psychologists,” was key in both describing the roles and benefits of meeting with various providers, as well as engaging mothers in treatment.

Nursing and Care Management

The addition of a nurse experienced with working with homeless populations has proven invaluable to the Program. The nurse coordinates all of the medical aspects of the family’s needs and conducts regular outreach to shelters, homes, and the schools. The nurse implements care management protocols which have been developed to guide the systematic support and monitoring of adults and children with MH problems. For example, one advantage to this approach is that the Nurse can make rapid changes to psychiatric medications if clients stop using them due to undesirable side effects.

APPENDIX A: INVITATION FOR CASE STUDY PROGRAM NOMINATIONS

A SPECIAL INVITATION

The National Health Care for the Homeless Council and HCH Clinicians' Network are collecting information and examples from the HCH field about "model" substance abuse treatment programs for people experiencing homelessness.

We invite you to nominate any substance abuse program that might be appropriate for this study. We will ask the programs selected to participate to provide documentation about their programs and to allow key personnel to participate in interviews. Interview topics will include treatment model selection, program nuts and bolts, resources, engaging and retaining strategies, defining success and effectiveness, and research.

The document to be developed and subsequently distributed to the field will serve as a companion to the recently published literature review "Substance Abuse Treatment: What Works for Homeless People?" which is available online at www.nhchc.org. Key findings from the literature will be "translated" into identifying the principles and practices that make substance abuse treatment effective in HCH settings. Our goal is to produce a practical, easy-to-use resource guide for projects seeking to improve care for homeless people with substance use disorders.

If you have any questions about this project, please contact project managers Suzanne Zerger at szerger@nhchc.org or 505 281-2770 or Ken Kraybill at kkraybill@nhchc.org or 206 296-4493.

Please let us know of any programs you would like to nominate by **Monday, September 30**. Be sure to include contact information for somebody working in the program.

Thank you,

John Lozier, Executive Director
National Health Care for the Homeless Council, Inc.

Brenda Proffitt, Director
Health Care for the Homeless Clinicians' Network

Elizabeth Marlow, Chairperson
Translating Research Into Practice Subcommittee

APPENDIX B: TOPICS OF INQUIRY AND QUESTIONS

TOPIC AREA	MEASURES/QUESTIONS
MODEL SELECTION	<p>Q: Have any formal assessments or surveys been done to assess the needs of homeless persons in your community? (specify – and get copies of reports if applicable) What can you tell me about the homeless persons in your community?</p> <p>Q: How was/were the current treatment and recovery model(s) for your program selected? (Include information about selection process for targeted treatment and recovery services specific to various subpopulations, e.g. gender-specific, families, youth, GLBT, dually diagnosed, HIV/AIDS & s.a.)</p>
PROGRAM SERVICES AND RESOURCES	<p>Q: Do you provide/do clients have access to opiate replacement therapies (methadone, LAAM)?</p> <p>Q: Does your program provide services at needle exchange sites (provided sites exist in the community)?</p> <p><u>Collaborations</u></p> <p>Q: Please describe your program’s direct involvement and/or collaborations in these areas (specify which are directly provided vs. via collaborations?).</p> <ul style="list-style-type: none"> • Outreach (Who does it? Where does it happen? What services provided? How interfaces with other aspects of treatment?) • Public inebriate program/sobering • Detoxification (Availability of social detox model? Medical detox model?) • Short-term residential/outpatient treatment (Modified therapeutic communities, hospital-based inpatient, intensive outpatient, day treatment, case management, contingency management interventions, brief interventions) • Extended rehabilitation • Transitional housing • Permanent housing/permanent supported housing <p>Q: How has your program gone about establishing and maintaining collaborative relationships? (including contracts, interagency agreements, etc.)</p> <p>Q: How well do these collaborations work? What are the keys to effective collaborations in your experience?</p> <p>Q: To what extent is your program representative of a linkage-based model vs. an integrated model of care? What do you see as the benefits and downsides of both models?</p> <p><u>Financial</u></p> <p>Q: What are the financial resources that support your program? Adequacy of financial resources? What works well? What’s needed?</p> <p>Collect copies of budgets and grant applications if respondent is willing.</p> <p><u>Staffing</u></p> <p>Q: Describe the staff employed in the program in terms of their titles, disciplines, and level of education or training.</p> <p>Q: To what extent do you think practitioners’ personal manner and interaction style influences client engagement, retention, and/or “success” in treatment?</p> <p>Q: What personal and interpersonal characteristics do you think are the most important to client “success”?</p>

	<p>Q: When hiring new provider staff, what do you look for? (Discuss importance of personal manner and interaction style in comparison to other factors such as education, training, experience, diversity variables.)</p> <p>Q: What is your perspective and practice on hiring staff who are formerly homeless and in recovery?</p> <p><i>General</i></p> <p>Q: How many clients on average is your program able to serve at any given time? Do you track the number of clients you have to turn away?</p> <p>Q: What are the key resource gaps in your ability to deliver more effective s.a. treatment?</p>
<p>ENGAGING AND RETAINING STRATEGIES</p>	<p>Q: What strategies does your program use to engage clients into treatment and recovery? Which do you consider the most effective – and why? (Ask for opinions about each of the following strategies, if not already discussed.)</p> <p style="padding-left: 40px;">Outreach Housing/Practical Assistance Safe, Non-Threatening Environment Strategies that Increase Motivation (e.g. motivational interviewing/motivational enhancement) Family-Based Treatment Engagement Strategy: (client and primary caretakers are engaged separately by the provider using motivating factors appropriate to context of families’ lives and to the developmental position of the client) Peer Leadership/Involvement</p> <p>Q: If I were a homeless person who came to your program for the first time seeking help for s.a., what steps would I go through initially?</p> <p>Q: What strategies does your program use to try to retain clients in treatment (can be broken down into various stages of treatment and recovery)? Which do you consider the most effective – and why?</p>
<p>DEFINING SUCCESS and EFFECTIVENESS</p>	<p>Q: How does/do your s.a. treatment and recovery program(s) define “success?” (Get copies of mission statements or stated goals)</p> <p>Q: How do you define “success” for the clients in your program? (Compare with program’s definition of success and discuss differences)</p> <p>Q: How do you try to determine the effectiveness of your program? (probe for specific measures or mechanisms)</p> <p>Q: What parts of the program are most effective?</p> <p>Q: What aspects of the program are least effective?</p> <p>Q: What changes would you make in order for your s.a. program to be more effective?</p> <p>Q: Does your program attempt to follow-up on clients who have transitioned to other services? (If yes, please describe.)</p> <p>Q: What are the <u>unique elements</u> of your s.a. program for homeless people compared to “mainstream” services for non-homeless individuals? (Include program-specific elements as well as approaches to care.) How does your program implement these homeless-specific elements?</p> <p>Q: To what degree do your program goals endorse: (Ask for % rating in addition to description)</p> <ul style="list-style-type: none"> • Medical model of treatment? • Non-medical or social model of treatment? • Abstinence-based or “zero tolerance” approach?

	<ul style="list-style-type: none"> • Harm or risk reduction approach? • Self-help and peer-support such as 12-step approach? <p>Q: From your perspective, how would you rate the following areas in terms of importance:</p> <ul style="list-style-type: none"> Complete sobriety and abstinence Graduation from the treatment program Attainment of life skills objectives, such as sobriety, employment, enrollment in school, ability to handle money, and housing Change in personal attitude or behavior Interpersonal improvements in terms of better relationships with family and friends Ability to cope with problems and stress <p>What, if anything, is missing from this list?</p> <p>Q: Please give an example of a “success story” of a client who has received services over most of the stages of the treatment and recovery continuum in your program? Describe (change name and any identifying details)</p>
RESEARCH	<p>Q: Has your program been involved in conducting and/or participating in research efforts? (describe)</p> <p>Q: To what extent – if at all – does/has your program use(d) published research to develop and/or modify your program model(s)?</p>