Harm Reduction Housing

A “Housing First” Approach to Ending Homelessness
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Midwest Harm Reduction Institute

• Increase understanding of the harm reduction philosophy
• Build the skills necessary to implement harm reduction strategies
• Strengthen harm reduction leadership across a diversity of disciplines and communities
• Develop an awareness of the attitudes that contribute to discrimination against drug users and other marginalized groups.
Harm Reduction

- People marginalized by high-risk behaviors have the right to access a continuum of service options and strategies that include outcomes such as reduced harm experienced, abstinence, and enhanced quality of life. The philosophy of harm reduction recognizes the resilience of people who engage in these behaviors and aims to reduce stigma associated with them. Harm reduction does not promote or enable harmful behaviors, or protect individual participants from experiencing the consequences of the choices they make.
Harm Reduction and Abstinence

- Harm reduction and abstinence are highly congruent goals.
- Harm reduction expands the therapeutic conversation, allowing providers to intervene with active users who are not yet contemplating abstinence.
- Harm reduction strategies can be used at any phase in the change process.
What Harm Reduction Is Not…

- Neither for or against drug use
- Tacit consent to use drugs
- “Don’t ask, don’t tell”
- “Trojan horse” for drug legalization
- “Anything goes”
- Anti-abstinence
Housing First

• Based on the belief that housing is a basic right
• Values consumer choice
• Addresses needs from the consumer’s perspective
• Homelessness is the only condition for gaining access to housing
• Housing is the foundation on which the process of recovery can begin
Is It Harm Reduction Housing?

- Are active drug users and those who engage in other high-risk behaviors served?
- Is participant feedback sought and valued?
- Who sets the goals of the interventions?
- Are workers and participants seen as equals?
- How is risk-related harm addressed?
- How are workers supported by the agency?
Successfully Housing Active Substance Users: Readiness

• Continuum of housing options—including abstinence-based—that makes room for everyone

• Leadership: a commitment to work with funders, government, neighbors, staff, and consumers to address issues openly and directly
Successfully Housing Active Substance Users: Process

• Involve consumers, funders, staff, community members, government—in the development of housing and services

• Help stakeholders see what’s in it for them through participation in community-based forums, marketing, and follow-up
Successfully Housing Active Substance Users: Implementation

• Learn from experiences of other harm reduction based housing projects
• Set goals and measure outcomes: if it’s not working, make a change
• Maintain open lines of communication with all stakeholders
Successfully Housing Active Substance Users: Design

• Staff training in harm reduction including engagement, substance use management, and motivational interventions

• Involve consumers every step of the way through surveys, focus groups, interviews, and advisory councils

• Understand community- and funder-based limitations
Supporting Staff

• Clinical supervision
• Training: substance use management; motivational interviewing, violence prevention
• Access to clinical support in times of crisis
• Cell phones
Evaluating Effectiveness

*Progress Involves More than just Abstinence*

- Measures of hospitalization, emergency department use, and criminal justice involvement suggest “Housing First” projects help produce a decline in these areas.

- Measures of engagement, motivation, and progression through the stages of change.
Evaluating Effectiveness

• Goal Attainment Scale: measurement of individual success at meeting his or her self-defined goal.

• Consumer Satisfaction.

• Consumer Tenure: length of residency correlated with improved well-being.
Effectiveness

• 225 homeless individuals with co-occurring disorders randomly assigned to housing contingent on treatment participation (control) or housing without treatment prerequisites (experimental).

• Interviews conducted every six months for 24 months.
Effectiveness

- Experimental group obtained housing earlier, remained stably housed, and reported higher perceived self-determination.

- Though utilization of substance use treatment was significantly higher for the control group, no difference was found in substance use or psychiatric symptoms.
Effectiveness

- A review of research related to 13 harm reduction based housing projects in Canada, the U.S., and the U.K. found a harm reduction approach combined with supportive housing is an effective way to address the needs of homeless individuals who use substances.
Effectiveness

• The literature suggested that treatment for homeless people with substance use issues requires comprehensive, highly integrated, and client-centered services, as well as stable housing.

• Service flexibility and a focus on individual needs was associated with stable housing tenure.
Step-by-step Guide to Harm Reduction in Practice

Making contact → Meeting immediate survival needs → Engaging

Maximizing health potential

Meeting needs to reduce harm → Focus on consumers own needs and goals

Holistic needs assessment → Focus on consumers own needs and goals
We Practice Harm Reduction by:

- Offering a range of options and choices to facilitate positive change
- Exploring the benefits of changing, reducing or eliminating high-risk behaviors
- Establishing and maintaining a relationship with participants who continue to engage in high-risk behaviors
- Defining and re-defining success with participants
We Practice Harm Reduction by:

• Helping participants build motivation
• Working with participants to develop adaptive coping strategies
• Being non-judgmental and providing balanced, factual information
• Recognizing decision-making power rests with the participant
Best Practices

• Balance the practice of harm reduction between the needs of individual, family, community and organization.

• Offer objective, factual information, both positive and negative, in the context of educating regarding choices and decision-making.

• Clarify consequences of choices, both positive and negative.
Best Practices

• Build policies and practices around safety issues and participant functioning – focus on expectations and responsibilities rather than rules.

• Acknowledge change is hard, ambivalence is normal, and look for opportunities to build motivation to change.

• Celebrate collaboratively defined successes and identify lessons learned from setbacks.
Case Management Strategies

• Show client unconditional regard and caring. Acknowledge his or her intrinsic value.

• Be a real person. Let the client see you as you really are. Blank screens are for movie theaters.

• Don’t get caught up in the client’s urgency. Take your time, think, be rational.
Case Management Strategies

• Be a constant object. Always act the same way to a client.

• Set limits firmly, but not sadistically. Be consistent, setting the same limits. Control yourself; not your clients.

• Empower the client, don’t enable the client. The client is responsible for his or her own life. You are responsible for a process of intervention. The outcome is the client’s business.
Case Management Strategies

• Never take away defenses until client has a replacement defense or coping mechanism. Help client develop new coping skills and shore up previous ones.

• Don’t try to be a drug treatment expert if you aren’t one. Use client as a consultant.

• Explore your own issues about drug use.
Case Management Strategies

• Avoid pushing total abstinence from drug use unless client is so motivated. Set the table, offering as many opportunities for the client to reduce harms related to drug use. Provide options in a non-judgmental, non-coercive way. Any reduction in harm is a step in the right direction.
Case Management Strategies

• Positive reinforcement is more effective than negative reinforcement. Reward works better than punishment. Use incentives.

• Get good supervision and/or peer consultation on emotional responses and attitudes. Remember the client is the expert here, and you are a consultant to the client. Act out of a place of humility.
Case Management Strategies

• Remember you are the client’s consultant, not his or her parent. Don’t be parental. We have mothers, fathers and significant others for that.

• The agenda belongs to the client and is a collaboration and exchange between the client and the worker. The worker facilitates the agenda with the client, the worker does not implement it on the client.
Case Management Strategies

• Consider your client’s relationship with drugs, the positives and the negatives, rather than judging drug use itself (licit or illicit) as good or bad. Focus on behaviors.

• Quality of life and well being are criteria for measuring success; not reduction in the consumption of drugs.
“HOUSING IS A RIGHT NOT A PRIVILEGE”
References

