

Literature Review:

Examining Harm Reduction Approaches for Alcoholism within the Chronically Homeless

Population

Examining Harm Reduction Approaches for Alcoholism:

Introduction

Homelessness is an issue that impacts 500,000 American lives on an average night (The Council of Economic Advisers, 2019, p. 2). These individuals are often in difficult and complex situations (The Council of Economic Advisers, 2019, p. 1). Often, these complex situations may include severe mental illness accompanied by a substance use disorder (The Council of Economic Advisers, 2019, p. 1). Unfortunately, many of the systems in place to treat these illnesses are failing this population; making homelessness difficult to resolve (The Council of Economic Advisers, 2019, p. 2).

Literature Review

In an effort to better treat the homeless population, harm reduction approaches have been introduced. In its most basic form, harm reduction is an effort to reduce any sort of harm (Logan and Marlatt, 2010, p. 202). The purpose of this literature review is to explore the effectiveness of harm reduction strategies and programs related to alcoholism within the chronically homeless population. Some of the strategies being discussed include managed alcohol programs, housing first, naltrexone, and motivational interviewing.

History of Harm Reduction

As a tool to combat the HIV epidemic, harm reduction was first developed in Europe (Denning, 2000, p. 33). A large contributor to the HIV epidemic was the use of needles by those suffering from substance abuse disorders who used intravenously; a solution to this is what is now known as needle exchange (Denning, 2000, p. 33). Harm reduction became a set of strategies used to help combat this public health crisis by reducing the harms associated (Denning, 2000, p. 33). Instead of focusing on abstinence, harm reduction focuses on safer

practices such as needle exchange programs, controlled drinking strategies, instructions on drug use, vein care, and other informative practices (Denning, 2000, p. 33). Many programs offer informative teachings and care, but the difference is harm reduction does not require abstinence from the use of substances (Denning, 2000, p. 34). This allows these individuals to access this care and encourages them to become informed before sobriety, that is often times forced upon them (Denning, 2000, p. 34). In addition, this type of strategy recognizes that the drug use may not be the most problematic problem an individual is facing (Denning, 2000, p. 35). It allows freedom for the person that is abusing substances to decide which pressing matter is most important (Denning, 2000, p. 35).

Due to the success harm reduction had on the HIV epidemic, harm reduction strategies and treatment approaches have become increasingly popular amongst the homeless population (Henwood et al., 2014, p. 81). Abstinence-based therapies do not take into consideration dual diagnosed clients, whereas harm reduction provides these individuals a treatment strategy that allows them to choose which issue is the most severe and needs to be dealt with first (Henwood et al., 2014, p. 80). Popularity of harm reduction treatment arose after the “housing first” gained traction within homeless services (Henwood et al., 2014, p. 81). Housing first allows individuals suffering from homelessness to go directly into permanent housing, instead of “earning” permanent housing through abstinence of drug and alcohol, a model used by other treatment approaches (Henwood et al., 2014, p. 81). Housing first eliminates the connection between treatment and housing; treatment services are still offered in these programs, but is not dependent upon sobriety (Henwood et al., 2014, p. 81). This strategy could potentially be an answer to those suffering from chronic illness accompanied by serious mental illness that use substances to “self-medicate” (Henwood et al., 2014, p. 81).

Substance Use Disorders

Substance use disorders are extremely common within this population (Bentler et al., 2013, p. 374). According to the National Institute of Drug Abuse, “Addiction is a chronic disease characterized by drug seeking and use that is compulsive, or difficult to control, despite harmful consequences” (2018). In 2007, about 53 percent of the homeless population had a substance use disorder diagnosis compared to the overall United States population only reporting nine percent (Bentler et al., 2013, p. 374). These percentages only increase with the chronically homeless population, it estimated to be about 80 percent (Bentler et al., 2013, p. 375). Another issue that arises from the prevalence of substance use disorders are the rates of overdoses, and overdose deaths (Bauer et al., 2016, p. 846). It is no surprise that overdose deaths are common among the general population, it is one of the leading causes of injury-related deaths (Bauer et al., p. 1). This prevalence is only increased with the homeless population (Bauer et al., p. 846). According to Bauer et al, “In a study of 28,033 adults seen at Boston Health Care for the Homeless Program (BHCHP) in 2003– 2008, drug overdose caused one in three deaths among those under the age of 45 years, a death rate 16 to 24 times higher than in the Massachusetts general population” (2016, p. 846; Boston Health Care for the Homeless Program, n.d.). With the overwhelming prevalence of substance use disorders as well as overdoses and overdose deaths, interventions to these issues may have a large impact on public health and emergency services (Bauer et al., 2016, p. 847).

Health Crisis

Another issue that surfaces when discussing substance use within the homeless population is the increasing health crisis. An example is the rate of infectious diseases such as HIV, Hepatitis, and others (National Institute on Drug Abuse, 2020). Infectious diseases are the

most common diseases associated with drug use but some other health issues that may increase from use include cancer, respiratory issues, cardiovascular diseases, kidney damage, and more (National Institute on Drug Abuse, 2020). It is also important to note that drug use can create changes in the brain, both short-term and long-term (National Institute on Drug Abuse, 2020). Which could potentially lead to the prevalence of severe, and oftentimes untreated, mental illness (Bentler, 2013, p. 375). One of the many barriers between the chronically homeless and stable housing.

In addition to these housing barriers, there are the many when it comes to access to health care. Which in turn results in the overuse of publicly funded emergency services (Larimer et al., 2009, p. 1349). Larimer et al., suggests the cost of spending from these frequent publicly funded health and criminal justice services is nearly equal to the cost it would be to house these individuals (2009, p. 1349). A study done at a housing first program in Seattle, Washington aimed to test this theory (Larimer et al., 2009, p. 1350). This study showed public cost and alcohol use data from individuals being housed compared to wait-list controls (Larimer et al., 2009, p. 1350). The residents being housed had access to on-site health care services, daily meals, and on-site case managers but no requirements for treatment (Larimer et al., 2009, p. 1350). Data was collected on both the housed group and the control group one year prior to the intervention and then again after six months (Larimer et al., 2009, p. 1350). After six months, the difference of public cost is astounding. “Housed participants had \$3569 less cost per month during the housed period relative to control participants” (Larimer et al., 2009, p. 1353). According to Larimer et al., there was also a two percent decrease each month in the average number of daily drinks for the housed individuals (Larimer et al., 2009, p. 1355). These results suggest housing first may be a solution to the frequent use of publicly funded services.

Chronic Homelessness

To dive deeper into the specific population being discussed throughout this paper, chronic homelessness can be defined as, “Chronic homelessness is used to describe people who have experienced homelessness for at least a year — or repeatedly — while struggling with a disabling condition such as a serious mental illness, substance use disorder, or physical disability” (“Chronically Homeless,” 2020). Unfortunately, about 24 percent of the overall homeless population in the US can be defined as chronically homeless (“Chronically Homeless,” 2020). The combination of these can pose difficult circumstances that make it extremely difficult to find and sustain stable housing if there are not adequate support systems in place (The Council of Economic Advisers, 2019, p. 2).

Alcohol Use Disorder

In addition to chronic homelessness being the targeted population being discussed, those accompanied with an alcohol use disorder will be discussed as well. The National Institute on Alcohol Abuse and Alcoholism define alcohol use disorder as “a chronic relapsing brain disorder characterized by an impaired ability to stop or control alcohol use despite adverse social, occupational, or health consequences (Alcohol Use Disorder, 2020, para. 1). About six percent of the United States adult population meets the diagnostic and statistical manual of mental disorders criteria for dependence and alcohol abuse within the past year (Chen, et al., 2019, p. 102). In comparison, about 80 percent of chronically homeless individuals report substance abuse problems (Bentler et al., 2014, p. 375). This statistics shows the severity of this issue within this population.

The homeless population suffers from a higher percentage of alcoholism for both men and women compared to the general population (Pauly et al., 2016, p. 2). Alcohol use in excess already poses adverse health risks but unfortunately, due to the prevalence of non-beverage alcohol consumption among this population, such as mouthwash, hand sanitizer, and rubbing alcohol, the harmful effects are more severe and common (Pauly et al., 2016, p. 2). Along with the negative effect's alcoholism presents, there are other harms this population faces such as violence, severe weather conditions, disease, and even death due to the lack of stable housing (Pauly et al., 2016, p. 2).

Excessive alcohol use has a large impact on mortality, cost, and morbidity within the United States (Chen, et al., 2019, p. 102). According to Collins, alcohol mortality and socioeconomic status have a strong correlation (2016, p. 86). Data on about 133 million individuals all over the world shows an increased risk of alcohol-related death of 78 percent in women and 66 percent in men in lower socioeconomic statuses (Collins, 2016, p. 86). Even with this knowledge regarding the negative effects and prevalence, the number of people in treatment is less than one third (Chen, et al., 2019, p. 102). This number is even more decreased when talking about medication remedies to alcohol use disorders (Chen, et al., 2019, p. 102). According to Chen et al., this may be due to health care providers not being fully educated on the effectiveness of these drugs and also poor medication regimens within this population (Chen, et al., 2019, p. 103).

It is important to note that with the chronically homeless population, abstinent based programs are ineffective (Clifasefi et al., 2016 p. 90). In fact, this population has attended, on average, 16 abstinence-based treatments (Clifasefi et al., 2016 p. 90). This is a significant number of attempts at treatment. According to Clifasefi et al., this is because these treatments are

not engaging for this population nor do they meet their recovery goals (Clifasefi et al., 2016 p. 90). Often, this population is more interested in reducing harm and consumptions rather than going completely abstinent (Clifasefi et al., 2016 p. 90).

Programs That Follow the Harm Reduction Model

Managed Alcohol Programs

Managed alcohol programs, also shortened to MAPs, is a harm reduction strategy used to combat alcoholism within the homeless population (Pauly et al., 2016, p. 2). These programs provide regulated amounts of alcohol to the participants in a shelter setting, typically (Pauly et al., 2016, p. 2). In addition to this, these programs may also offer health care, counseling, food, life skills training, and more (Pauly et al., 2016, p. 2). This program reduces a multitude of harms but one it is known for is the reduction of consumption of non-beverage alcohol such as mouthwash, hand sanitizer, and rubbing alcohol (Pauly et al., 2016, p. 2). Not only are these forms of alcohol damaging to the physical body, it also creates further barriers to receiving housing (Pauly et al., 2016, p. 2). Receiving regulated amounts of known quality alcohol helps these individuals manage drinking patterns (Pauly et al., 2016, p. 2). Regulation of alcohol consumption and reduction of non-beverage alcohol consumption are not the only reduces of harm MAP can provide (Evans et al., 2015, p. 118). Other harm reductions may include reduction of police encounters, emergency room visits, as well as improvements in keeping up with medical care and hygiene (Evans et al., 2015, p. 119).

Many forms of harm reduction strategies are criticized heavily. A pilot study done at the Kwaie Kii Centre in Thunder Bay, Ontario examines how a managed alcohol program may change drinking patterns and reduce harm (Pauly et al., 2016, p. 2). The managed alcohol

program being evaluated in this study is a 15 bed, mixed gendered facility (Pauly et al., 2016, p. 2). It was built in an effort to combat the community harms related to public intoxication, homelessness, and non-beverage consumption (Pauly et al., 2016, p. 2). Within this facility, residents can obtain one alcoholic drink in 90-minute intervals from 8am to 11pm (Pauly et al., 2016, p. 3). In addition to known quality alcoholic drinks residents also receive food, housing, counseling, skills training, and health care (Pauly et al., 2016, p. 3). Requirements to be chosen for this program include chronic homelessness, an alcohol use disorder, and a large amount of encounters with the police (Pauly et al., 2016, p. 3).

This particular study used a mixed methods design, qualitative interviews to develop a better understanding of participants experience as well as quantitative data to better grasp the effectiveness of the program (Pauly et al., 2016, p. 3). In addition, this study also had a control group that consisted of individuals of mixed gender as well and were residing in the shelter next door to the MAP program (Pauly et al., 2016, p. 3). This shelter provided meals throughout the day, housing, and limited transportation. (Pauly et al., 2016, p. 3). Residents in the shelter were required to leave during the day if weather permitted but residents in the MAP program were allowed to stay in (Pauly et al., 2016, p. 3). In addition, this study used quantitative surveys, liver function tests, alcohol consumption records, healthcare and police records, and qualitative interviews as their measures in the study (Pauly et al., 2016, p. 4).

Of the self-reported non-beverage alcohol consumption, it showed individuals in the program reported significant fewer days of non-beverage alcohol consumption compared to the control group (Pauly et al., 2016, p. 6). In addition, during the qualitative interviews, program participants reported a desire to not consume non beverage alcohol (Pauly et al., 2016, p. 6). It is important to note that these individuals could easily have access to non-beverage alcohol but

more often than not, would choose the wine provided by the MAP (Pauly et al., 2016, p. 6). Of the self-reported alcohol-related harms survey, participants reported fewer harms compared to the controls, although not significant (Pauly et al., 2016, p. 6). These harms include withdrawal seizures, housing status, and legal troubles (Pauly et al., 2016, p. 6). Overall, the results of this study showed a positive impact of managed alcohol programs within the homeless population.

Another study done by Evans et al, explores the relationship between place and the process to healing, following a “enabling places” framework (Evans et al., 2015, p. 119). This framework is used to provide an explanation of how the process of recovery can be affected by the place in which recovery occurs (Evans et al., 2015, p. 119). MAP programs provide the connections needed to advance individual’s identity, social connection, and purpose (Evans et al., 2015, p. 119). This study aimed to prove that not only do MAP programs work because of the reduction of harm related to excessive alcohol consumption but also because they provide a supportive space for recovery (Evans et al., 2015, p. 119). Evans et al. chose 10 men from a MAP facility in Ontario, Canada to interview for the study (Evans et al., 2015, p. 119). From these interviews three distinct actor-networks can be identified: self-management, togetherness, and awareness (Evans et al., 2015, p. 120). Regarding self-management, participants reported a sense of control over their drinking due to the program giving out hourly doses (Evans et al., 2015, p. 222). Unfortunately, this may have a negative effect as well. Some reported feeling fear that they would not be capable of following a routine dosage outside of the facility; possible return to previous habits of heavy drinking (Evans et al., 2015, p. 222).

Another thing noted in this research is the sense of togetherness the participants felt while in the MAP (Evans et al., 2015, p. 121). Some of them even reported knowing each other from the streets prior to coming to the MAP which allowed them to feel more comfortable and

welcomed (Evans et al., 2015, p. 121). In addition, many felt a sense of commonality between participants which also aided in those feelings of togetherness (Evans et al., 2015, p. 121). Another factor that contributed to these feelings were the support workers (Evans et al., 2015, p. 121). These workers complete a plethora of tasks such as listening empathetically, assisting in daily living activities, de-escalation, and more (Evans et al., 2015, p. 121). It comes to no surprise that these workers contributed to the overall feeling of togetherness for these participants. Lastly, awareness of the harms alcohol has on the physical body had a large impact (Evans et al., 2015, p. 122). The physicians within the program did regular liver function tests and blood screenings (Evans et al., 2015, p. 122). The results from these tests showed the damage done from years of heavy drinking as well as educated the participants on signs of liver failure (Evans et al., 2015, p. 122). Multiple noted they did not have this previous knowledge and this realization “scared” them (Evans et al., 2015, p. 122).

Housing First

Housing first is another approach that aligns with harm reduction (Andrasik et al., 2011, p. 111). This approach is not abstinence-based, meaning the individual does not have to be clean of substances to be in a program nor to receive housing (Andrasik et al., 2011, p. 111). Also, this approach allows everyone, regardless of history of substance abuse, mental illness, and number of years on the streets the ability to obtain housing (Housing First In Permanent Supportive Housing, 2014, pg. 1). According to the HUD exchange, a platform used for providing information on programs combating homelessness, notes these as key factors of housing first: quick access to housing, easily obtainable admission policies, slim to none prerequisites, supportive services available but not required, full rights and legal protections given to the tenant, prevents evictions, and works well with any type of housing model (Housing First In

Permanent Supportive Housing, 2014, p. 1-2). With these set of principles, housing first for the homeless population creates an avenue that makes housing easily obtainable compared to alternative routes.

There are two types of housing first approaches, scattered-site HF approach and project-based HF (Andrasik et al., 2011, p. 112). In this review, project-based hf, will be the primary housing first approach being evaluated (Andrasik et al., 2011, p. 112). With project-based hf, individuals are in single units within a single housing project (Andrasik et al., 2011, p. 112). In these single housing project units, there is access to case-management, but it is not required nor is attendance of treatment (Andrasik et al., 2011, p. 112). In addition, there is no requirement to stay abstinent of drug or alcohol use and permanent, stable housing is provided (Andrasik et al., 2011, p. 112). These factors have led to the hypothesis that hf approach is one effective approach within the chronically homeless (Andrasik et al., 2011, p. 112).

In the study by Andrasik et al., qualitative data was collected with the goal to provide an accurate summary of alcohol's role in client's lives while in housing first programs (2011, p. 111). First, 90 percent of the individuals upon move in showed signs of alcohol dependence (Andrasik et al., 2011, p. 114). Additionally, many participants related alcohol to "medicine" because the withdrawals would result in severe sickness and alcohol was the only "cure" (Andrasik et al., 2011, p. 114). This also held true with psychiatric symptoms such as hearing voices, many individuals drank to "stop the voices" (Andrasik et al., 2011, p. 114). Another common observation from these qualitative studies was the sense of community drinking provided these individuals (Andrasik et al., 2011, p. 114). According to Andrasik et al., one resident said, "this is my family. all these alcoholics and whatever. That's my family. that's my

people.” (2011, p. 114). This resident chose to continue to reside in the project even though he achieved abstinence (Andrasik et al., 2011, p. 114).

This study effectively showed harm reductions within those individuals such as a sense of community, housing, counseling services, and more. A study done by Collins et al., takes this a step further and examines the hypothesis that housing first leads to an increase in alcohol use and related issues (2012, p. 512). This is a popular criticism to harm reduction strategies as a whole. In this study, participants suffered from chronic homelessness as well as alcohol problems (Collins et al., 2012, p. 512). This was a two-year study that included a 95-sample size, predominantly male, and ethnically diverse (Collins et al., 2012, p. 512). The results showed a significant decrease of alcohol-related issues as well as a decrease in alcohol dependence symptoms (Collins et al., 2012, p. 513-514). It also proved the enabling hypothesis to be inaccurate, alcohol use decreased about 7-8 percent every three months (Collins et al., 2012, p. 514). Over the two-year follow up, participants reported avoiding drinking to intoxication as well as a 65 percent to 23 percent decrease of DTs (Collins et al., 2012, p. 514). In conclusion, this study provided evidence to back the claim that harm reduction approaches do not increase alcohol use. (Collins et al., 2012, p. 518).

It is important to know housing first does not increase alcohol use, but also key to know how providers understand this approach as well. A report done in New York by Henwood et al. takes a look at the understanding of harm reduction versus abstinence in relation to homelessness amongst providers (2014, p. 82). This study was a longitudinal qualitative study that included 20 providers from a housing first program and 21 providers from other programs that focused on treatment first (Henwood et al., 2014, p. 82). The results of this study showed three common themes: a welcomed alternative, working with ambiguity, and accommodating abstinence

(Henwood et al., 2014, p. 84-86). Housing first provider participants expressed a more honest, open relationship with their client but also feelings of not doing enough for the client (Henwood et al., 2014, p. 85 & 86). Whereas treatment first providers expressed a juggle between following/enforcing policies within the program such as mandatory rehab after a relapse or giving the client a second chance at the current program (Henwood et al., 2014, p. 86). Henwood et al. states, “Understanding harm reduction as existing on a continuum of practices tailored to individual needs and capabilities highlights the wide variation of situations that HF providers encounter within their day-to-day practice” (2014, p. 87). Applying this logic, allowing a client in a treatment first based program to have multiple chances at completing the program successfully, is a form of harm reduction. In conclusion, recovery is a individual journey, harm reduction strategies place the power of recovery in the individual experiencing it and shifts away from viewing addiction as a moral failing (Henwood et al., 2014, p. 87).

Naltrexone

As discussed previously, alcohol treatment by medication such as naltrexone is not a popular form of treatment for alcohol use disorders (Chen et al., 2019, p. 103). This is a result of many things but a main factor being patients’ inability to keep a steady regime in taking the medication (O-NTX) (Chen et al., 2019, p. 102.) A study done by Chen et al., compares oral naltrexone (O-NTX) to extended release naltrexone (XR-NTX) (Chen et al., 2019, p. 103). Extended release naltrexone is an injectable form of naltrexone to specifically combat the poor adherence to drug regimens (Chen et al., 2019, p. 103).

The study done by Chen et al., gathered participants from the Bellevue Hospital Center in New York City that met the criteria. (Chen et al., 2019, p. 103). This criterion included the following: alcohol use disorder, 18 years or older, informed consent, and a goal to get clean

(Chen et al., 2019, p. 103). Participants were then randomly chosen to receive either a one-month subscription of oral naltrexone or a single injection of extended release naltrexone (Chen et al., 2019, p. 105). The primary outcome of this study is based off a good clinical outcome (GCO) which means two or less heavy drinking incidents in four-week intervals (Chen et al., 2019, p. 105). In this study four drinks or more for women and five drinks or more for men is considered heavy drinking and one or more heavy drinking incidents in those four-week intervals would result in a “GCO failure” (Chen et al., 2019, p. 106). The results from this study XR-NTX (n=117) versus O-NTX (N=120) shows 12.5 percent of XR-NTX drank daily and 10.7 percent of the O-NTX also drank daily. Chen states, “In summary, the delivery of XR-NTX versus O-NTX using a Medical Management primary care treatment model offers an innovative and potentially cost-effective approach to reducing the burden of AUDs in primary care settings” (2019, p. 109).

A study done by V.S. Grazioli et al., accessed the overall effectiveness of extended release naltrexone along with harm reduction counseling amongst the chronically homeless population (2015, p. 64). Within this study, there were 31 participants who all were experiencing chronic homelessness along with alcohol dependence (V.S. Grazioli et al., 2015, p. 64). The results of this study showed three main changes: buffering the effects of alcohol on the body, changing of drinking patterns, and overall reduction of alcohol consumption (V.S. Grazioli et al., 2015, p. 66). Participants reported a desire to eat more and healthier, as well as consume liquids that were not alcohol such as water; all of which promotes harm reduction strategies (V.S. Grazioli et al., 2015, p. 66). In addition, one third of participants reported changing their drinking patterns to be less harmful as well as having increments of abstinence (V.S. Grazioli et al., 2015, p. 66). In conclusion, safer drinking strategies and harm reduction strategies such as extended

release naltrexone have a better chance at being accepted among the chronically homeless population (V.S. Grazioli et al., 2015, p. 67).

Motivational Interviewing

Motivational interviewing is a treatment and style of interviewing that follows the harm reduction approach to many different types of issues, but the focus will be on substance use disorders throughout this section (Denning, 2000, p. 51). MI is a great tool to assess where a client is at in terms of motivation, while other forms of practice have relied heavily on negative consequences such as “rock bottom” (Denning, 2000, p. 51). In addition, motivational interviewing is a patient-centered, nonjudgmental, and short-term form of therapy that allows the clinician to observe a client’s ambivalence and motivation for change (Satre et al., 2016, p. 572). With this form of therapy, it is the client’s responsibility to measure what behaviors “need” to be changed and explore their commitment to that change which is why it is a form of harm reduction (Satre et al., 2016, p. 572). Instead of forcing abstinence onto the patient like abstinent programs typically do, this form of treatment allows the client to make those decisions for themselves (Satre et al., 2016, p. 572). Due to this type of approach, it allows clients to feel they have control over their recovery and the addiction in general. (Satre et al., 2016, p. 572).

Individuals involved in this study were gathered from the Kaiser Permanente Southern Alameda Medical Center Departments of Psychiatry in Fremont, CA and Union City (Satre et al., 2016, p. 572). Participants chosen had to be 18 years or older, report hazardous drinking, and have diagnosed depression or experience depressive symptoms (Satre et al., 2016, p. 573). Hazardous drinking was based on the DSM-5 and participants completed a PHQ-9 questionnaire that is also based on the DSM criteria (Satre et al., 2016, p. 573). In this study, participants had to complete a 45-minute session of MI as well as two 15-minute sessions completed over the

phone (Satre et al., 2016, p. 573). The control group was given brochures on substance abuse (Satre et al., 2016, p. 573). Rates of PHQ-9 depression scores and hazardous drinking in the past 30 days were comparable at the initial start of the study between the control group and the MI group intervention (Satre et al., 2016, p. 576). Results from the study showed the MI group was less likely to report hazardous drinking at the six-month mark compared to the control (Satre et al., 2016, p. 576). It is also important to note that both groups showed decreases in hazardous drinking (Satre et al., 2016, p. 576).

As stated previously throughout this essay, individuals within the homeless population may develop a sense of community through alcohol use. Although this may be beneficial in some ways, D.P. Kennedy et al., reviewed the results of a pilot study that looked at the impacts of motivational interviewing social network intervention to reduce alcohol use within new housing first residents (2018, p. 36). Participants of this study included residents from the single room occupancy housing corporation and the skid row housing trust, both of which are in Los Angeles, California (D.P. Kennedy et al., 2018, p. 37). 49 participants met the criteria of the study and at random, were assigned usual care (control) or the motivational interviewing social interaction intervention (D.P. Kennedy et al., 2018, p. 37). The participants given the MI intervention met with a facilitator, every two weeks, for a total of four, 15 minutes sessions (D.P. Kennedy et al., 2018, p. 38). The remaining participants continued with the usual care (D.P. Kennedy et al., 2018, p. 38).

The results of this study show, readiness to change alcohol use and abstinence self-efficacy decreased with the control and increased within the MI intervention participants (D.P. Kennedy et al., 2018, p. 40). This also applies to the amount of binge drinking days and drinking quantity reported (D.P. Kennedy et al., 2018, p. 40). In conclusion, the results from this study

show a general, hopeful approach when using motivational interviewing techniques in reducing alcohol use and increasing the readiness to change among the homeless (D.P. Kennedy et al., 2018, p. 43).

Limitations

According to Des Jarlais, a large reason harm reduction strategies are controversial in the United States is due to the US federal government's push back despite scientific research and activism (Des Jarlais, 2017, p. 1). The United States has a long history of the condemning substance use as a moral failing (Des Jarlais, 2017, p. 2). Furthermore, another possible contributing factor is the stigmatization of minority groups (Des Jarlais, 2017, p. 2). For example, Mexican Americans and the use of marijuana or the use of cocaine by African Americans (Des Jarlais, 2017, p. 2). Unfortunately, due to this stigmatization and negative view of substance use, it led to a society that fears drugs, and the individuals that use them (Des Jarlais, 2017, p. 2). In addition to this overwhelmingly negative outlook on individuals with substance use, when harm reduction strategies began to gain traction as a possible solution, a lot of other issues involving drug use as well as HIV/AIDS started to arise. (Des Jarlais, 2017, p. 3). This included the spread of HIV in the US, Reagan's "just say no," and the crack cocaine epidemic (Des Jarlais, 2017, p. 2-3). This further demonized drug use and made it extremely hard for harm reduction strategies such as needle exchange to gain traction or favor by elected officials and the public (Des Jarlais, 2017, p. 3).

In addition to the negative attitudes the United States government and public has had toward individuals who use substances, there is also a major lack of services and support for harm reduction within rural America (Sanjay et al., 2019, p. 1988) The scope of this problem did not take hold among rural American until the HIV and hepatitis C virus outbreak in Scott

County, Indiana (Sanjay et al., 2019, p. 1988). In a way, this outbreak forced the Governor Mike Pence to implement a syringe-exchange program which was successful (Sanjay et al., 2019, p. 1988). Due to the success of this program, it awoken many activists, policymakers, epidemiologists, and more to the overall approach of harm reduction (Sanjay et al., 2019, p. 1988). In addition, this outbreak led to Congress overturning a ban previously made that prohibited the use of federal funding to go to syringe-exchange programs (Sanjay et al., 2019, p. 1988). Overall, the Scott County outbreak led to the start of a lot of changes in policy, attitude, and support (Sanjay et al., 2019, p. 1988).

Unfortunately, that was not the end of criticism toward harm reduction approaches (Sanjay et al., 2019, p. 1989). There is still a large portion of people that fear harm reduction goes against social order and encourages drug use (Sanjay et al., 2019, p. 1989). This attributes to the fact that despite what research shows, only 21 states have approved syringe-exchange programs (Sanjay et al., 2019, p. 1989). Many of the most vulnerable rural populations are experiencing, not only the apprehensiveness to harm reduction, but substance use care in general (Sanjay et al., 2019, p. 1989). This adds to the already abundant barriers people with substance use disorders in rural areas already face. Some of the known barriers include lack of funding, lack of available transportation, bureaucratic issues, and lack of interagency cooperation (Oser and Pullen, 2014, p. 893). One of the most notable barriers presented to rural communities is a lack of substance abuse treatment funding (Oser and Pullen, 2014, p. 894). Many substance abuse clinicians are being underpaid and overworked in rural communities which leads to an overall reduced success rate for those with substance use disorders (Oser and Pullen, 2014, p. 894).

Wyoming is not immune to some of the barriers that rural communities face. According to the Wyoming Department of Health, alcohol is the most commonly abused substance within the state (2018, p. 22). In 2016, Wyoming scored a 3.44 on a capacity report that measured available resources, workforce, communication, engagement of the community, leadership, sustainability, and readiness to change within each county (The Wyoming Department of Health, 2018, p. 20). 26 percent of Wyoming's counties scored below a 3.2 -- a score of three shows "some capacity" (The Wyoming Department of Health, 2018, p. 20-21). Overall, the general overview of the Wyoming Department of Health shows a large focus in prevention. This focus on prevention does not benefit Wyoming's homeless population, especially those who have been suffering from years of mental illness, substance use, and chronic homelessness. Leaving hundreds of Wyoming citizens falling through the cracks.

Conclusion

After reviewing the literature regarding harm reduction, it is evident it is an effective approach for reducing harm in those suffering from alcohol use disorder and chronic homelessness. In addition, there is emerging evidence that it has the potential to reduce alcohol use and consumption in this population as well. Overall, there is a lot to learn and more research to be done but harm reduction seems to be a step in the right direction in terms of substance use disorders.

References

- Alcohol Use Disorder. (2020, June 04). Retrieved from <https://www.niaaa.nih.gov/alcohol-health/overview-alcohol-consumption/alcohol-use-disorders>
- Andrasik, P., M., Clifasefi, L., S., Collins, E. S., Dana, A., E., Kirouac, M., King, M., Malone, K., D., Stahl, N., Welbaum, C. (2012). Where harm reduction meets housing first: Exploring alcohol's role in a project-based housing first setting. *International Journal of Drug Policy*, 23(2), 111-119. <https://doi.org/10.1016/j.drugpo.2011.07.010>.
- Babbie, E. (2015). *Empowerment series: Research methods for social work*. Boston, MA: Cengage Learning.
- Bauer, L. K., M.D., Brody, Jennifer K, M.D., M.P.H., León, C., MPH, & Baggett, Travis P, M.D., M.P.H. (2016). Characteristics of homeless adults who died of drug overdose: A retrospective record review. *Journal of Health Care for the Poor and Underserved*, 27(2), 846-859.
doi:<http://dx.doi.org.libproxy.uwyo.edu/10.1353/hpu.2016.0075>
- Bentler, M. P., Ibabe, I., Nyamathi, A., Stein, A., J. (2013). Predictors of substance abuse treatment participation among homeless adults. *Journal of Substance Abuse Treatment*, 46. <http://www.sciencedirect.com/science/article/pii/S0740547213002420>
- Bentler, M. Peter, Ibabe, Izaskun, Nvamathi, Adeline, & Stein A., Judith. (2014). Predictors of substance abuse treatment participation among homeless adults. *Journal of Substance Abuse Treatment*, 46(3). 374-381, <https://doi.org/10.1016/j.jsat.2013.10.008>.
- Bernadette (Bernie) Pauly, Gray, E., Perkin, K., Chow, C., Vallance, K., Krysovaty, B., & Stockwell, T. (2016). Finding safety: A pilot study of managed alcohol program

- participants perceptions of housing and quality of life. *Harm Reduction Journal*, 13 doi:<http://dx.doi.org.libproxy.uwyo.edu/10.1186/s12954-016-0102-5>
- Boston Health Care for the Homeless Program. (n.d.). Retrieved December 11, 2020, from <https://www.bhchp.org/>
- Chen, J., Garment, A., Gold, H., Goldfield, K., Kermack, A., Laska, E., Lee, J. D., Malone, M., McDonald, R., Obi, R., Rotrosen, J., Schatz, D., Tofighi, B., Vittitow, A. (2019). Extended-release vs. oral naltrexone for alcohol dependence treatment in primary care (XON), *Contemporary Clinical Trials*, Volume 81, Pages 102-109, ISSN 1551-7144, <http://www.sciencedirect.com/science/article/pii/S1551714418305627>
- Chronically Homeless*. (2020, January). National Alliance to End Homelessness. Retrieved from <https://endhomelessness.org/homelessness-in-america/who-experiences-homelessness/homeless/#:~:text=Chronic%20homelessness%20is%20used%20to,use%20disorder%2C%20or%20physical%20disability.>
- Collins S. E. (2016). Associations Between Socioeconomic Factors and Alcohol Outcomes. *Alcohol research : current reviews*, 38(1), 83–94.
- Collins, S. E., Malone, D. K., Clifasefi, S. L., Ginzler, J. A., Garner, M. D., Burlingham, B., Lonczak, H. S., Dana, E. A., Kirouac, M., Tanzer, K., Hobson, W. G., Marlatt, G. A., & Larimer, M. E. (2012). Project-based Housing First for chronically homeless individuals with alcohol problems: within-subjects analyses of 2-year alcohol trajectories. *American journal of public health*, 102(3), 511–519. <https://doi.org/10.2105/AJPH.2011.300403>
- Clifasefi S., Collins, S., Grazioli, V., Herndon P., Hawes, S., Holttum J., Hoffmann, G., Jones C., Kaese G., Lenert J., Mackelprang, J., Nelson L. (2016). In their own words: Content

analysis of pathways to recovery among individuals with the lived experience of homelessness and alcohol use disorders. *International Journal of Drug Policy*, 27, 89-96. <https://doi.org/10.1016/j.drugpo.2015.08.003>.

David P. Kennedy, Karen Chan Osilla, Sarah B. Hunter, Daniela Golinelli, Ervant Maksabedian Hernandez, Joan S. Tucker. (2018). A pilot test of a motivational interviewing social network intervention to reduce substance use among housing first residents, *Journal of Substance Abuse Treatment*, Volume 86, Pages 36-44, <https://doi.org/10.1016/j.jsat.2017.12.005>

Denning, Patt. 2000. *Practicing Harm Reduction Psychotherapy: An Alternative Approach to Addictions*. The Guilford Press.

Des Jarlais, D.C. Harm reduction in the USA: the research perspective and an archive to David Purchase. *Harm Reduct J* 14, 51 (2017). <https://doi.org/10.1186/s12954-017-0178-6>

Evans J., Lohfeld, L., Semogas, D., Lynne S. (2015). “This place has given me a reason to care”: Understanding ‘managed alcohol programs’ as enabling places in Canada, *Health & Place*, 33, 118-124. <https://doi.org/10.1016/j.healthplace.2015.02.011>.

Henwood, Benjamin F, PhD., M.S.W., Padgett, Deborah K, PhD., M.P.H., & Tiderington, E., M.S.W. (2014). Provider views of harm reduction versus abstinence policies within homeless services for dually diagnosed adults. *The Journal of Behavioral Health Services & Research*, 41(1), 80-9. doi:<http://dx.doi.org.libproxy.uwyo.edu/10.1007/s11414-013-9318-2>

Henwood, B.F., Padgett, D.K. & Tiderington, E. Provider Views of Harm Reduction Versus Abstinence Policies Within Homeless Services for Dually Diagnosed Adults. *J Behav*

Health Serv Res 41, 80–89 (2014). <https://doi-org.libproxy.uwyo.edu/10.1007/s11414-013-9318-2>

Larimer ME, Malone DK, Garner MD, et al. Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons With Severe Alcohol Problems. *JAMA*. 2009;301(13):1349–1357. doi:10.1001/jama.2009.414

Logan, D. E., & Marlatt, A. G. (2010, January). Harm reduction therapy: A practice-friendly review of research. Retrieved from <https://onlinelibrary-wiley-com.libproxy.uwyo.edu/doi/abs/10.1002/jclp.20669>

Mcquiston, H. L., Gorsroochurn, P., Hsu, E., Caton, C. L., & M. (2014). Risk factors associated with recurrent homelessness after a first homeless episode. *Community Mental Health Journal*, 50(5), 505-13. doi:<http://dx.doi.org.libproxy.uwyo.edu/10.1007/s10597-013-9608-4>

National Association of Social Workers. (2017). *Code of ethics of the National Association of Social Workers*. Retrieved from: <http://www.naswdc.org/pubs/code/code.asp>

National Institute on Drug Abuse. (n.d.). National Institute on Drug Abuse (NIDA). Retrieved October 08, 2020, from <https://www.drugabuse.gov/>

Pullen, E., & Oser, C. (2014). Barriers to Substance Abuse Treatment in Rural and Urban Communities: Counselor Perspectives. *Substance Use & Misuse*, 49(7), 891–901. <https://doi-org.libproxy.uwyo.edu/10.3109/10826084.2014.891615>

Sanjay, K., Hayden, M., & Rich, J. (2019). Lessons from scott county — progress or paralysis on harm reduction? *The New England Journal of Medicine*, 380(21), 1988-1990.

doi:<http://dx.doi.org.libproxy.uwyo.edu/10.1056/NEJMp1901276>

Satre, D. D., Leibowitz, A., Sterling, S. A., Lu, Y., Travis, A., & Weisner, C. (2016). A randomized clinical trial of Motivational Interviewing to reduce alcohol and drug use among patients with depression. *Journal of Consulting and Clinical Psychology*, 84(7), 571–579. <https://doi-org.libproxy.uwyo.edu/10.1037/ccp0000096>

The Council of Economic Advisers. (September 2019). *The State of Homelessness in America*. [PDF File]. <https://www.whitehouse.gov/wp-content/uploads/2019/09/The-State-of-Homelessness-in-America.pdf>

Véronique S. Grazioli, Jennifer Hicks, Greta Kaese, James Lenert, Susan E. Collins. (2015). Safer-Drinking Strategies Used by Chronically Homeless Individuals with Alcohol Dependence, *Journal of Substance Abuse Treatment*, Volume 54, 63-68, <https://doi.org/10.1016/j.jsat.2015.01.010>.

Wyoming Department of Health. (2018). *Wyoming Department of Health Alcohol Prevention Plan*. [PDF File]. <https://health.wyo.gov/wp-content/uploads/2018/07/Alcohol-State-Plan.pdf>

“What Is A Standard Drink?” (n.d.). National Institute on Alcohol Abuse and Alcoholism. Retrieved November 21, 2020 from <https://www.niaaa.nih.gov/alcohols-effects-health/overview-alcohol-consumption/what-standard-drink>