Non-Abstinence-Based Supportive Housing for Persons with Co-Occurring Disorders: A Human Rights Perspective

Rupert van Wormer & Katherine van Wormer

Social Work Department, University of Northern Iowa, Cedar Falls, Iowa, USA

Available online: 23 Nov 2009

To cite this article: Rupert van Wormer & Katherine van Wormer (2009): Non-Abstinence-Based Supportive Housing for Persons with Co-Occurring Disorders: A Human Rights Perspective, Journal of Progressive Human Services, 20:2, 152-165

To link to this article: http://dx.doi.org/10.1080/10428230903301394
Non-Abstinence-Based Supportive Housing for Persons with Co-Occurring Disorders: A Human Rights Perspective

RUPERT van WORMER and KATHERINE van WORMER
Social Work Department, University of Northern Iowa, Cedar Falls, Iowa, USA

Surveys of providers of social services in Portland, Oregon, in 2003 and 2007 revealed a significant policy shift in meeting the housing needs of chronically mentally ill, homeless persons with ongoing substance-abuse problems. The shift in policy, taking place in Portland, Seattle, Washington, Minneapolis, and other U.S. cities, from a sobriety-first requirement to a housing-first philosophy has occurred largely because of cost-effectiveness. Only when such housing is provided as a human right can we say that a true paradigm shift has occurred.

KEYWORDS human rights, homelessness, harm reduction, Portland, substance abuse

Quietly but surely, major cities across the United States are adopting pragmatic policies concerning chronically homeless people who have substance-abuse problems. The shift of which we are speaking is an approach that has moved from a punitive policy that consisted of providing housing to some homeless people under very restrictive conditions to the provision of housing in a harm-reduction model. The focus of this article is the crisis, in a capitalist society, that is evidenced by the conditions facing chronically homeless people who live under bridges and on the streets, on sidewalks, and in alleys and public shelters. This population consists of persons wrestling with serious mental and addiction disorders. A case study is presented that shows how one city—Portland, Oregon—was able to better meet the needs of chronically homeless persons as well as of the urban community.
through the adoption of more pragmatic approaches to dealing with this population.

The first portion of this paper chronicles the positive developments in urban housing that are taking place in Portland and other major cities across the United States. Interviews conducted in 2003 and again in 2007 inform this discussion of recent policy change. The changes that are taking place in Portland—the movement from a treatment-first, housing-later policy to a decision to provide housing first, regardless of continued alcohol and other drug use—can be viewed as a microcosm of changes that are taking place across the urban landscape. The shift in policy from a punitive to a pragmatic approach to chronic homelessness is endorsed by an increasing number of U.S. mayors and is being adopted with federal funding incentives. Although some conservative commentators have derided this as the “bunks for drunks” policy, proponents have couched their arguments in terms of cost-effectiveness and safety/sanitation issues.

The final portion of the paper considers the limitations of an exclusively economic approach to housing and argues that housing should be regarded not as a privilege or a reward for desirable behavior but as a fundamental human right.

Clients with co-occurring disorders are vulnerable to housing instability and homelessness because their illnesses commonly lead to erratic, agitated behaviors that result in eviction by landlords or family (Mueser, Noordsy, Drake, & Fox, 2003). According to the Substance Abuse and Mental Health Services Administration’s (SAMHSA) data concerning clients treated for substance-abuse problems in the United States, more than 175,000 admissions to substance-abuse treatment were homeless in 2004; the homeless composed 13% of all admissions, an increase from 10% in 2000 (SAMHSA, 2006). Alcohol was the primary substance of abuse. Although it is generally thought that the addiction causes the homelessness, it is probably the case that the stress caused by homelessness and the availability of alcohol and other drugs on the streets can cause or contribute to the addiction. We know this is true of the runaway and homeless teens (van Wormer & Davis, 2008).

Chronic homelessness is long-term or repeated homelessness accompanied by a disability. The federal government’s definition of chronic homelessness includes homeless individuals with a disabling condition (substance use disorder, serious mental illness, developmental disability, or chronic physical illness or disability) who have either (1) been homeless continuously for one whole year, or (2) been homeless four or more times in the past three years (National Alliance to End Homelessness, 2007). Nationally, about 18% of the homeless are chronically homeless people (Swarns, 2008).

As the homelessness crisis in the United States enters its third decade, few are as adversely affected as persons with both a serious mental illness and addiction problems. The prevalence of homelessness in persons with serious mental illness is 15%, according to research published in the American
Journal of Psychiatry by Folsom and colleagues (2005). These researchers argued for the cost-effectiveness of providing resources and treatment to this population in light of their extremely high hospitalization and incarceration rates.

Research by the Department of Housing and Urban Development (HUD) estimated that on any given day, more than 120,000 single adults with severe mental illness are homeless in the United States (Swarns, 2008). This figure actually represents a drop of around 30% from several years before; the drop is due to a shift in housing policy. (Data were collected before the recent national economic foreclosure crisis, however.) HUD’s focus is on financing housing for chronically homeless persons; tens of thousands of new units of supportive housing are constructed each year to get this population off the streets. Research has further shown that 57% of the U.S. homeless population report having had a mental health problem at some point during their lifetimes (Legander, 2006), and about one half of them have an alcohol and/or drug problem in addition to a mental disorder (SAMHSA, 2006).

Over the past decades, homeless adults with severe mental illness and co-occurring chemical dependency have become an increasingly visible part of most urban communities. The U.S. Conference of Mayors reported in 2008 that requests for emergency shelter assistance grew an average of 12% in the 25 cities, an increase attributed to the lack of affordable housing and the effect of the foreclosure crisis (HandsNet, 2008). Working families are increasingly at risk.

The overall homeless population is made up of people from a diversity of backgrounds, but people with mental illness who are from disadvantaged backgrounds are at greater risk of becoming homeless. Of the single-person homeless population, racial and ethnic minorities are over-represented, with an estimated 46% of this population being African-American, 24% white, 12.8% Hispanic, 2.5% Native American, and 1.6% Asian (U.S. Conference of Mayors, 2007). A press release from HUD reports the following demographic breakdown in a recent survey of a sample of all sheltered homeless people across the United States:

- Geographic: 77% are in central cities; 23% are in suburban and rural areas.
- Household Type: 70% are individuals; 30% are persons in families with children.
- Race: 64% are members of minorities.
- Gender: 69% of all sheltered homeless individuals are men.
- Age: 55% of all homeless individuals are 31 to 50 years old.
- Veteran Status: 13% of all sheltered homeless adults are veterans. (Sullivan, 2008, pp. 1–2).
Of course, a key factor in homelessness is the shortage of affordable housing for low-income people. In the past, single-room-occupancy housing sheltered many poor individuals, including poor persons suffering from addictive disorders. Much of this low-income housing was eliminated in the 1970s and 1980s, leaving isolated single adults with fewer housing options and therefore an increased chance of homelessness, especially people with co-occurring disorders.

Another factor that may have contributed to an increase in this subset of the homeless population was policy changes that wiped from the government roles persons who claimed disability by virtue of addiction problems. In 1996, the 104\textsuperscript{th} Congress declared people disabled because of drug or alcohol addiction ineligible for both disability insurance and Supplemental Security Income (SSI; Katz, 2001, p. 216). As a result, more than 100,000 chemically addicted people lost both their monthly SSI or SSDI (Social Security Disability Insurance) checks and the Medicaid or Medicare benefits included with these programs. Some of these individuals were eventually able to regain their benefits after being reassessed and determined to have a major mental illness.

SUPPORTIVE HOUSING

Permanent supportive housing, in its current form, is a relatively new intervention. In response to the growing and continuing problem of homelessness in the United States in the 1980s, the federal government, with bipartisan support, passed the Stewart B. McKinney Homeless Assistance Act of 1987 (U.S. Department of Housing and Urban Development, 2008). This act provides funding for a variety of housing-related projects that target homelessness, including emergency shelter, housing vouchers, and supportive housing. Subtitle C of this act authorized the creation of the Supportive Housing Program. Administered by HUD, this program is designed to develop supportive housing and services that will allow homeless persons to live as independently as possible (U.S. Department of Housing and Urban Development, 2008). This program currently funds supportive housing projects (both transitional and permanent) throughout the United States by providing annual noncompetitive grants for which states, local governments, and private nonprofit organizations can apply. There are no restrictions in this funding concerning whether the residents in the housing provided abstain from substance use.

A variety of supportive housing projects exist, but most of the current transitional and long-term supportive housing programs that provide services to persons with severe mental illness are abstinence-based (Mancini, Linhorst, Broderick & Bayliff, 2008). Some projects even require that applicants complete a detoxification program before entering the residence and that residents agree to be substance free while in the program (Bholai-Pareti &
R. van Wormer and K. van Wormer

Stem, 2002). Individuals who have co-occurring disorders have low completion rates in such programs (Mancini et al., 2008). Such individuals simply do not possess the behavioral and cognitive skills necessary to negotiate the strict rules and rigid demands of abstinence-based programs. Moreover, they lack support systems and external resources.

Given the high failure rates, why are so many of these projects abstinence based? The probable reason is tradition. Substance-abuse treatment in the United States has been and still is based on the principles of Alcoholics Anonymous, which advocate total abstinence for all alcoholics (van Wormer & Davis, 2008). Treatment-center philosophy, following 12-Step goals but being far more rigid, often excludes people from their treatment program if they fail to maintain their sobriety. So it was natural for housing programs to follow a treatment philosophy that is abstinence based. However, the provision of adequate housing could serve as an incentive for addicts to become clean and sober. And the enforcement of abstinence would ensure a sober environment for other residents.

Another reason for the preference for the requirement of abstinence in order to obtain housing may be prejudice against the kind of client that would be attracted to non-abstinence-based services because among mentally ill chemical abusers, the homeless constitute the largest and most problematic subgroup, placing unique demands on the mental health- and drug-treatment systems. Few practitioners previously would have chosen to work with such a troublesome group. Also, in many cases, organizations may simply lack the skills to accommodate persons with co-occurring disorders, or they may prefer to work with less challenging clients.

Indeed, few organizations have made it their mission to provide supportive housing to this subset of the homeless population. “Wet” programs utilize a flexible atmosphere while providing close monitoring and motivational or client-centered techniques. Such strategies are of proven effectiveness for work with this hard-to-treat population (Mueser et al., 2003). These organizations incorporate a harm-reduction approach in their policies and practices. *Harm reduction* is defined as “a set of practical strategies that reduce negative consequences of drug use, incorporating a spectrum of strategies from safer use, to managed use to abstinence” (Harm Reduction Coalition, 2008).

**THE PORTLAND STUDY**

While working in Seattle as a case manager with clients with co-occurring disorders (mental illness and chemical dependency), the first author of this paper discovered firsthand how difficult it was to find housing for this population. Many of his clients had been homeless for long periods of time due to the shortage or lack of appropriate housing. Although many of the supportive housing programs in Seattle that did accept people with co-occurring disorders
required total abstinence, the place where the first author worked (The Downtown Emergency Services Center) was a pioneer in providing permanent housing to the “worst of the worst” of the mostly alcoholic homeless mentally ill.

To determine the availability of similar supportive housing for persons with co-occurring disorders in the nearby city of Portland, the first author designed a simple questionnaire. The selection of Portland was potentially intriguing because this area has a reputation for innovative and progressive policies such as physician-assisted euthanasia of terminally ill persons (see Oregon Politics by Clucas, Steel, & Hankels, 2005). The study basically asked key persons in the mental health and housing sector of the community what the need was for supportive housing and how that need was being met. The response rate was low, at 38%, or 8 of 21 informants consulted; it was low presumably because of the controversial nature of the issue of providing housing to alcoholic and otherwise addicted individuals who continued to drink or use drugs.

Most of the respondents were administrators of agencies dealing with housing, AIDS, mental health, and substance-abuse issues. One respondent was a resident. Six of the eight participants indicated they believed there was a need for non-abstinence-based supportive housing that was not being met.

Sample comments include (from a housing program manager), “I often hear of the need for ‘wet’ housing.” A supervisor at a substance-abuse agency whose work involves licensing supportive housing projects stated, “All of the facilities have house rules that prohibit the use of alcohol and/or non-prescribed drugs on the premises.” A resident of a treatment-based establishment noted:

The need is unmet and great. Go check the people at the Camp of Last Resort under the north side of the Morrison St. Bridge to verify my answer. Many people there have been kicked out of this place for substance abuse on the premises.

In addition to the above comments, all of which relate to the need for, or lack of, non-abstinence-based supportive housing, other participants indicated that policy changes were beginning to occur. For example, one supervisor of a residential facility wrote: “Our center has two large programs that are considered ‘wet/damp’ housing. This is a significant change for these programs that has resulted in many complex problems.” Very significantly, the program manager of a housing department made the following comment:

There is a need for all kinds of supportive housing in Multnomah County. We are in the process of creating 400 new units for chronically homeless people; some will be clean and sober, some will be wet or damp housing, but all will come with necessary housing and services tailored to people in need of this type of housing.
New Directions in Portland

In 2003, about the time the study was conducted the city of Portland, at a moment when the homeless-living-on-the-streets problem was overwhelming city agencies and threatening the tourist trade, city and county leaders developed a 10-year plan (The National Alliance to End Homelessness, 2005). Called Home Again: A Ten-Year Plan to End Homelessness in Portland and Multnomah County, the purpose of the plan was to provide permanent housing in conjunction with needed medical and social services for the most chronically homeless population. The model that would be used was the non-abstinence-based housing-first model. The Community Engagement Program, an earlier recipient of government funding for a non-abstinence-based project to provide housing, then got further support and funding from the city to continue the program on a large scale.

Thomas Moore, the external evaluator who directed an extensive, empirically based evaluation of the project, whom we interviewed, published his findings, and they are widely cited in the literature (Moore, 2006). Moore’s research determined that the city of Portland saved $15,006 per person annually in providing housing to frequent users of emergency departments and public safety systems. Now 1200 units of low-income housing are provided in Portland for homeless people with mental illness. The savings are considerable. This calculation was based on the costs of the program, including housing and social and medical services that were incurred by a homeless person living on the streets and in shelters subtracted from the pre-enrollment costs to the community for one year. It is because of such cost savings to the city and the government that these housing-first programs have won acceptance nationwide. So is it true that there is a paradigm shift toward harm reduction in the form of non-abstinence-based housing?

In 2007, interviews were conducted with the program director of the Community Engagement Program (CEP), the project director for the chronic homeless initiative, and the program evaluator of CEP, Thomas Moore. Our goals were to determine whether indeed a shift in public policy regarding treatment philosophy had taken place over the past few years.

All three individuals showed great enthusiasm about the direction and success of the program. As stated by Sarah Goforth, the program’s director:

I think the whole country is in the middle of a shift. The push from the federal government is to get chronically homeless folks off of the streets. Housing First has been a hard thing to get people to fund or accept. The results are in several states that this approach does work. However, it requires a lot of supportive services. [The Downtown Emergency Service Center] DESC has supportive services or their latest project would be a disaster. Cities and states and the feds want to give housing money but it is next to useless unless it comes with services match. . . . In Portland we are very fortunate to have local government support CEP.
The project director and grants manager, Claudia Krueger, concurs:

The paradigm is shifting, and it has been a difficult one for our agency, which employs about 80% people in recovery. That is the hardest group of people to convince that a Housing First approach has merit. The beauty, however, is in seeing people succeed who were completely written off by all the traditional treatment agencies. There are people who have been able to embrace recovery after they have a chance to get off the streets. And others who have been able to significantly improve their quality of life and health status, even though they continue to use. Those are success stories, too.

INNOVATIVE PROGRAMMING ACROSS THE UNITED STATES

So what is happening nationwide? A survey of the literature reveals that a great deal is happening in the field of housing-first initiatives. The Anishinabe Wakiagun and the Glenwood, both in Minneapolis, are leading examples of "wet" (abstinence is not required) supportive housing projects in the United States. A search of the literature reveals the following exemplary non-abstinence-based programs for persons with mental illness and substance abuse issues—Anishinabe Wakiagun, Minneapolis; Pathways to Housing, New York City; Canon Barcus Community, San Francisco; and Downtown Emergency Service Center, Seattle.

Anishinabe Wakiagun is a non-abstinence-based program geared to the needs of late-stage, chronic inebriate Native Americans who would not otherwise have roofs over their heads. One of the measurement goals is to reduce the number of emergency room visits by the residents. Funding comes primarily from the state and county; follow-up evaluation research shows considerable savings in health and incarceration costs to the state and county as the result of the work at this facility. The program includes intensive staffing 24 hours a day, a manager, and an on-site free health care clinic (American Indian Community Development Corporation, n.d.; Corporation for Supportive Housing, 2005).

The ideology, as stated on the Pathways to Housing website is: “We believe not only that housing is a basic right but also that people have the inherent ability to improve their lives” (Tsemberis, 2007). Pathways to Housing, which was founded in 1992, offers scattered-site permanent housing to more than 1000 homeless individuals who have psychiatric disabilities and addiction. Priority is given to women and elderly persons who are neediest. Sobriety and treatment for mental disorders are not conditions of support because housing is seen as a right, not a privilege. This program finds the housing in privately owned apartments. Residents typically have income from disability payments (SSI and SSDI), according to the website (Corporation
for Supportive Housing, 2004). The proven 85% retention rate of residents is far superior to that achieved by traditional programs (Jensen, 2005). A similar offering exists on a much smaller scale in North Chicago, where BE-HIV provides housing to men and women who have been homeless, are living with HIV/AIDS, and are currently using alcohol and/or drugs. The program has been replicated in more than 30 American cities and across the globe—for example, in regions of Japan, Canada, the Netherlands, Spain, and Portugal (Tsemberis, 2007).

Operating from a harm-reduction philosophy, the Canon Barcus Community House in San Francisco is owned and operated by Episcopal Community Services. Residents have special needs related to substance abuse combined with serious mental disorders and/or AIDS. Funding is provided by the church and by public loans and grants. Intensive staffing is provided 24 hours a day (Corporation for Supportive Housing, 2004).

DESC, where the first author has been employed as a social worker for seven years, is an innovative program that has offered housing to homeless persons with serious mental health disorders since 1996. DESC’s innovative programming includes housing and intensive case management services for “chronic public inebriates” in the Seattle region. They provide housing to persons who, as chronically homeless persons with serious mental disorders, had cost the most to the community in medical care, jail lock-up, and other emergency services. DESC maintains hundreds of units and offers close supervision to individuals struggling with recovery from addictive disorders and mental illness on an ongoing basis. Funding comes from federal and private grants, for example, the Bill and Melinda Gates Foundation. Individuals receive financial monitoring of their income from SSI and SSDI. On-site clinical support specialists, most of whom are professionally trained social workers, develop individualized service plans and strategies to support healthy living practices. Staff members are on duty around the clock to ensure building security and to provide crisis management and intervention (Downtown Emergency Service Center, 2009).

DESC’s harm-reduction program has often operated within a hostile milieu, however. To understand actions the city has taken against “street people,” see www.signsofhomelessness.org. A recent article in The New York Times (Kowal, 2006) described Seattle’s program as one for the unsympathetic homeless and noted that it is a program that is widely criticized on radio talk shows as “bunks for drunks.” The highly controversial program has been vociferously criticized on national television, too (for example, by talk show hosts Glenn Beck and Bill O’Reilly). Nevertheless, DESC is also a program that has the active support of HUD, including endorsement of the housing-first, harm-reduction policies, which are understood to be cost-effective, pragmatic remedies. As described in the article in The New York Times,
These apartments fit into the “housing first” philosophy, newly adopted by many cities, intended to give permanent housing and intensive services to long-term homeless people. Local officials have already approved other buildings for the mentally ill and people with chronic medical conditions, said Adrienne Quinn, director of Seattle’s Housing Office.

A third of the residents . . . are American Indian; an estimated 20 percent are military veterans. The average age is 45. Most receive state or federal disability payments, and all residents pay 30 percent of their income as rent under HUD’s guideline for low-income housing.

By choice, or if they need frequent medical attention, 26 residents live on the first floor in office-sized cubicles. (Kowal, 2006)

What is remarkable about all of this programming is that it was formulated and funded under the conservative Bush administration and existed side by side with federal policies of zero tolerance for illicit drug use. In terms of treatment philosophies, housing first represents a paradigm shift of sorts. This after-the-fact remedy does not get at the root causes of homelessness, however, so it is not really a solution to chronic homelessness, nor is it a solution to homelessness in general. No progressive social worker would argue against the transition to harm-reduction strategies, a transition we applaud from a humanitarian standpoint, but the rationale for the services is not really humanistic. This programming is funded and endorsed for purely mercenary reasons—to save the cities from the expenses of cleaning up, treating, and locking up the people who live on the streets. There is no sense of providing housing because it is right or because it is a right.

**A HUMAN RIGHTS PERSPECTIVE**

Arguments based on cost-effectiveness carry weight with conservatives as well as progressives and are effective in the short term for a limited population. Such programming does little, however, to protect the bulk of homeless people from being denied housing or from discriminatory statutes that lead to repeated arrests and “sweeps” to break up homeless communities. Homelessness will be eradicated only through official recognition of housing as a human right.

Community organizers such as the Kensington Welfare Rights Union (KWRU) in Philadelphia argue that housing is a human right under Article 25 of the Universal Declaration of Human Rights (1948). This Article states, “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services.” In its continuing campaign, KWRU has been recognized internationally for its
outstanding human rights work in the United States (Feemster, 2004). The U.S. Congress ratified only those parts of the United Nations Declaration that are consistent with the U.S. Constitution and the International Covenant on Civil and Political Rights. The United States has signed but not ratified the latter portion of the document that is relevant to housing rights—the International Covenant on Economic, Social, and Cultural Rights. This means that the country recognizes such rights but is not legally bound to provide them.

KWRU is the lead organization in the Poor People’s Economic Human Rights Campaign, whose mission it is to end poverty in the United States (Bricker-Jenkins, 2004). Members of KWRU view themselves as allies of the poor instead of advocates; they take a collaborative and empowerment approach to helping people help themselves and to helping them organize so they can help others. KWRU adopts a human rights framework as a means of transforming private social ills into public issues (Bricker-Jenkins, Young, & Honkala, 2007).

Economic arguments that point out cost-effectiveness have been used in combination with a human rights focus by Los Angeles city and county officials to establish housing as a human right (Jarvis, 2008). A 10-year plan to end homelessness, Bring Los Angeles Home, has been “established on the ideals set forth in that Universal Declaration of Human Rights” (p. 429). But unfortunately, as indicated by Jarvis, who is a legal researcher, even in Los Angeles, the rights acknowledged on paper have been breeched in practice. The city continues to arrest individuals and subject them to cruel and unusual punishment.

CONCLUSION

Strides are being made to provide housing for one category of homeless people—those who are chronically mentally ill. All across the United States today, one city after another is turning to housing-first programming, a remarkable development given the dominant attitudes of society that relate to the notion of the “deserving” and the “undeserving” poor in conjunction with what was, until recently, called the war on drugs.

Harm reduction and housing first are models that are compatible with human rights. As an ideology, harm reduction is geared toward the public health of all citizens. Absent an acceptance of housing as a basic human right, the rationale for the provision of supportive housing has been its cost-effectiveness for the community. This rationale, however, is limited. It is limited to the provision of services to only the most destitute and physically ill, persons whose expenses to the city and county are the most extreme. And this argument depends on a situation in which the homeless individual’s needs have not been met over a considerable period of time. Providing such late-stage treatment is certainly better than no treatment at all, but it
fails to get at the root causes of the problem. Meanwhile, the shelters will be overflowing with more recent victims of homelessness.

Official endorsement of housing as a human right would represent a true paradigm shift and would be a major contribution to the public health of the nation. A human-rights focus shifts the emphasis from the needs of the individual to the rights of the individual and can be an effective tool in challenging governments to address social problems. In the language of human rights, the government would have an obligation to see that adequate housing is available to all people and to provide supportive housing for persons with serious disabilities. Were the U.S. Congress to ratify the International Covenant on Economic, Social, and Cultural Rights, housing-first policies would receive the sanction of human rights law.

REFERENCES


